



RED FLAGS BERMUDA

A QUICK REFERENCE GUIDE FOR CHILD DEVELOPMENT IN THE EARLY YEARS

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



earlyyearsnurturingbda.org



**EARLY YEARS NURTURING
BERMUDA**

c/o Bermuda Registered Charity #948

(Last updated: August 2024)





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It is not a formal screening, assessment or diagnostic tool.

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For more information about this guide, please contact Early Years Nurturing Bermuda at info@earlyyears nurturingbda.org.

TABLE OF CONTENTS

Disclaimer Notice 1

INTRODUCTION 3

Introduction to the Red Flags Bermuda guide..... 4

Why early identification impacts the successful transition to school 5

How to talk to parents/caregivers about concerns 6

Duty to report 7

DOMAINS 8

Abuse and neglect..... 9

Anxiety 12

Attention difficulty and/or hyperactive behaviour..... 14

Autism spectrum disorder (ASD) 15

Behaviour 17

Dental and oral health..... 19

Feeding skills 20

Fetal Alcohol Spectrum Disorder (FASD) 21

Fine motor skills 22

Gross motor skills 23

Hearing 25

Learning disabilities 27

Maternal mental health 28

Mild traumatic brain injury (concussion)..... 29

Nutrition 30

Prematurity 32

Regulation 33

Relationship and attachment 34

Resilience..... 36

Selective mutism 37

Sensory..... 38

Sleep..... 39

Social/emotional..... 40

Speech and language..... 41

Tobacco smoke (second- and third-hand) 44

Vision..... 45

RESOURCES..... 46



INTRODUCTION

INTRODUCTION TO THE RED FLAGS BERMUDA GUIDE

What is the *Red Flags Bermuda* guide?

Red Flags Bermuda is a quick reference tool to assist early years professionals, parents, primary caregivers, and members of the community in knowing when and where to refer children from birth to the age of six years for whom there are potential health, growth, and development concerns.

It has been adapted to make information on available resources in Bermuda more accessible to members of the public, as well as to early years professionals for whom the original Red Flags tools, worldwide, were developed.

Red Flags Bermuda hopes to assist individuals in identifying when children could be at risk of not meeting their expected health outcomes or developmental milestones. It also includes other areas that may impact child health, growth, and development due to the dynamics of parent-child interaction, such as maternal mental illness, abuse, etc.

Red Flags Bermuda allows individuals to review and better understand, on a continuum, the domains that are traditionally outside of their own area of expertise.

This guide is evidence-informed. References are indicated in the endnotes.

The purpose and goal of the *Red Flags Bermuda* guide

The purpose of Red Flags Bermuda is to promote the early identification of children who may be in need of additional resources to meet their developmental milestones and expected health outcomes.

The goal of Red Flags is to ensure that all children in Bermuda are able to achieve their optimal developmental and health potential.

How to use the *Red Flags* guide

- If children are not meeting the milestones for their specific age, further investigation is strongly recommended.
- Refer for further assessment even if you are uncertain whether the red flags noted are a reflection of a cultural variation or a real concern
- Note that some of the indicators focus on the parent/caregiver or the interaction between the parent/caregiver and the child, rather than solely on the child
- If a child appears to have multiple domains requiring formal assessment by several disciplines, it is encouraged to refer to all of the appropriate agencies
- Contact information in Bermuda can be found at the end of each domain under **Where to go for help**. The most up-to-date list of resources can be found at earlyyearsnurturingbda.org or the Government of Bermuda's helpingservices.bm.
- If referrals are made to private sector agencies, alert families that they will be responsible for costs incurred

Acknowledgements

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WHY EARLY IDENTIFICATION IMPACTS THE SUCCESSFUL TRANSITION TO SCHOOL

“Children are competent, capable of complex thinking, curious and rich in potential. They grow up in families with diverse social, cultural and linguistic perspectives. Every child should feel that he or she belongs, is a valuable contributor to his or her surroundings, and deserves the opportunity to succeed.”¹

Starting school is a significant milestone in the life of a family. There are many factors that contribute to a child’s transition to school and ongoing success. The child’s capacity to learn when they enter school is strongly influenced by the neural wiring that takes place in the early years of life.² By doing everything possible to enhance early development, a child can be provided with an equal opportunity to maximize their potential.³

Current brain research shows that children’s capacity for deep learning begins prior to birth with 700 neural connections being made every second in the first three years of life.⁴ The first years of a child’s life are a period of heightened opportunity and also a time of increased risk that can compromise optimal development for life.²

To maximize early potential, **How Does Learning Happen?** establishes four foundational conditions or “ways of being” for children that optimize their learning and healthy development:

- **Belonging:** a sense of connectedness and relationship to others
- **Well-Being:** a state of mental wellness and physical health
- **Engagement:** a sense of involvement, curiosity and wonder
- **Expression:** the ability to communicate for different purposes and in different ways

When these four foundations are the focus of children’s early experiences both at home and in the community, children are supported in the development of:

- Playing and getting along with others
- Talking, listening, questioning and problem solving
- Making decisions
- Creating, building, exploring, wondering, investigating and sharing
- Showing interest in symbols and text
- Feeling comfortable in new places
- Demonstrating self-help and self-regulation skills¹

These above skills and abilities contribute to a child’s successful transition to school.

Why the *Red Flags* guide?

Sometimes there are areas of a child’s growth and development that are delayed or not progressing as expected, which can hinder the child’s advancement in these skills and abilities.

A ‘wait and see’ approach can be detrimental. Early identification of possible concerns in a child’s development will lead to early referral, assessment and intervention, ensuring that they start school at their full potential, ready to learn.

The community collectively wraps around children and their families and builds on their strengths.

The community also comes together to provide support and services when the progression of a child’s development differs from what is anticipated.

The Red Flags guide has been developed to identify those children who need extra support. If there are concerns about a particular area(s) of development for a child, refer to the appropriate domain in this guide (see **Table of Contents**).

HOW TO TALK TO PARENTS/CAREGIVERS ABOUT CONCERNS

Sharing sensitive news

One of the most challenging issues for a health care or early years professional working with young children can be relaying concerns about a child's health or development to a parent or caregiver. When a potential concern is identified, either by observation or screening, the family should be notified so that positive next steps can be taken. In these circumstances, effective communication is essential. It can be very difficult to relay these concerns to parents and caregivers; however, for a child to reach his or her full developmental potential, it is important to have these conversations. If concerns are presented in a positive and caring manner, this will build trust between the professional and the family.⁶

Sharing sensitive news can be challenging both for the family and the person delivering the news. Upon receiving this information about their child, the parent/caregiver may react with a range of emotions including shock, anger, disbelief, fear and sometimes relief at having their observations and questions about their child acknowledged.⁶

Although no single way works best, there are some things to keep in mind when addressing concerns with a family. The following framework will provide some tips and encouragement for sharing concerns in a clear, informative and supportive manner:

Prepare for a successful conversation

- Know the facts
- Plan to meet face to face
- Meet in a private location
- Allow plenty of time without interruptions⁷

Share the information

- Begin by sharing the child's strengths and positive behaviours⁸
- Ask the parents/caregivers what they know about their child's development^{6,7}
- Remember and remind parents/caregivers that they know their child best⁸
- Share observations/concerns that have been noted about the child's development⁸
- Highlight the expected developmental milestones for the child's age⁸
- Show concern and compassion⁸
- Explain the consequences of not taking action such as the wait and see approach^{6,8}
- Explain the range of possibilities for supporting the child such as referral, assessment, intervention, etc.⁸

Plan for next steps

- Thank parents/caregivers for their support
- Provide available resources for further reading and information
- Ensure that your concerns have been documented and that there is a plan for follow-up action
- Empower the parents/caregivers by enlisting their support to plan a course of action regarding next steps for their child
- Allow time for questions and concerns by the parents/caregivers
- Provide parents/caregivers with available resources such as brochures or contact information⁸

Presenting information in this manner lends credibility to the concerns identified.^{6,7}

DUTY TO REPORT

The saying “it takes a village to raise a child” is never more true than when we talk about protecting children. Keeping the most vulnerable members of our community safe is everyone’s responsibility. Knowing when a child is at risk and in need of protection is important for all adults in Bermuda; however, it’s especially important for professionals who work with children in the early years of life. These professionals share the responsibility of keeping children safe and promoting their welfare.

We all share a responsibility to protect children from harm. This includes situations where children are abused or neglected in their own homes. Bermuda’s Child and Family Services provides protection for these children. The public, including professionals who work with children, should promptly report suspicions that a child is or may be in need of protection to a children’s aid society like Child and Family Services. The phrase “child in need of protection” often refers to physical, sexual, and emotional abuse, as well as neglect and risk of harm. These are such occurrences, to be reported. For more information, refer to the Abuse section in this guide.

Who is responsible for reporting a child in need of protection?

Anyone with reasonable grounds to suspect that a child is or may need protection should promptly report the suspicion (and the information upon which it is based) to a children’s aid society.

What are “reasonable grounds” to suspect child abuse or neglect?

It is not necessary for you to be certain a child is or may be in need of protection to make a report to a children’s aid society. “Reasonable grounds” refers to the information that an average person, using normal and honest judgment, would need in order to decide to report.

What is a child?

For legal purposes, a child is usually regarded as a person under seventeen years of age.

How and when should a report be made?

Abuse or neglect should be reported as soon as you suspect it - 24 hours a day, seven days a week. A phone call could bring immediate help to a child at risk. It is not your responsibility to determine whether abuse or neglect has occurred. The Bermuda Police Service and Child and Family Services are responsible for the investigation and assessment of abuse and neglect of children, as well as the ultimate management of a case when a child is taken into care. **Contact authorities immediately if you have concerns about a child!**

IF A CHILD IS IN IMMEDIATE DANGER CALL 911

Child Abuse Hotline: 278-9111

Bermuda Police Service: 211 or 295-0011

Some more key facts about child protection and how to report a concern about the welfare of a child can be found at:

www.police.bm/content/what-child-abuse#1

www.scarsbermuda.com/reporting-abuse/mandatory-reporting/



DOMAINS

In alphabetical order

ABUSE AND NEGLECT

What is abuse?

Child abuse has many faces, and while all abuse hurts, different kinds of abuse can hurt in different ways. Below are the definitions of each type of abuse as well as their possible indicators. Abused children do not always show obvious warning signs of abuse or neglect, but sometimes there are subtle indicators. Know the subtle signs of abuse and if you have any concerns at all about a child, contact authorities.

Physical abuse¹⁶

Physical abuse occurs when a child is at risk of or has suffered physical harm inflicted by a person having charge of the child. It also occurs when a person fails to adequately supervise, protect, care for or provide for a child. Physical abuse also includes a pattern of neglect in supervising, protecting, caring for or providing for a child. Physical abuse can be one or two isolated incidents or can occur over a prolonged period of time.

Sexual abuse^{16*}

Sexual abuse occurs when a child is at risk of or has been sexually molested or sexually exploited by a person having charge of a child or by another person. It also occurs when the person having charge of a child knows, or should know, of the possibility of sexual molestation or exploitation by another person and fails to protect a child. Sexual abuse includes sexual touching, engaging in sexual activity with a child, exposing genitals to a child, and incest.

Emotional abuse¹⁶

Emotional abuse occurs when a child is at risk of or has suffered emotional harm demonstrated by serious anxiety, depression, withdrawal, self-destructive or aggressive behaviour or delayed development and there are reasonable grounds to believe this harm results from the actions, failure to act or pattern of neglect by the person having charge of the child. It also occurs when a child exhibits the above serious behaviours and the person having charge of the child does not provide services or treatment to alleviate the harm. Emotional abuse can also include exposure to domestic violence. Emotional abuse happens when a caregiver treats a child in an extremely negative way that damages self-esteem and the concept of “self.” This type of behaviour might include constant yelling, demeaning remarks, rejection or isolation, or exposing a child to domestic violence.

Neglect¹⁶

Neglect occurs when a child is at risk of or has been harmed as a result of the caregiver’s failure to adequately supervise, protect, care for or provide for a child. It also occurs when a child has a medical, mental, emotional or developmental condition that requires services or treatment and the person having charge of the child does not provide these services or treatment.

Most parents and caregivers don’t intend to neglect their children. Instead, neglect is usually the result of ignorance about parenting and an inability to plan ahead. When a caregiver fails to provide a child’s basic needs like food, sleep, safety, supervision, appropriate clothing or medical treatment on a consistent basis, this is neglect.

In addition to the above forms of abuse and neglect, there are other forms of abuse which may be overlooked. These include abandonment/separation, caregiver incapacity, and domestic violence. It is important to consider these in addition to the above forms of abuse and neglect.

Abandonment/separation¹⁶

Abandonment/separation occurs when a child has been left alone unsupervised or when a parent has died or is unavailable to exercise his or her custodial rights over a child and has not made adequate provision for a child’s care and custody. It also occurs when a child is in residential placement and the parent refuses or is unable or unwilling, to resume the child’s care and custody.

Caregiver incapacity¹⁶

Caregiver incapacity is when, although no harm has come to a child and no evidence is apparent that a child may be in need of intervention, the caregiver demonstrates, or has demonstrated in the past, characteristics that indicate the child would be at risk of harm without intervention. These characteristics can include a history of abusing/neglecting a child, being unable to protect a child from harm, problems such as drug or alcohol abuse, mental health issues or limited caregiving skills.

Domestic violence¹⁶

(Witnessing family violence)

Domestic violence is characterized by violent or abusive behaviours which occur within the child's home environment. Domestic violence includes but is not limited to partner violence. The violence occurs between the child's parent/primary caregiver and any other adult who resides in or frequents the home. This may include the mother's partner, adult relative, boarder, or anyone else who has a relationship with the family. The frequency and severity (intensity) of violence can range from homicide or a single very serious incident resulting in injuries that require hospitalisation to a pattern of less serious physical violence (e.g. slapping, pushing) and/or a pattern of verbal abuse, threats of harm or criminal harassment.

Domestic violence can have a profound effect on children and may result in or raise the risk of child abuse or neglect.

PROBLEM SIGNS

If a child presents with **one or more** of the following indicators of **physical abuse** consider this a **red flag**:

Behavioural indicators

- Cannot recall how injuries occurred or offers an inconsistent explanation
- Wary of adults
- Cringes or flinches if touched unexpectedly
- Displays a vacant stare (for infant)
- Extremely aggressive or withdrawn
- Indiscriminately seeks affection
- Extremely compliant and/or eager to please¹⁷

Physical indicators

- Injuries such as bruises, welts, cuts, fractures, burns and internal injuries
- Injuries that are not consistent with explanation
- Presence of several injuries that are in various stages of healing
- Presence of various injuries over a period of time
- Facial injuries in infants and preschool children
- Injuries inconsistent with the child's age and developmental phase¹⁷

PROBLEM SIGNS

If a child presents with **one or more** of the following indicators of **sexual abuse** consider this a **red flag**:

Behavioural indicators

- Age-inappropriate play of sexual nature with toys, self or others
- Age-inappropriate sexually explicit drawing and/or descriptions
- Bizarre, sophisticated or unusual sexual knowledge
- Seductive behaviours¹⁷

Physical indicators

- Unusual or excessive itching in the genital or anal area
- Torn, stained or bloody underwear (may be observed if the child needs bathroom assistance)
- Injuries to the genital or anal areas such as bruising, swelling or infection
- Sexually transmitted disease¹⁷

PROBLEM SIGNS

If a child presents with **one or more** of the following indicators of **emotional abuse** consider this a **red flag**:

Behavioural indicators

- Severe depression
- Extreme withdrawal or aggressiveness
- Overly compliant, too well mannered, too neat or too clean
- Extreme attention seeking
- Display of extreme inhibition in play¹⁷

Physical indicators

- Bed wetting that is non-medical in origin
- Frequent psychosomatic complaints, headaches, nausea, abdominal pains
- Failure to thrive¹⁷

PROBLEM SIGNS

If a child presents with **one or more** of the following indicators of **neglect** consider this a **red flag**:

Behavioural indicators

- Pale, listless, unkempt
- Frequent absences from school
- Inappropriate clothing for the weather, dirty clothes
- Frequent forgetting of a lunch¹⁷

Physical indicators

- Poor hygiene
- Unattended physical problems or medical needs such as dental work or glasses
- Consistent lack of supervision¹⁷

Where to go for help

If you suspect child abuse or neglect, you are legally obligated to report to one of the local child protection agencies.

Please immediately call the Child and Family Child Abuse Hotline if the concerns relate to a child protection issue.

Bermuda Police Service: 211 or 295-0011

Child Abuse Hotline: 278-9111

IF A CHILD IS IN IMMEDIATE DANGER CALL 911

A list of additional child protection agencies and community services is available at www.earlyyearsnurturingbda.org.

Note: For related medical issues, contact the primary health care provider. Acute injuries may require that the child be taken to the emergency department at the nearest hospital.

ANXIETY

Anxiety disorders in children range from 2.4 per cent to 17 per cent.¹⁸ Research suggests that there can be long-term implications of experiencing anxiety in childhood, including an increased risk for additional diagnosis, mental health challenges in adulthood, as well as lower functioning in academic performance, peer relationships and family relationships.^{19, 20, 21}

It is important to note that mild fears and anxiety are part of normal human development. The number of fears that children experience typically decreases as children mature.²² Although childhood fears can be normal experiences, it is important to pay closer attention to experiences of anxiety that are exaggerated and beyond what one would expect given a situation.²³

Symptoms of anxiety that become more intense and more extensive and that interfere with a child's school, peer or family functioning may warrant mental health interventions. When overly anxious, most children exhibit physical symptoms, including increased heart rate, increased breathing, sweating, nausea, stomach aches, headaches, etc., as well as some form of avoidance of situations, people or objects that cause anxiety.²⁴

Types of anxiety in children

Specific phobias

Children with specific phobias have fears that are specific to a particular situation or object. In general, these children try to avoid contact with the situation or object. Examples of specific phobias include dogs, the dark, spiders, storms and injections.^{18, 23}

Separation anxiety

Children with separation anxiety exhibit an excessive fear related to being away from a main caregiver, most commonly the child's mother. They often fear that something terrible will happen to a parent while they are apart and they will never see the parent again. At times, significant life stressors can trigger separation anxiety, such as a change in schools, a move or the death of a relative.^{16, 21}

Generalized anxiety

This is a condition in which the child has many worries and fears. Children with generalized anxiety are often described by parents as “worrywarts.” Worries can be in the areas of health, schoolwork, sports performance, bills, burglaries, etc. New situations often provoke an anxiety response.^{16, 21}

Social anxiety

Children with social anxiety exhibit a fear of situations in which they will have to interact with others or be the focus of attention. At the core of social anxiety is a fear of being embarrassed, humiliated or rejected. Typical feared situations include meeting new people, talking on the telephone, joining team sports and talking at school or preschool.^{16, 21}

PROBLEM SIGNS

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

- Consistent avoidance of a specific feared situation or object
- Emotional dysregulation or panic in the presence of the feared situation or object
- Upset beyond what is expected when separated from primary caregiver
- Child expression of concern about primary care- giver being hurt or getting sick
- Refusal to sleep at other people's homes if own parents are not there
- Complaints of stomach ache, feeling sick or other somatic symptoms in anticipation of being separated from caregiver
- Difficulty staying or going into a room by them- selves, "clinging" behaviour, staying close to and "shadowing" the parent around the house
- Difficulty at bedtime and possible insistence that someone stay with them until they fall asleep
- More than usual fear in new situations
- Fear of making mistakes and not performing well
- Child asks lots of questions and often seeks reassurance from parents
- Worries more than usual after seeing a scary movie or watching a news program
- Shyness
- Difficulty joining in activities and making new friends
- Avoids speaking to new people or answers with brief responses
- Worries that someone will laugh at them or that they will be embarrassed
- Dislikes being centre of attention^{18, 23}

Where to go for help

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

- Their family physician/paediatrician
- Child Health Services 278-6460
- Child Development Programme
Ages: Birth to 4 years
295-0746
- Child and Adolescent Services (MAWI)
Ages: 4-18 years
239-6344
- Private psychological/behaviour support services

A list of additional public & private agencies that can help is available www.earlyyearsnurturingbda.org, in the 'Resources' section.

ATTENTION DIFFICULTY AND/OR HYPERACTIVE BEHAVIOUR

A child should be referred for assessment if his/her patterns of attention and/or hyperactivity difficulties interfere with functioning or development; demonstrate symptoms in more than one setting; and negatively impact social, academic, or work functioning in a direct way. Some symptoms must be present before age 12.²⁵

Attention difficulties and/or hyperactive behaviours can be seen at times in all typically developing children, so it is important to consider the following prior to making a referral for assessment:

- The child's developmental age, e.g. children under the age of 18 months are generally not formally assessed for attention difficulty and/or hyperactive behaviour; attention span and self-regulation naturally vary in early childhood years
- Situational factors such as stress, time of day, boredom, sleep and diet
- Environmental factors such as family disruption, life changes and cultural influences

There are other developmental/mental health issues that can present with attention difficulty and/or hyperactive behaviours including Learning Disabilities, Autism Spectrum Disorder and Anxiety. Refer to the appropriate domains in the guide to determine other possible referrals for the child/family.

PROBLEM SIGNS

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

Ages 18 months to 5 years

- Unable to concentrate or pay attention for periods of time
- Restless or unable to sit still
- Poorly co-ordinated or clumsy
- Shifts quickly from one activity to another
- Wanders away²⁶

Ages 4 to 6 six years

- Easily distracted e.g. has difficulty paying attention or listening to the speaker, easily sidetracked
- Excessive levels of activity i.e. hyperactive e.g. has difficulty sitting still, fidgets often regardless of activity
- Impulsive e.g. runs into traffic, takes risky actions without thinking, has difficulty taking turns, interrupts/blurts things when asked not to, talks excessively
- Disorganized e.g. has problems organizing personal belongings, loses things often, has difficulty following schedule or difficulty remembering routines/explanations²⁷

Where to go for help

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

- Their family physician/paediatrician
- Child Health Services 278-6460
- Child Development Programme
Ages: Birth to 4 years
295-0746
- Child and Adolescent Services (MAWI)
Ages: 4-18 years
239-6344
- Private psychological/behaviour support services

A list of additional public & private agencies that can help is available www.earlyyearsnurturingbda.org, in the 'Resources' section.

AUTISM SPECTRUM DISORDER (ASD)

Autism spectrum disorder (ASD) is a lifelong developmental disorder characterized by impairments in social communication and the presence of repetitive and stereotyped behaviours. ASD is often associated with other developmental, health and behavioural challenges such as language impairment, uneven cognitive and adaptive skills, seizures, and attention deficit hyperactivity disorder (ADHD).

See the following domains in this guide for more information and other possible referrals:

- **Attention difficulty and/or hyperactive behaviour**
- **Behaviour**
- **Regulation**
- **Sensory**
- **Social/emotional**
- **Speech and language**

The severity of symptoms for ASD can vary widely; however, all individuals with an ASD diagnosis have impairments in the ability to function in social settings and often in many other areas in daily life.

PROBLEM SIGNS

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

Social concerns

- Does not smile in response to another person
- Poor/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 or lack of varied, spontaneous make-believe play
- Prefers to play alone i.e. decreased interest in other children
- Poor interactive play
- Regression i.e. any loss of social skills at any age
- Prefers to do things for them self rather than ask for help
- Awkward or absent greeting of others

Communication concerns

- Delayed or atypical language
- Unusual language e.g. repeating phrases from movies, echoing other people, repetitive use of phrases, odd intonation (echolalia)
- Inconsistent response or lack of response to their name or instructions i.e. may respond to sounds but not language
- Decreased ability to compensate for delayed speech by gesturing/pointing
- Poor comprehension of language (words and gestures)
- Regression i.e. any loss of language skills at any age (regression), particularly between 15 and 24 months
- Inability to carry on a conversation

Behavioural concerns

- Repetitive hand and/or body movements e.g. finger wiggling, hand and arm flapping, tensing of fingers, complex body movements, spinning, jumping
- Severe repeated tantrums due to interruption of routine, interruption of repetitive behaviour or unknown reasons
- Unusual sensory interests e.g. visually squinting or looking at things out of the corner of the eye, smelling, licking, mouthing objects, hyper-sensitive hearing
- Narrow range of interests in which they engage repetitively
- Insistent 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 i.e. high or low tolerance

Where to go for help

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

- Their family physician/paediatrician
- Child Health Services 278-6460
- Child Development Programme
Ages: Birth to 4 years
295-0746
- Child and Adolescent Services (MAWI)
Ages: 4-18 years
239-6344
- BASE (Bermuda Autism Support & Education):
505-9147
- Beyond Inclusion: beyondinclusionbda@gmail.com
or www.beyondinclusionbda.com
- Private psychological/behaviour support services
- Tomorrow's Voices - Bermuda Autism Early Intervention
Centre: 297-4342

A list of additional public & private agencies that can help is available www.earlyyearsnurturingbda.org, in the 'Resources' section.

BEHAVIOUR

All children engage in challenging behaviour from time to time, which may or may not persist or be of concern. Behaviour is often a child's way of communicating their wants and needs and, in some cases, may be their only method of communication.²⁸ Children make their needs known through observable actions. For example, a child may indicate with gestures that they want a certain item or don't want something they've been given, that they want more or less of your attention or that of a peer, that they don't want to do a certain task or to go to a particular place, or that they don't want to stop doing an activity that they are enjoying.

Behaviour is also a child's way of telling their caregiver that he or she is in physical pain or discomfort, tired, hungry or ill.²⁹

Generally, a child demonstrates certain behaviour in the presence of certain people and not others, in specific situations or environments, and under some conditions while not in others.³⁰

When determining if a behaviour is of concern, it is important to keep in mind the context, age and stage of the child, as well as to ascertain if there is an explanation for the behaviour.³¹

When challenging behaviour happens many times each day, for long periods of time, or presents an immediate risk to the child or others, it may require assessment and intervention from a professional.

PROBLEM SIGNS

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

Self-injurious behaviour

- Bites self; hits self; grabs at self
- Picks at skin; sucks excessively on skin; bangs head on surfaces
- Eats/ingests inedible items
- Vomits when no obvious illness³¹

Aggression towards others

- Hits; kicks; scratches; bites; pulls hair; pushes; shoves
- Cruelty to animals
- Throws objects at a person³¹

Property destruction

- Bangs, throws, slams, breaks objects
- Sets fires³²

Difficulties with social behaviour

- Unable to remain on task for specified length of time³²
- Excessively energetic or physically overactive³²
- Restless; unable to sit still; continuously standing up, sitting down, or moving³²
- Screams; cries excessively; swearing and/or verbal threats³²
- Name-calling³²
- Hoards; steals; lies³²
- Has no friends; socially isolated; will not make eye or other contact; withdrawn³¹
- Anxious; fearful/extremely shy; agitated³¹
- Sudden mood changes; laughs, cries and/or screams for no obvious reason³¹
- Compulsive behaviour; obsessive thoughts; bizarre talk³²
- Undresses in public³¹
- Touches self or others in inappropriate ways³¹
- Advanced/inappropriate knowledge/behaviour of a sexual nature for developmental age appropriateness³¹
- Flat affect, inappropriate emotions, unpredictable angry outbursts³¹

Cooperation

- Refuses to follow instructions; needs several verbal prompts to complete a task
- Difficulty following multiple step instructions
- Runs away
- Resists any form of physical contact including when provided assistance³¹

Life skills

- Deficits in age appropriate skills e.g. eating, toileting, dressing, play, etc.²⁹
- Loss of skill previously mastered²⁹
- Change in typical habits e.g. eating, sleeping, toileting, etc.²⁹
- Difficulty managing transitions/routine changes³¹
- Often needs physical prompting to move or to do things; consistently tired or sleepy³¹

Sleep

- Excessive tiredness e.g. yawning, falling asleep
- Reports nightmares, frequent awakenings
- Late/early bedtimes and awakenings²⁹

Repetitive behaviour (in excess, or in the absence of functional play skills)

- Hand-flapping; hand-wringing; rocking; swaying³¹
- Taps surfaces³¹
- Twirling; object manipulation i.e. lining up toys, spinning wheels, etc.³²

Communication

Limited or no means of communication through:

- Verbal i.e. words
- Augmentative or alternative communicative system e.g. Picture Exchange Communication System, American Sign Language, Proloquo2Go, etc.
- Engages in any of the above behaviours in order to gain access to items or to avoid or leave a situation³¹

If you identify any of the above Red Flags, please also refer to the following domains in this guide for other possible referrals:

- **Autism**
- **Nutrition**
- **Sleep**
- **Speech and language**

Where to go for help

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

- Their family physician/paediatrician or
- Child Health Services 278-6460
- Child Development Programme
Ages: Birth to 4 years
295-0746
- Child and Adolescent Services (MAWI)
Ages: 4-18 years
239-6344
- The Family Centre
Ages: 5-14 years
232-1116
- Private psychological/behaviour support services
- Private counselling providers

A list of additional public & private agencies that can help is available at www.earlyyears nurturingbda.org, under the 'Resources' section.

DENTAL AND ORAL HEALTH

Poor oral health care can result in the development of early childhood caries (ECC). ECC is a severe form of cavities with tooth decay in the baby teeth of children up to six years of age.^{33,34} It is considered to be a chronic disease which affects more than 10 per cent of preschool-age children in Canada.³⁵ ECC often begins on a child's upper front teeth just under the lip.³⁵ Chalky white or brown spots may be signs of caries (tooth decay/cavities).³⁵ ECC can lead to pain, infection, difficulty eating and sleeping, speech problems, poor health and a higher risk of tooth decay in later years.³³ Dental problems in early childhood have been shown to impact general growth and cognitive development and cause poor school behaviour and negative self-esteem.³⁴ Therefore, access to dental care and early development of good oral hygiene habits are important for children.

PROBLEM SIGNS

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

Exposure of teeth to fermentable carbohydrates (foods/liquids that can easily break down into acids) through:

- Too much sugar in diet³³
- Going to sleep or walking around with a bottle or sippy cup containing anything but water³³
- Retaining the nipple in an infant's mouth for prolonged periods when not actively breastfeeding³⁵
- If using pacifiers, dipping them in anything sweet such as syrup, sugar or honey³³
- Long-term use of sweetened medication³³

Physiological factors

- Sharing toothbrushes or utensils or intimate contact such as kissing (this can transfer oral bacteria from parent/caregiver to the child)^{34, 35, 36}
- Lack of exposure to fluoridated water³⁵
- Factors associated with poor enamel development, such as prenatal nutritional status of the mother, poor prenatal health and malnutrition of the child³⁷
- Prematurity or low birth weight (possible enamel deficiencies)³⁷

Other risk factors

- Lack of routine infant oral health care e.g. not wiping baby's mouth and gums after each feeding³³
- Poor oral hygiene e.g. ineffective or infrequent brushing less than twice per day³⁸
- Parent/caregiver not performing tooth brushing or oral health care for child (children up to six years of age are not able to brush or floss effectively, so parent/caregiver has to do it for them)^{33, 38}
- Sibling history of early childhood caries³⁷
- Parent/caregiver with untreated dental disease^{34, 35}
- Lower socioeconomic status^{35, 37, 39}
- Lower education level of parent/caregiver⁴⁰
- Limited access to dental care⁴⁰
- Deficit in the parental/caregiver dental knowledge³⁶
- Use of bottle or sippy cup beyond 18 months³⁴
- No dental visit by age one or shortly after primary teeth begin to erupt^{33, 36, 39}

Note: The Bermuda Dental Association recommends that the first visit to a dentist should occur within six months of the eruption of the first tooth or by one year of age.

Where to go for help

If there are concerns, advise parents/caregivers to contact:

- Their child's dentist
- Dental & Oral Health Clinic - Department of Health 278-6440

A list of dentists and additional public agencies that can help is available at www.earlyyearsnurturingbda.org, under the 'Resources' section.

FEEDING SKILLS

Good feeding skills are an important part of the overall development in childhood. As they progress in a step-wise manner, each depending on the one before, it is important to support and encourage the progression, especially during the early stages.

PROBLEM SIGNS

If a child experiences **one or more** of the following, consider this a **red flag**:

0 to 6 months

- Persistent breast refusal⁴²
- Inability to effectively remove adequate milk from breast when latched well⁴²
- Inability to coordinate sucking, swallowing and breathing during feeding⁴²
- Consistent coughing during feeds that is not caused by the flow being too fast⁴³
- Insufficient weight gain⁴⁴
- Discomfort or apparent pain or fussiness after feeds⁴⁵
- Parent has depressive symptomatology in the early postpartum period (may impact breastfeeding duration, self-efficacy and increase breastfeeding difficulties)⁴⁶

6 to 8 months

- Insufficient weight gain or growth⁴⁴
- Discomfort or apparent pain or fussiness after feeds⁴⁵
- Lack of interest in solid foods
- No transition to solids
- No introduction to cup drinking⁴⁷

9 to 12 months

- Insufficient weight gain or growth⁴⁴
- No transition to a variety of food textures⁴⁷

12 to 18 months

- Insufficient weight gain or growth⁴⁴
- No transition to cup drinking⁴⁷
- Not eating a variety of foods from each food grouping (iron-rich protein foods, whole grains and vegetables and fruit)
- Not self-feeding any table foods (finger foods)⁴⁷

18 months

- Insufficient weight gain or growth⁴⁴
- Not self-feeding a variety of textures⁴⁷

2 years

- Insufficient weight gain or growth⁴⁴
- Not chewing pieces of a variety of food textures and consistencies⁴⁷
- Often coughs while eating or drinking⁴⁸

Where to go for help

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

- Their family physician/paediatrician or
- Health Visitor 278-6460
- Child Health Services 278-6460
- Child Development Programme
Ages: Birth to 4 years
295-0746

A list of additional public & private agencies that can help is available at www.earlyyearsnurturingbda.org, under the 'Resources' section.

FETAL ALCOHOL SPECTRUM DISORDER (FASD)

Fetal Alcohol Spectrum Disorder (FASD) is a term that describes the range of disabilities caused by drinking alcohol during pregnancy. These disabilities can vary from mild to severe.⁴⁹ According to the Public Health Agency of Canada's website, "those affected often have delays in development, intellectual problems and problems in their social lives. Impairments may include: learning disabilities (particularly math), difficulty understanding the consequences of actions, depression, obsessive-compulsive disorder, physical disability such as kidney and internal organ problems and skeletal abnormalities such as facial deformities.

During pregnancy, it is not safe to drink alcohol — any type, any amount, at any time. The only way a person develops FASD is through prenatal alcohol exposure.

FASD is estimated to affect 2-5% of people in Western countries.⁵⁰ FASD is difficult to diagnose and often goes undetected. Diagnostic assessments are typically completed by a multidisciplinary team and include both a medical and a neurodevelopmental assessment.

The following are some characteristics of children with FASD may have:

Infants

- Low birth weight; failure to thrive; small size; small head circumference
- Disturbed sleep; unpredictable sleep patterns/ cycles
- Often trembling and difficult to soothe; may cry a lot
- Problems with bonding
- Weak sucking reflex; little interest in food; feeding difficulties
- Weak muscle tone
- High susceptibility to illness
- High sensitivity to sights, sounds and touch

Preschoolers

- Slow to acquire skills
- Feeding and sleep problems
- Poor motor coordination and poor fine and gross motor control
- Short attention span
- Difficulty following directions or doing as instructed

- Hypersensitivity i.e. irritability, stiffness when held or touched, refusal to brush hair or teeth, over-reaction to injury
- Easily distracted or hyperactive
- Difficulty with changes and transitions; prefers routines
- Receptive and expressive language delays

School-age children

- Sleep difficulties
- Difficulty processing received information
- Difficulty with comprehension e.g. reading
- Ongoing expressive and receptive language delays
- Poor attention span; low impulse control
- Difficulty keeping up as school demands become increasingly abstract
- Consistent repetition needed to learn a skill or to transfer learning from one situation to another
- Ongoing sensory difficulties which may lead to behaviour changes or challenges
- In need of constant reminders

Where to go for help

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

- Their family physician/paediatrician or
- Health Visitor 278-6460
- Child Health Services 278-6460
- Child Development Programme
Ages: Birth to 4 years
295-0746

A list of additional public & private agencies that can help is available at www.earlyyearsnurturingbda.org, under the 'Resources' section.

Resources

Fetal Alcohol Spectrum Disorder Information and Resources Guide for York Region

<https://www.ontario.ca/page/fetal-alcohol-spec-trum-disorder-fasd-programs-and-services> - MCCSS FASD Programs and Services

<http://www.children.gov.on.ca/htdocs/English/indigenous/fasd.aspx> - MCCSS Indigenous FASD/ Child Nutrition Program

<https://www.aboutkidshealth.ca/Article?content-id=857&language=English> About Kids Health (Hospital for Sick Children) Information about FASD

FINE MOTOR SKILLS

Fine motor skills are actions and abilities involving the small muscles in the hands and fingers. Examples of fine motor activities include picking up objects, drawing/writing, dressing, and using hands to eat and play. These skills also involve hand-eye coordination.⁵¹

Healthy child development

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

By 4 months

- Brings hands to mouth⁵²
- Turns head from side to side to follow a toy or an adult face⁵²
- Brings hands to middle of their body while lying on their back⁵²

By 6 months

- Reaches for a toy when lying on back⁵³
- Uses hands to reach, grasp, bang and splash⁵²

By 9 months

- Picks up small items using thumb and first finger^{52, 54}
- Passes an object from one hand to the other⁵²
- Releases objects voluntarily⁵⁴
- Bangs objects on table or floor⁵⁴

By 12 months

- Holds, bites and chews food, e.g. crackers⁵²
- Takes things out of a container⁵²
- Points with index finger^{52, 55}
- Plays games like peek-a-boo⁵⁵
- Holds a cup to drink using two hands⁵⁵
- Picks up and eats finger foods^{51, 55}

By 18 months

- Helps with dressing by putting out arms and legs⁵²
- Stacks three or more blocks^{51, 56}
- Picks up and eats finger foods⁵²

By 2 years

- Puts items into a small container⁵²
- Takes off own shoes, socks or hat^{52, 57}
- Scribbles with crayons or marks paper⁵⁷
- Eats with a spoon with little spilling^{52, 57}

By 3 years

- Turns the pages of a book⁵²
- Dresses or undresses with help^{52, 58}
- Turns lid off a jar or turns knobs⁵²
- Holds a pencil between thumb and fingers⁵⁹
- Copies a circle already drawn⁵⁸

By 4 years

- Holds a crayon or pencil correctly⁵²
- Undoes buttons or zippers⁵²
- Cuts with scissors^{52, 60}
- Dresses and undresses with minimal help⁶⁰

By 5 years

- Uses scissors to cut along a thick line drawn on paper⁵²
- Dresses and undresses with little help⁵²

PROBLEM SIGNS

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

Infants

- Inability to hold or grasp an adult finger or a toy/ object for a short period of time⁵³

All children

- Hands are fisted most of the time
- Inability to play appropriately with a variety of age-appropriate toys; avoids crafts and manipulatives
- Consistently ignores or has difficulty using one side of body; uses one hand/arm⁵³



GROSS MOTOR SKILLS

Gross motor skills are actions and abilities involving the movement of our large muscles. These include movements of our arms, legs, feet or entire body. Examples include crawling, sitting, standing, walking, running, keeping balance, jumping, climbing and changing positions.⁶¹

Healthy child development

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

By 2 months

- Holds head up when held to an adult's shoulder
- Lifts head up when on tummy⁶²

By 4 months

- Keeps head in line with the middle of their body and brings hands to chest when lying on back
- Lifts head and chest and supports self on forearms when placed on tummy

- Holds head steady when supported in a sitting position⁶²

By 6 months

- Rolls from back to side⁶³
- Pushes up on hands when on tummy^{62, 63}
- Sits with support⁶²

By 9 months

- Sits on floor without support^{62, 64}
- Moves self forward on tummy or rolls continuously to get an object⁶⁴
- Stands with support^{62, 64}

By 12 months

- Gets up to a sitting position from lying down without help⁶²
- Pulls to stand at furniture⁶²
- Walks holding onto furniture or hands of an adult^{62, 65}

By 18 months

- Squats to pick up a toy and stands back up without falling⁶²

By 2 years

- Walks backwards or sideways pulling a toy⁶²
- Able to throw and attempt to catch ball without losing balance⁶⁷
- Kicks a ball⁶⁸

By 3 years

- Stands on one foot briefly^{62, 69}
- Climbs stairs using the handrail⁶²
- Throws a ball forward at least one metre (three feet)⁶²

By 4 years

- Stands on one foot for one to three seconds without support⁶²
- Goes up stairs using alternating feet^{62, 70}
- Runs, stops, and starts without falling⁷⁰
- Catches a large ball with outstretched arms⁶²

By 5 years

- Hops on one foot several times
- Throws and catches a ball successfully most of the time
- Plays on playground equipment without difficulty⁶²

PROBLEM SIGNS

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

By 3 months

- Little or no movement in legs; no kicking motion when lying on back
- Unable to lift head when lying on tummy⁶⁷

By 6 months

- Unable to sit using hands for support
- Difficulty controlling head movements⁶⁷

By 9 months

- Unable to sit independently
- Uses only one side of the body to move
- Legs crossed or stiff
- Legs unable to bear weight⁶⁷

By 12 months

- Stiff arms or legs
- Not yet pulling to stand
- Only able to sit with weight to one side⁶⁷

By 18 months

- Not able to walk or stand independently⁶⁷

By 24 months

- Not walking up or down stairs even with support
- Falls easily⁶⁷

Where to go for help for fine and gross motor skills

If there are concerns, advise the parent/caregiver to contact their family physician/paediatrician. The child's primary care provider may refer to:

- Child Development Programme
Ages: Birth to 4 years
295-0746
- Department of Health - Community Rehabilitation
278-6427
- A private agency or service provider

A list of additional public & private agencies that can help is available at [www.earlyyearsnurturingbda.org](http://www.earlyyears nurturingbda.org), in the 'Resources' section.

HEARING

Permanent hearing loss affects approximately one to three children out of 1000.⁷¹ The hearing loss may affect one ear or both and may be of any degree from mild hearing loss to complete deafness. It can be difficult to identify a child with hearing loss, particularly when the loss is relatively mild, since the child may seem to respond to many sounds. Many children may also experience temporary hearing loss, particularly if they have a history of issues with congestion or ear infections. Any degree of hearing loss may have an impact on a child's ability to learn speech and language or to hear clearly in a noisy situation, but this is especially true as the severity of the hearing loss increases.⁷¹

Healthy child development

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

By 6 months

- Makes cooing sounds⁷²
- Increases or decreases sucking behaviour in response to sound⁷³
- Startles in response to sudden, loud noises⁷⁴
- Makes different cries for different needs—such as hungry, tired⁷⁴
- Recognizes familiar voices and quiets when spoken to⁷⁴
- Responds to changes in the tone of parent/care-giver voice⁷³
- Watches parent/caregiver's face as they speak⁷⁴
- Smiles and laughs in response to parent/caregiver's smiles and laughs⁷⁴
- Imitates coughs or other sounds e.g. ah, eh, buh⁷⁴

By 9 months

- Responds to their name
- Responds to the telephone ringing or a knock at the door
- Understands being told “no”
- Gets what they want through sounds and gestures, such as reaching to be picked up
- Plays social games with you such as peek-a-boo
- Babbles and repeats sounds e.g. babababa, duhduhduh⁷⁴

By 12 months

- Localizes correctly to sound by turning head toward the sound⁷²
- Follows simple one-step directions, for example “sit down”⁷⁴
- Looks across the room to something you point to⁷¹
- Recognizes words for common items like “cup”, “shoe”, “book” or “juice”⁷³
- Uses three or more words⁷⁴
- Uses gestures to communicate, for example waves bye-bye, shakes head “no”⁷⁴
- Pays attention when spoken to⁷²
- Gets parent/caregiver's attention using sounds, gestures and pointing while looking at their eyes⁷⁴
- “Performs” for attention and praise⁷⁴
- Combines lots of sounds as though talking — abada baduh abee⁷⁴
- Shows interest in simple picture books⁷⁴

By 18 months

- Understands the concepts of “in and out”, “off and on”⁷⁴
- Points to several body parts when asked⁷⁴
- Uses at least 20 words⁷⁴
- Starts to put words together⁷²
- Responds with words or gestures to simple questions — “Where's teddy?”, “What's that?”⁷⁴
- Looks at your face when talking to you⁷²
- Makes at least four different consonant sounds — b, n, d, g, w, h⁷⁴
- Enjoys being read to and looking at simple books with you⁷⁴

By 2 years

- Follows two-step directions, for example, “Go find your teddy bear and show it to Grandma”⁷⁴
- Uses 100 or more words⁷⁴
- Understands more words than they can say⁷²
- Uses at least two pronouns, e.g. “you”, “me”, “mine”⁷⁴
- Consistently combines two or more words in short phrases — “daddy hat”, “truck go down”⁷⁴
- Asks simple questions, for example, “What's that?”⁷²
- Enjoys being with other children⁷⁴
- Begins to offer toys to peers and imitates other children's actions and words⁷⁴

- People can understand their words 50 to 60 per cent of the time⁷⁴
- Takes turns in a conversation⁷²
- Forms words and sounds easily and effortlessly⁷⁴
- “Reads” to stuffed animals or toys⁷⁴

By 3 years

- Understands the concepts of size (big/little) and quantity (a little, a lot, more)⁷⁴
- Uses some adult grammar — “two cookies”, “bird flying”, “I jumped”⁷⁴
- Uses more than 350 words⁷⁴
- Uses action words, for example “run”, “spill”, “fall”⁷⁴
- Uses sentences of three or more words most of the time⁷²
- Answers simple questions, for example “Where is the car?”⁷²
- Participates in short conversations⁷²
- Begins taking short turns with other children, using both toys and words⁷⁴
- Puts sounds at the start of most words⁷⁴
- Produces words with two or more syllables or beats, for example “ba-na-na”, “com-pu-ter”, “a-pple”⁷⁴
- Remembers and understands familiar stories⁷⁴

By 4 years

- Tells a short story or talks about daily activities⁷²
- Talks in sentences with adult-like grammar⁷²
- Generally speaks clearly so people understand⁷²
- Hears you when you call from another room⁷²
- Listens to television at the same volume as others⁷²
- Answers a variety of questions⁷²
- Understands words for some colours, like red, blue and green⁷³
- Understands words for some shapes, like circle and square⁷³
- Understands words for family, like brother, grandmother and aunt⁷³

By 5 years

- Pronounces most speech sounds correctly⁷²
- Participates in and understand conversations even in the presence of background noise⁷²
- Recognizes familiar signs, for example stop signs⁷²
- Makes up rhymes

- Hears and understands most of what is said at home and school⁷²
- Listens to and retells a story and asks and answers questions about a story⁷²
- Understands words for order like first, next and last⁷³
- Understands words for time like yesterday, today and tomorrow⁷³
- Follows longer directions like “Put your pajamas on, brush your teeth and then pick out a book”⁷³
- Follows classroom directions like “Draw a circle on your paper around something you eat”⁷³

PROBLEM SIGNS

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

- Early babbling stops⁷⁵
- Frequently gets colds and ear infections⁷⁵
- Frequently pulls at ears⁷⁵
- Does not understand people unless facing them⁷⁵
- Speaks loudly or turns up the volume of the television or radio⁷⁵
- Does not respond when called⁷⁵

Where to go for help

If there are concerns, advise the parent/caregiver to contact their family physician/paediatrician. The child’s primary care provider may refer to:

- Child Development Programme
Ages: Birth to 4 years
295-0746
- Bermuda Hearing Services
236-1088
- A private agency or service provider

A list of additional public & private agencies that can help is available at www.earlyyears nurturingbda.org, under the ‘Resources’ section.

LEARNING DISABILITIES

Learning Disabilities (LDs) are the result of impairment in one or more psychological processes that affect the acquisition, retention, understanding, organization or use of verbal and/or non-verbal information. LDs are lifelong. LDs are distinct from intellectual disabilities as they are specific, not global impairments. LDs may co-exist with other conditions, including attention disorders, behavioural and emotional disorders, sensory impairments or other medical conditions.

LDs are also related to difficulties in processing information:

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

LDs can affect how a person interprets, remembers, understands and expresses information. LDs take many forms, vary in severity and intensity, and may impact many areas of functioning from childhood into adulthood. LDs may affect academic performance (e.g. spelling, reading, listening, focusing, remembering and writing), social functioning, life skills (e.g. planning, organizing, predicting) and physical interaction with the world (e.g. balance, coordination, movement).

Between 5 and 10% of Canadians have LDs. LDs are not widely understood and are not caused by factors such as cultural or language differences, inadequate or inappropriate instruction, socioeconomic status or lack of motivation.

Typically, LDs are diagnosed by an educational psychologist only after the child enters school and is learning to read and write.

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

PROBLEM SIGNS

If a child is experiencing a delay in **one or more** of the following domains in this guide consider this a **red flag**:

- Attention Difficulty and Hyperactive Behaviour
- Behaviour
- Fine motor skills
- Social/emotional
- Speech and language

Where to go for help

Refer to the specific domains above to find out where to go for help as early as possible to reduce the impact on the child's learning. Long-term support is usually indicated.

For more information about learning disabilities:

- Bermuda Centre for Creative Learning (BCCL): 824-1111 or www.bccl.bm
- Beyond Inclusion: beyondinclusionbda@gmail.com or www.beyondinclusionbda.com
- The Reading Clinic: 292-3938 or www.thereadingclinic.bm

A list of additional public & private agencies that can help is available at www.earlyyearsnurturingbda.org, under the 'Resources' section.

MATERNAL MENTAL HEALTH

Mental illnesses such as depression and anxiety are conditions where a person's thinking, mood and behaviours severely and negatively impact how a person functions in his or her life. Mental illness that occurs in pregnancy or after having a baby is referred to as perinatal mental illness.

If left untreated, maternal perinatal mental illness can have negative effects on both the mother and her baby. For example, it can put a woman at risk for premature delivery or may affect her ability to meet her own self-care needs and those of her child. This can put the child's health and development at risk.⁷⁹

PROBLEM SIGNS

If a mother is experiencing **any** of the following for more than two weeks after the birth of a baby, consider this a **red flag**:

- General feelings of unhappiness without reason
- Crying
- Mood swings
- Anxiety
- Insomnia
- Changes in appetite
- Irritability
- Loneliness or isolation
- Worry about their ability as a mother
- Conflicts in their roles and relationships
- Inability to cope⁸⁰

Postpartum or baby blues are very common. Up to 84 per cent of new mothers will experience it. The negative feelings usually peak on day three to five postpartum and will improve by day 12.⁸¹

Depression occurs in up to 19 per cent of women.⁸⁰ Encouraging women to speak to a healthcare provider and get help early benefits both themselves and their children.

Women with certain risk factors may be more vulnerable to experiencing maternal mental illness.

If a woman has **any** of the following risk factors, consider this a **red flag**:

- Personal history of anxiety, depression or other mental illnesses
- Family history of poor mental health
- Conflict with the partner relationship
- Lack of practical, financial or emotional supports
- Poor social support
- Stressful life events, e.g. infertility, pregnancy loss, unhealthy relationships, loss of a family member or friend^{80, 81}

Where to go for help

If there are concerns of **maternal mental illness**, or if the woman has **risk factors**, advise the woman/family to contact her primary health care provider for a referral to:

- Health Visitor 278-6460
- Mid-Atlantic Wellness Institute (MAWI) 236-3770
- The Family Centre 232-1116
- A private psychiatrist/psychologist

A list of additional public & private agencies that can help is available at www.earlyyearsnurturingbda.org, under the 'Resources' section.

Postpartum psychosis is a rare but serious mental illness with risks to the mother and baby. Symptoms can appear within 72 hours to four weeks postpartum.

If the mother is experiencing any of the following symptoms of postpartum psychosis, consider this a red flag:

- Dramatic changes in mood, i.e. from elated to depressed
- Out of touch with reality; cognitive impairment
- Delusions and/or hallucinations
- Severe depression
- Agitation
- Confusion
- Thoughts of harming self or baby^{80, 82}

If the mother has any of the above symptoms of postpartum psychosis, **do not wait**:

- **Establish the safety of the baby and/or child(ren)**
- **Do not leave the mother alone**
- **Get help: CALL 911**

MILD TRAUMATIC BRAIN INJURY (CONCUSSION)

A mild traumatic brain injury is also called a “concussion.”⁸⁴ In children under the age of six years, concussions are most commonly caused by falls, motor vehicle crashes, bicycle crashes or other sports-related injuries, being struck by/against objects, and assault.⁸⁴ It can be more difficult to recognize the symptoms of a concussion in infants, toddlers or preschoolers because they communicate differently than older children.

PROBLEM SIGNS

If a child experiences **one or more** of the following consider this a **red flag**:

- Headache or persistent rubbing of their head
- Nausea or vomiting
- Unsteady walking, loss of balance or poor coordination
- Loss of ability to carry out newly learned skills, e.g. toilet training, speech
- Lack of interest in favourite toys
- Cranky, irritable or difficult to console
- Changes in eating or sleeping patterns
- Tiring easily or listlessness
- Sensitivity to light or noise
- Visual problems⁸⁵

If **any** of the following symptoms develop, consider this a **red flag** and take the child to the local emergency department/**seek medical attention immediately**:

- Loss of consciousness⁸⁶
- Large bumps, bruising or unexplained swelling on the head⁸⁴
- Increased drowsiness or difficult to rouse^{84, 85}
- Neck pain^{84, 85}
- Repeated vomiting⁸⁵
- Blood or fluid in the ear⁸⁴
- Pupils are unequal in size⁸⁴
- Seizures^{84, 85}
- Increased confusion e.g. cannot recognize people or places⁸⁵
- Slurred speech⁸⁵
- Weakness, numbness in arms/legs⁸⁵
- Changes in behaviour e.g. irritability, aggression⁸⁵

Where to go for help

If you suspect a child has had a concussion:

- Take the child to the local emergency department/ seek medical help immediately⁸⁵

NUTRITION

Poor nutrition in babies and young children can lead to many negative outcomes such as failure to thrive, obesity, anemia, restrained eating, poor eating habits that become lifelong, lack of school readiness and inability to learn at school.⁸⁷ Further investigation, including possible referral to a registered dietitian (RD) for nutrition assessment and ongoing follow-up may be warranted for infants and children who present with red flags.

PROBLEM SIGNS

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

General nutrition risk factors

- There is a sharp incline or decline in serial growth measurements or the growth line remains flat on the WHO Growth Charts for Canada⁸⁸
- If parent or caregiver has made informed decision to offer infant formula and it is prepared and/or stored incorrectly^{89, 90}
- Uses a propped bottle⁸⁸ or is not supervised during feeding⁸⁸
- Unsafe or inappropriate foods are given, e.g. raw eggs, unpasteurized milk and foods that are choking hazards⁹¹
- Feeding is forced or restricted^{88, 89}
- Is pressured to eat through prodding, scolding, punishment, pleading, bribing or coercing, e.g. “clean your plate” or “come on, you’ve tried it before”^{90, 92}
- Does not eat a variety of foods⁹⁰
- Inadequate access to a sufficient variety and quantity of food⁹³

Age-specific nutrition risk factors

Birth to 6 months

- After five days of age, has less than six wet diapers each day⁹⁴
- Within the first two weeks, loses more than 10 per cent of birth weight⁹³
- By two weeks, does not regain birth weight⁸⁸ or does not gain 20 grams or more per day⁹³
- Consumes cow’s or goat’s milk (including pasteurized or raw), plant-based beverages (soy, rice, almond), evaporated milk or home- made formula⁸⁸
- Consumes water, juice, herbal teas or other liquids⁸⁸
- Introduces complementary foods too early (before infant is showing signs of developmental readiness), including adding cereal to a bottle⁸⁸
- Consumes honey, including pasteurized or cooked⁹⁰
- Uses a propped bottle or infant is not supervised during feeding⁸⁸
- Skips feeds in attempts to facilitate longer sleep times⁹⁵
- Not receiving vitamin D supplement of 400 IU daily if breastfed or receiving breastmilk⁸⁸
- Parent has depressive symptomatology in the early postpartum period (may impact breastfeeding duration, self-efficacy and increase breastfeeding difficulties)⁹⁶

6 to 9 months

- Does not consume iron-rich foods daily (such as beef, lamb, chicken, turkey, eggs, legumes, tofu, iron fortified cereal)⁹⁰
- Consumes cow’s or goat’s milk or plant-based beverages (soy, rice, almond) as main milk source⁹⁰
- Consumes fruit juice, fruit drinks/punch, sports drinks, pop or beverages containing artificial sweeteners or caffeine (coffee, tea, hot chocolate)^{90, 97}
- Consumes raw or unpasteurized milk or milk products or unpasteurized juice⁹⁰
- Consumes honey, including pasteurized or cooked⁹⁰
- By 9 months, lumpy textures have not been introduced or consumed⁹⁰
- Unsupervised during feedings⁹⁰
- Not receiving vitamin D supplement of 400 IU daily if breastfed or receiving breastmilk⁸⁸

9 to 12 months

- Does not consume iron-rich foods daily (such as beef, lamb, chicken, turkey, eggs, legumes, tofu, iron fortified cereal)⁹⁰
- By 9 months, lumpy textures have not been introduced or consumed⁹⁰
- Consumes > 750 mL (24 oz) of cow's or goat's milk a day⁹⁰
- Consumes skim or partly skimmed (2% or 1% M.F.) cow's or goat's milk or plant-based beverages (soy, rice, almond) as main milk source⁹⁰
- Consumes fruit juice, fruit drinks/punch, sports drinks, pop or beverages containing artificial sweeteners or caffeine (coffee, tea, hot chocolate)^{90, 96}
- Consumes raw or unpasteurized milk or milk products or unpasteurized juice⁹⁰
- Consumes honey, including pasteurized or cooked⁹⁰
- Unsupervised during feedings⁹⁰
- Not receiving vitamin D supplement of 400 IU daily if breastfed or receiving breastmilk⁸⁸

1 to 2 years

- Does not eat a variety of textures and family foods including iron-rich foods each day⁹⁰
- Dietary fat intake is restricted⁹⁰
- Consumes more than 750 mL (24 oz) cow's or goat's milk a day and/or more than 175 mL (6 oz) of juice a day.⁹⁰ Consuming these beverages in excessive amounts displaces complementary foods⁹¹
- Does not eat a variety of foods from Canada's Food Guide⁹⁰
- Has not transitioned from bottle to an open cup by 18 months⁹⁰
- Drinks from a bottle filled with fluids other than water at night⁹⁰
- Consumes skim or partly skimmed (2% or 1% M.F.) cow's or goat's milk or plant-based beverages (soy, rice, almond) as main milk source⁹⁰
- Consumes fruit drinks/punch, sports drinks, pop or beverages containing artificial sweeteners or caffeine (coffee, tea, hot chocolate)^{90, 96}
- Consumes raw or unpasteurized milk or milk products or unpasteurized juice⁹⁰
- Unsupervised during feedings⁹⁰
- Does not eat three small meals plus two to three nutrient-dense snacks a day⁹⁰

- Coughs and chokes often when eating at 24 months⁹⁸
- Not receiving vitamin D supplement of 400 IU daily if breastfed or receiving breastmilk⁸⁸
- Scores "high nutrition risk" on Toddler NutriSTEP® nutrition screen⁹⁹

2 to 6 years

- Consumes most of their milk and other beverages from a bottle¹⁰⁰
- Consumes fruit drinks/punch, sports drinks, pop or beverages containing artificial sweeteners or caffeine (coffee, tea, hot chocolate)^{93, 101}
- Rarely or never eats meals with their family⁹¹
- Consumes plant-based beverages other than fortified soy beverage as main milk source.¹⁰² This includes products like rice, almond or oat beverages
- Consumes raw or unpasteurized milk or milk products¹⁰³ or unpasteurized juice¹⁰⁴
- Exceeding milk recommendations can compromise iron status. Two cups of skim or partly skimmed (2% or 1% M.F.) cow's milk per day is sufficient to maintain healthy vitamin D and iron stores for most children¹⁰⁵
- Depends on vitamin/mineral supplements or speciality oral supplements instead of offering a variety of foods⁹¹
- Scores "high nutrition risk" on Toddler or Preschooler NutriSTEP® nutrition screen^{86, 98}

Where to go for help

If there are concerns, advise the parent/caregiver to talk to their child's primary care provider or contact the Department of Health's:

- Health Visitor 278-6460
- Nutritionist/Dietitian 278-6467

A list of additional public & private agencies that can help is available at www.earlyyears nurturingbda.org, under the 'Resources' section.

PREMATURITY

Typically, a fetus spends an average of 40 weeks growing and developing before birth. According to the World Health Organization (WHO), **babies born before completing 37 weeks are defined as preterm or premature**. In the majority of cases, these infants are healthy and experience typical development.

However, many infants born prematurely require medical care after birth, and some have continuing challenges that affect their growth and development compared to full-term babies.

For these reasons, regular monitoring of a child's growth and development by a professional is important to ensure that children are developing appropriately for their age and that children at risk can access appropriate services. Several factors influence whether or not a child born prematurely will experience medical care and/or ongoing support. These factors include:

- How prematurely the child was born
- The baby's birth weight
- If the baby experiences complications at birth - this is known to put them at risk for challenges as children and adults.

There are a variety of reasons that children can be born prematurely. Prematurity may be linked to:

- Maternal conditions (e.g. high blood pressure, infection, substance abuse, trauma, chronic illness)
- Fetal conditions (e.g. fetal malformation, chromosomal abnormalities, infection).

Sometimes the reason for a premature birth is unknown.

To reiterate, it is very important to contact a practitioner early. This will help ensure early assessment, diagnosis, and implementation of the care a child needs for the best possible outcome.

In Bermuda, the Special Care Baby Unit (SCBU), adjacent to the Maternity Unit at the King Edward Memorial Hospital (KEMH), cares for babies born before 28 weeks and other special needs babies

REGULATION

The development of self-regulation is rooted in the relationship/attachment system that exists between an infant and his or her caregiver.^{108, 109, 110} Babies are not born with the capacity to regulate their feelings, actions or bodies and rely completely on their caregivers to attune to their distress.

When caregivers can recognize their own stress, stay calm and then provide the nurturing and structure needed to alleviate their baby's distress they have used their secure relationship to help the child regulate. In the first three years of a child's life, the child is dependent on his or her parents to interpret their distress and support them to calm down and regulate. This is a process known as co-regulation and its growth and development is closely aligned with the relationship and attachment between a parent and child.^{107, 108, 111} Beyond the child's third birthday, the child begins to meaningfully use words to identify feelings and thoughts. Their emerging language skills then begin to help them think, wait, problem solve, ask for help and remember ways to calm themselves down when they are distressed. Initially infants need a tremendous amount of co-regulation from others to manage distress. They will need less and less adult support as children as their own capacity to regulate increases.^{107, 108, 110}

In the first three years, the role of the parent is to help the child recover from stress and prevent the child from feeling overloaded. Common stressors might include hunger, fatigue, worry, fear, pain, being alone or sensory overload (voice tone, anger, lighting, temperature). Toxic stress occurs when the child experiences distress too frequently, too quickly, when they can't adapt to "normal" challenges and transitions, when it takes a long time to recover (more than 10 to 20 minutes) or when distress affects a healthy sleep cycle.¹⁰⁸ Toxic stress also interrupts a child's ability to regulate if the caregiver has not been successful or mostly consistent in soothing the child.^{107, 112, 113} Children who have experienced toxic stress will react more frequently and more intensely with little or no understood provocation. They will react with actions that fall into the categories of fight (physical or verbal), flight (running behaviours) or freeze/immobilize (hiding, spacing out, daydreaming). Children who experience this level of toxic stress tend to have disruptions to normal sleep patterns so that they sleep too much, sleep too little or can't get into a sleep pattern that allows them to feel rested.¹⁰⁸ These children often are defined by what is seen as "bad behaviour" when the root of the reaction is that their needs have not been met and their brain interprets that as dangerous. The brain then reacts with fighting, flight or freezing.¹⁰⁸

Red flags exist within this domain for parents who are unable to calm themselves, understand their child's needs and respond to their child in ways that soothe. The Adverse Childhood Experiences (ACE) Study identifies a number of parental risk factors including involvement in abuse, neglect, substance use, separations or loss, and criminality that might compromise parents' ability to notice and offer support to their child.¹⁰⁸

PROBLEM SIGNS

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

- Shows distress easily
- Has difficulty adapting to changes
- Has difficulty making transitions
- Takes more than 20 minutes to calm down after being upset
- Sleeps too much for their age
- Sleeps too little for their age
- Reacts frequently with little or no understanding of what provoked them
- Reacts with intensity
- Engages in physical fighting, verbal aggression and has poor social skills
- Runs away
- Hides from
- Daydreams more than usual^{108, 114, 115, 116}

Where to go for help

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

- Their family physician/paediatrician or
- Child Health Clinic 278-6460
- Child Development Programme
Ages: Birth to 4 years
295-0746
- Child and Adolescent Services
Ages: 4-18 years
239-6344
- Private psychological/behaviour support services
- Private counselling providers

A list of additional public & private agencies that can help is available at www.earlyyearsnurturingbda.org, under the 'Resources' section.



RELATIONSHIP AND ATTACHMENT

One of the most significant contributions to healthy brain development in a child's life is the parent-child relationship.¹¹⁷ These interactions form the building blocks for future relationships creating an internal model the child uses to reference how all future relationships are interpreted and measured. The new understandings we have from the field of neurobiology lays the foundation for brain development that is rooted in the connection and relationship an infant and child experiences with his or her caregiver.^{116, 118}

These relationships can be described and understood in the context of Mary Ainsworth's four attachment styles: secure, anxious-ambivalent, anxious-avoidant, and disorganized.¹¹⁹

It is important to note and remember that most parent-child interactions result in a secure attachment pattern.¹¹⁸

Secure attachment: This is a relationship in which the infant or child can feel physically and emotionally safe. The parent is able to meet the needs of the child, soothe the child and experience joy in their relationship with the child. The parent, through this experience, "serves" the child positive and rich physical, emotional and verbal messages that the child "returns" to the parent with smiles, gurgles and cuddles. The child experiences

a world (the extent of their world is their parent) that is safe, responsive and can make them feel calm when distressed.^{118, 120, 121}

Anxious-ambivalent attachment: This is a relationship in which the infant or child experiences some level of uncertainty or stress in their relationship with their parent/caregiver. The anxiety or stress the child experiences may result from a variety of situations such as a loss, illness, parental mental health, poverty, physical abuse, neglect, poor nutrition, prenatal maternal stress and parental trauma where the parent is sometimes attentive and responsive and sometimes not. As a result of this uncertainty, the child might seem unsure and display some ambivalence wanting to approach his or her parent for comfort while also showing some resistance to that approach.^{118, 119, 120}

Anxious-avoidant attachment: Much like the anxious-ambivalent attachment pattern, this is a relationship in which the infant or child experiences some level of uncertainty or stress in their relationship with their parent/caregiver. The anxiety or stress the child experiences may result from a variety of situations such as a loss, illness, addictions, parental mental health, poverty, physical abuse, neglect, poor nutrition, prenatal maternal stress and parental trauma and the parent has proven to the child that his or her responses are not predictable and reliable. As a result of this uncertainty, the child avoids the parent and may either seem inconsolable or show little or no affect.^{118, 119, 120}

Disorganized attachment pattern: The disorganizing attachment pattern is the most concerning and the most difficult to notice. This occurs when the caregiver who is supposed to be the person who responds to the child's needs for safety, comfort, feeding and connection is actually frightening or frightened of the child. This child is caught in a difficult dilemma as the person who is supposed to be safe is actually scary. Survival drives the child to the caregiver but the caregiver is the source of the child's distress. The frightening parents might be abusive, neglectful or hostile toward the child or they use language or voice tones that are frightening. The developing brain needs cues from the parent's facial expressions to regulate and grow.¹¹⁷ Examples of the still face experiment show that the infant who does not see responsiveness in the parent's facial expression becomes distressed and dysregulated.^{118, 119, 120}

The parent who is frightened of their child may be slow to move in to respond, unable to read his or her baby's cues and know what the baby actually needs from them. This parent is unable to consistently calm his or her child or respond to the child and often carries a worried look on their face. This stresses the child who is then unable to respond to the parent in ways that encourage the parent to engage with them again.¹²²

A child who has experienced an insecure or disorganizing caregiver might:

- Explore their environment and other people only minimally, either reluctantly or without interest
- Be preoccupied and clingy with the parent
- Become distressed and anxious if the parent leaves, even for a short period
- Reach out for the parent and then resist them
- Seem angry and rejecting toward the parent
- Seem passive in relating to the parent
- Show minimal interest in the parent
- Seem independent, resisting help from others
- Explore the room and toys busily
- Not use the parent as a secure base to seek proximity when stressed
- Show minimal acknowledgement when the parent leaves the child
- Ignore or avoid the parent when the parent returns to the room
- Easily go with strangers or talk to strangers
- Be overly sensitive to sounds, textures, food or smells
- Be overly tolerant/ignoring of things like noises, dirty hands, lighting or wet clothing

- Be reactive and angry without noticeable provocation
- Fight, flee (run) or freeze when in distress (become immobile, look dazed, daydream, forgetful, shut down emotionally)
- Cry with a weak or angry response
- Whine constantly
- Resist cuddling
- Use poor eye contact or seem uncomfortable with eye contact
- Not respond to smiles
- Show delayed physical motor skill development (in combination with other flags)^{118, 119, 121, 123}

Where to go for help

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

- Their family physician/paediatrician
- Health Visitor 278-6460
- Child Development Programme
Ages: Birth to 4 years
295-0746
- Child and Adolescent Services
Ages: 4-18 years
239-6344
- The Family Centre
Ages: 5-14 years
232-1116
- Private psychological/behaviour support services
- Private counselling providers

A list of additional public & private agencies that can help is available at www.earlyyears nurturingbda.org, under the 'Resources' section.



RESILIENCE

Resilience is the ability to “bounce back” from stressors and difficult situations. It helps adults and children handle stress, overcome childhood disadvantages, recover from trauma and reach out to others. Studies show that resilient people have happier relationships and are less prone to depression, more successful in school and jobs, and live healthier and longer lives.¹²⁴ The way a person thinks about life’s challenges can affect his or her ability to cope with them. Parents have “thinking habits” that can help or hinder responses to stressful situations. Young children mimic the way significant adults in their lives respond to these situations. If the parent or caregiver demonstrates any of the red flag thinking habits, the child may develop these thinking habits too.

PROBLEM SIGNS

If a child **habitually** uses the following ways of thinking, consider this a **red flag**:

- Takes things personally and blames self or others for the stressful situation
- Expresses belief that the stressful situation is permanent
- Expresses belief that the stressful situation will affect many areas of life¹²⁵

Where to go for help

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

- Their family physician/paediatrician
- Child Health Clinic 278-6460
- Child Development Programme
Ages: Birth to 4 years
295-0746
- Child and Adolescent Services
Ages: 4-18 years
239-6344
- Private psychological/behaviour support services

A list of additional public & private agencies that can help is available at [www.earlyyearsnurturingbda.org](http://www.earlyyears nurturingbda.org), under the ‘Resources’ section.

SELECTIVE MUTISM

Selective mutism is the persistent inability to speak in specific situations where speaking is expected, despite being able to speak in other situations. This difficulty must last beyond one month and must not be limited to the first month of school or daycare. Selective mutism typically emerges when children are two to five years old.^{126, 127} Despite this early age of onset, children with this disorder are most commonly identified when they first enter daycare or school when a lack of verbal communication is first observed outside of the home. Research suggests that selective mutism occurs in up to two per cent of children in elementary school¹²⁸ and occurs one and half to two times more often in girls than in boys.¹²⁹ The most common profile of children with selective mutism are those that speak freely at home, are less comfortable speaking freely outside of the home — for example, at the grocery store or at a restaurant — and are least comfortable speaking at school.¹²⁶ Factors that contribute to the development of selective mutism include a shy or anxious temperament, a family history of anxiety or shyness, speech and language challenges, adjustment to a new culture, and limited social interactions with peers outside of school.¹³⁰

PROBLEM SIGNS

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

- Does not speak in a specific situation, for more than one month, excluding the first month of school or daycare
- Clear discrepancy in the quality and quantity of spoken language between the home and other environments
- Relies heavily on nonverbal communication in certain situations; for example, pointing, nodding, and other gestures
- Speaks “through” the parents in public situations such as whispering to them instead of conversing directly to others
- Reluctance to speak to teachers, students, principals or school secretaries
- Avoids speaking and will respond with averted gaze, blushing or other symptoms of anxiety
- Speaks quietly or privately to other children, but not to adults

- May express a fear of being heard or seen speaking in specific situations
- Covers mouth when speaking so others cannot see his or her lips moving
- Experiences accompanying somatic symptoms, particularly when going into unfamiliar environments where speaking is required¹²⁹

Where to go for help

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

- Their family physician/paediatrician or
- Child Health Services 278-6460
- Child Development Programme
Ages: Birth to 4 years
295-0746
- Child and Adolescent Services (MAWI)
Ages: 4-18 years
239-6344
- Private psychological/behaviour support services

A list of additional public & private agencies that can help is available at www.earlyyears nurturingbda.org, under the ‘Resources’ section.

SENSORY

Sensory processing or sensory integration refers to the ability of our nervous system to receive information through our senses (taste, smell, auditory, visual, touch, movement and body position) and organize it in a meaningful and appropriate way.¹³¹

PROBLEM SIGNS

If a child presents **any** of the following behaviours in extreme or with exaggeration, and these behaviours do not seem typical for a child of his or her age, consider this a **red flag**:

Auditory

- Responds negatively to unexpected or loud noise¹³²
- Is distracted or has trouble functioning if there is a lot of background noise¹³¹
- Enjoys strange noises/looks to make noise for noise sake¹³¹
- Seems to be “in their own world”¹³³

Visual

- Needs help to find objects that are obvious to others¹³²
- Avoids eye contact¹³²
- Squints or looks out of the corner of the eye¹³⁴
- Is attracted to bright, flashing objects like TV or computer screens¹³²
- Is more bothered by bright light as compared to same age children e.g. blinks, squints, cries, closes eyes, etc.¹³⁵

Taste/smell

- Avoids certain tastes/smells that are typically part of the child’s diet¹³¹
- Chews/licks non-food objects¹³⁶
- Gags easily¹³⁴
- Is a picky eater, especially regarding textures, flavours, smells and temperature¹³¹

Movement and body position

- Continually seeks out all kinds of movement activities (e.g., being whirled by adult, play-ground equipment, moving toys, spinning, rocking)¹³³
- Becomes anxious or distressed when feet leave the ground¹³¹
- Has poor endurance — tires easily; seems to have weak muscles¹³⁴
- Avoids climbing, jumping, uneven ground or roughhousing¹³⁵

- Bumps into things, failing to notice people or objects in the way¹³²
- Seems not to get dizzy when others usually do¹³³

Touch

- Becomes upset during grooming e.g. during hair cutting, face washing, fingernail cutting¹³¹
- Has difficulty standing in line or close to other people, or stands too close, always touching others¹³¹
- Shows an emotional or aggressive response to being touched¹³⁴
- Fails to notice when face or hands are messy or wet¹³¹
- Craves lots of touch: heavy pressure, long-sleeved clothing, hats, and certain textures¹³⁴

Activity Level

- Always on the go; difficulty paying attention
- Very inactive — seems to tire easily and will often slump in chairs or lean against objects for support
- Seems unaware of pain¹³⁴

Social/emotional

- Needs more protection from life than other children i.e. defenseless physically or emotionally
- Has difficulty with changes in routines, plans or expectations
- Is stubborn or uncooperative; easily frustrated
- Has difficulty making friends
- Has difficulty understanding body language or facial expression
- Does not feel positive about own accomplishments i.e. low self-esteem¹³⁴

Where to go for help

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

- Their family physician/paediatrician or
- Child Development Programme
Ages: Birth to 4 years
285-0746
- Child and Adolescent Services (MAWI)
Ages: 4-18 years
239-6344
- Community Rehabilitation - Department of Health
278-6427
- Private support services

A list of additional public & private agencies that can help is available at www.earlyyears nurturingbda.org, under the ‘Resources’ section.



SLEEP

Sleep is a critical activity of child development. Adequate sleep promotes self-regulation, growth, physical health, memory and cognitive functioning. In typically developing infants and toddlers, lack of sleep has been associated with parental stress, attachment difficulties and maternal depression. In atypically developing infants, sleep problems are often attributed to neurological or physical abnormalities, although psychosocial factors also play a role.¹³⁷

It takes time for infants to develop a sleep-wake cycle and some infants take longer than others. Various factors such as time, cues, biology, environment and infant temperament all play a part.¹³⁸ The amount of sleep varies greatly from one child to another. Infants up to six months of age may spend up to 16 hours a day sleeping, but as little as 10 hours has also been reported. Infants from six to 12 months may sleep up to 14 hours per day, toddlers about 10 to 13 hours and preschoolers 10 to 12 hours.¹³⁹

PROBLEM SIGNS

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

- Dependence on caregiver presence and soothing actions, i.e. nursing or rocking¹³⁶
- Resistance to or fears and anxieties around sleeping¹³⁶
- Poor airway functioning/airway obstruction i.e. noisy breathing, snoring or breathing pauses due to enlarged adenoids or respiratory infection¹³⁶
- Excessive crankiness or temper tantrums¹⁴⁰
- Problems in cognitive functioning i.e. attention, learning and memory¹⁴¹
- Coordination problems e.g. accidents, injuries, slower reaction time¹⁴²

Where to go for help

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

- Their family physician/paediatrician or
- Health Visitor 278-6460
- Child Development Programme
Ages: Birth to 4 years
295-0746

A list of additional public & private agencies that can help is available at www.earlyyears nurturingbda.org, under the 'Resources' section.

SOCIAL/EMOTIONAL

Social and emotional development encompasses both intrapersonal skills (i.e. understanding and managing one's own emotions) and interpersonal skills (i.e. the ability to effectively verbally and non-verbally communicate with other people), as it looks at the child's experience, demonstration and control of emotions and the capacity to create meaningful and reciprocal relationships with others.^{143, 144} The main characteristics of social and emotional development in a child include:

- Recognizing and comprehending both his or her own feelings as well as others'
- Coping with deep emotions and expressing them in a productive way
- Regulating their behaviour
- Developing and preserving connections with people^{145, 146}

It is important to note that social and emotional development is a lengthy process and children continue with development in this domain well into the teenage years and at times into young adulthood.¹⁴⁷

PROBLEM SIGNS

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

Ages 0 to 9 months

- Lack of response to sounds
- Lack of expression/smile in response to others/ responds to others in an atypical way
- Avoids close contact
- Inability to self-soothe or calm themselves^{148, 149}

Ages 9 to 12 months

- Lack of interest in peers
- Great difficulty waiting for something
- Rigidity in regards to routine, clothing, toys, food, etc.
- Little to no eye contact
- Lack of imitation of simple actions
- Lack of response to his or her name
- Lack of shared attention between two people on an item
- Lack of ability for turn-taking in games
- Responds in the same way to familiar people as with strangers^{145, 147, 148}

Ages 1 to 2 years

- Moves from one activity to another and only stays at an activity for a brief time
- Requires support to stay on task
- Lack of ability to show/explain objects to others
- Frustration when changes occur
- Lack of interest in objects and/or activities in which peers are engaging
- Lack of initiation of self-play^{143, 145, 148, 150}

Ages 2 to 3 years

- Lack of interest in pretend play
- Difficulty with separation from caregiver
- Lack of initiation or response to interactions with peers
- Prefers to play in a different area than peers
- Lack of symbolical use of objects
- Lack of participation in group activities
- Unusual expression in intensity of aggression
- Displays severe fears that hinder daily living^{143, 148, 149}

Ages 3 to 5 years

- Lack of initiation or joining in play with peers
- Lack of sharing with peers
- Lack of cooperative play skills e.g. group decisions, role duties, fair play
- Inability to select own friends
- Demonstrates dependency on caregivers for majority of needs and wants
- Demonstrates passivity or fearfulness that limits engagement with activities in which peers are participating^{142, 143, 144}

Where to go for help

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

- Their family physician/paediatrician or
- Child Development Programme
Ages: Birth to 4 years
295-0746
- Child and Adolescent Services (MAWI)
Ages: 4-18 years
239-6344
- The Family Centre
Ages: 5-14 years
232-1116
- Private psychological/behaviour support services

A list of additional public & private agencies that can help is available at www.earlyyears nurturingbda.org, under the 'Resources' section.

SPEECH AND LANGUAGE

Approximately one in 10 preschool children has difficulties acquiring speech, language and/or social communication.^{151, 152} Because communication skills are critical to the child's future success in socialization, learning to read and write (literacy) and do math (numeracy), it is important to identify those children who might need support in this domain.^{150, 151}

This domain considers the development of attention, comprehension, expression via gestures and words, the development of clear, intelligible speech, social skills and play skills.

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 sudden loud noises
- Makes different cries for different needs, i.e., hungry, tired
- Watches the face of parent/caregiver as they talk
- Smiles/laughs in response to parent/caregiver smiles and laughter
- Imitates coughs or other sounds such as “ah,” “eh,” buh^{150, 153}

By 9 months

- Responds to his or her name^{150, 154}
- Turns to look for a source of sound,¹⁵⁵ or responds to the telephone or a knock at the door^{150, 153}
- Understands being told “no”,^{150, 153} and other short instructions¹⁵⁴
- Imitates facial expressions¹⁵⁴
- Gets attention or help,¹⁵⁴ or what they want, through gestures, e.g. reaching to be picked up^{150, 153} and sounds¹⁵⁴
- Plays social games with parent/caregiver e.g. peek-a-boo^{150, 153}
- Enjoys being around people^{150, 153}
- Fusses or cries if familiar caregiver looks or behaves differently¹⁵⁴
- Babbles and repeats sounds such as “babababa” or “duhduhduh”^{150, 153}
- Mouths and chews on objects¹⁵⁶
- Looks for dropped object or hidden toy¹⁵⁴

By 12 months

- Follows simple one-step directions such as “Sit down”, “Find your shoes”^{150, 157}
- Follows simple requests and questions such as “Where is the ball?”¹⁵⁵
- Looks across the room to something when an adult points to it^{150, 156}
- Consistently uses three or more ‘words’ such as “dada” or “mama,” using the same sounds to indicate same object or person, even if these ‘words’ are not pronounced accurately^{150, 156}
- Uses specific gestures to communicate needs or to protest e.g. waves hi/bye, shakes head “no”^{150, 156}
- Gets attention using sounds, gestures and pointing while looking at the eyes of parent/caregiver^{150, 156}
- Brings/extends toys to show parent/caregiver^{150, 156}
- “Performs” for social attention and praise^{150, 156}
- Combines lots of sounds together as though talking e.g. “abada baduh abee”^{150, 156}
- Shows an interest in simple picture books^{150, 156}
- Starts and plays social games with parent/ caregiver; takes turns e.g. “peek-a-boo,” “patty cake”¹⁵⁴
- Finger-feeds him/herself some foods¹⁵⁵
- Holds, bites and chews crackers^{150, 155}

By 18 months

- Understands the concepts of “in and out,” “off and on”
- Points to three or more 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
- Points to familiar pictures using one finger
- Demonstrates some pretend play with toys e.g. gives teddy a drink, pretends a bowl is a hat^{150, 158}

By 24 months

- Follows two-step directions e.g. “Go find your teddy bear and show it to Grandma”¹⁵⁹
- Uses 100 or more words¹⁵⁸
- Uses at least two pronouns such as “you,” “me,” “mine”¹⁵⁸
- Consistently combines two to four words in short phrases e.g. “daddy hat,” “truck go down”¹⁵⁸
- Forms words/sounds easily and effortlessly¹⁵⁸
- Uses words that are understood by others 50 to 60 per cent of the time¹⁵⁸
- Enjoys being around other children¹⁵⁸
- Begins to offer toys to peers and imitate other children’s actions and words¹⁵⁸
- Holds books the right way up and turns pages one at a time¹⁵⁸
- “Reads” to stuffed animals or toys¹⁵⁰
- Scribbles with crayons¹⁵⁸

By 30 months

- Understands the concepts of size such as big/little and quantity such as a little/a lot, more¹⁶⁰
- Uses some adult grammar e.g. “two cookies,” “bird flying,” “I jumped”¹⁵⁹
- Uses more than 350 words¹⁵⁹
- Uses action words e.g., run, spill, fall¹⁵⁹
- Produces words with two or more syllables or beats e.g. “ba-na-na,” “com-pu-ter,” “a-pple”¹⁵⁹
- Uses consonant sounds at the beginning of words e.g. “big” instead of “ig”¹⁵⁹
- Begins taking short turns with peers, using both words and toys¹⁵⁹
- Demonstrates concern when another child is hurt/sad¹⁵⁹
- Demonstrates pretend play involving several actions e.g. feeds dolls and then puts them to sleep; puts blocks in train then drives train and drops blocks off¹⁵⁹
- Recognizes familiar logos and signs involving print e.g. golden arches of McDonalds, “Stop” sign¹⁵⁰
- Remembers and understands familiar stories¹⁵⁹
- Speaks in sentences of at least three words¹⁵⁹
- Tries to join in with singing songs or making rhymes¹⁵⁹
- Recognizes self in a mirror or a photo¹⁵⁹

By 3 years

- Understands “who,” “what,” “where” and “why” questions¹⁵¹
- Creates long sentences using five or more words¹⁵¹
- Talks about past events e.g. trip to grandparents’ house, day at child care¹⁵¹
- Tells simple stories¹⁵¹
- Understood by most people outside of the family, most of the time¹⁵¹
- Shows affection for favourite playmates¹⁵¹
- Engages in multi-step pretend play with actions and words e.g. pretending to cook a meal or repair a car¹⁵¹
- Understands and uses some describing words e.g. “big,” “dirty,” “wet”¹⁵⁴
- Joins in play with a group of two or more peers¹⁶¹
- Listens to stories or music for five minutes with an adult¹⁶⁰
- Aware of the function of print e.g. in menus, lists, signs¹⁵¹
- Beginning interest in, and awareness of, rhyming¹⁵¹

By 4 years

- Follows directions involving three or more steps e.g. “Get some paper, draw a picture, and give it to mom”¹⁵¹
- Shows four colours when asked¹⁵⁴
- Asks and answers a lot of questions e.g. “Why?”, “What are you doing?”¹⁵⁴
- Uses adult-type grammar¹⁵¹
- Tells stories with a clear beginning, middle and end¹⁵¹
- Talks with adults and other children to try to solve problems¹⁵¹
- Speaks clearly enough to be understood by strangers almost all the time¹⁵¹
- Demonstrates increasingly complex imaginative play using words, characters, action and interactions with peers¹⁵¹
- Able to generate simple rhymes e.g. “cat-bat”¹⁵¹
- Matches some letters with their sounds e.g. “letter T says ‘tuh’”¹⁵¹
- Enjoys singing children’s songs¹⁵⁴
- Participates with peers in small group activities, sharing and taking turn e.g. catch, snakes and ladders¹⁵⁴

By 5 years

- Follows group directions, e.g. “All the boys get a toy”¹⁵¹
- Understands directions involving “if...then” e.g., “If you’re wearing runners, then line up for gym”¹⁵¹
- Describes past, present and future events in detail¹⁵¹
- Uses almost all of the sounds of their language with few to no errors¹⁵¹
- Seeks to please his/her friends¹⁵¹
- Shows increasing independence in friendships¹⁵¹
- Knows all the letters of the alphabet¹⁵¹
- Identifies the sounds at the beginning of some words e.g., “Pop starts with the ‘puh’ sound”¹⁵¹

PROBLEM SIGNS

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

- Stuttering i.e. using repetitions of words, syllables, sound prolongations, or blocks e.g. “I-I-I”, “da-da-daddy”, “mmmommy” “b—all”¹⁶²
- Ongoing hoarse voice or unusual voice quality¹⁶³
- Difficulty with feeding or swallowing¹⁶⁴
- Excessive drooling¹⁶³

Speech and language challenges are sometimes associated with other developmental concerns. Also refer to the following domains in this guide for other potential referrals:

- **Autism Spectrum Disorders (ASD)**
- **Hearing**
- **Feeding skills**

Where to go for help

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

- Their family physician/paediatrician or
- Child Development Programme
Speech & Language
295-0746
- Speech, Language and Hearing Services
278-6427
- Private speech language pathologist/support services

A list of additional public & private agencies that can help is available at www.earlyyears nurturingbda.org, under the ‘Resources’ section.

TOBACCO SMOKE (SECOND AND THIRD-HAND)

Early, regular exposure to second and third-hand smoke impacts health long-term. Children are most at risk for serious health problems from tobacco smoke.¹⁶⁵

A baby or child may be exposed to tobacco smoke at home, daycare or other environments.

Second-hand smoke is exhaled by the smoker into the air and inhaled by other people in close proximity.¹⁶⁶ There is no safe limit of exposure.¹⁶⁷

Third-hand smoke is the chemical residue that is left on furniture, carpets, toys, fabrics and dust after a cigarette, cigar or pipe is put out. It has the same toxic chemicals as second-hand smoke and can remain for months or years. Young children can take in many times more third-hand smoke than adults.¹⁶⁸

While planning for a pregnancy, as well as during pregnancy, exposure to tobacco smoke can affect the health of the baby and it can also make it difficult for individuals to conceive.¹⁶⁹

E-cigarettes are gaining in popularity and we need more research on the effects of exposure to second-hand vapour. We know that the vapour from e-cigarettes is not harmless.¹⁷⁰ Therefore, it is recommended to treat vape aerosol the same as tobacco smoke. Protect children from exposure.

Accidental ingestion is also a concern with babies and young children. It is important to keep e-cigarette devices and liquid out of the reach of young children.¹⁷¹

Children are most at risk for health and growth and development concerns when exposed to second and third-hand smoke due to the following:

- They breathe faster
- Their bodies are smaller
- It's harder for them to break down the chemicals found in tobacco smoke
- They cannot remove themselves from smoking environments
- Babies crawl on the floor and put their hands and objects in their mouths taking in more chemicals than adults¹⁷⁰

Children who are regularly exposed to second and third-hand smoke are at risk for the following:

- Sudden Infant Death Syndrome (SIDS)
- Sleep challenges
- Colic
- Coughing and/or wheezing more frequently
- Asthma
- Bronchitis, ear infections, pneumonia and croup
- Learning challenges that lead to lower scores in math, reading and logic
- Behavioural issues such as hyperactivity
- Heart disease in adulthood
- Smoking themselves as a teenager or adult¹⁶⁷

PROBLEM SIGNS

If a child is experiencing the following, consider this a **red flag**:

- Regular exposure to second and/or third-hand tobacco smoke
- Frequent asthma attacks, respiratory and ear infections

Where to go for help

If the parent/caregiver is a tobacco user, encourage them to work toward a tobacco-free life and keep vehicles and homes smoke-free by suggesting they access agencies from the 'Resources' section of www.earlyyearsnurturingbda.org.

VISION

A great deal of a child's early learning occurs through vision. Children who are born with (or acquire in early childhood) blindness or low vision are at a greater risk for developmental delays and communicative disorders. Monitoring a child's visual development is important since early identification can often reduce or eliminate the risk of long-term complications. The Canadian Association of Optometrists recommends children have their first eye exam between ages six and nine months and annually

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 together¹⁷³

By 3 months

- Eyes glance from one object to another
- Eyes follow a moving object or person
- Stares at a caregiver's face
- Begins to look at hands and food¹⁷²

By 6 months

- Eyes move to inspect surroundings
- Reaches for objects
- Looks at more distant objects
- Smiles and laughs when they see you smile and laugh¹⁷²

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 toy¹⁷²

By 2 years

- Uses vision to guide reaching and grasping for objects
- Looks at simple pictures in a book
- Points to objects or people
- Looks for and points to pictures in books
- Looks where they are going when walking and climbing¹⁷²

PROBLEM SIGNS

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

- Swollen or encrusted eyelids
- Bumps, sores or sties on or around the eyelids
- Drooping eyelids
- Lack of 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 co-ordinated 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 lights¹⁷²

Where to go for help

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

- Their family physician/paediatrician or
- Child Health Services 278-6460
- Child Development Programme
Ages: Birth to 4 years
295-0746
- Vision Bermuda 292-3231
- An optometrist or ophthalmologist

A list of agencies that can help are available at www.earlyyearsnurturingbda.org, under the 'Resources' section.



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