Developmental assessment in the over 5s

Max Davie

► Additional data (online supplementary file) are published online only. To view these files please visit the journal online (http://ep.bmj.com/content/97/1.toc).

Correspondence to
Dr Max Davie, Lambeth Community Health, Mary Sheridan Centre, 5 Dugard Way, London SE11 4TH, UK; max.davie@nhs.net

Accepted 16 March 2011
Published Online First 5 May 2011

Abstract

The paediatrician's role in the developmental assessment of children under the age of 5 is well established, and so he/she might also have a role in the assessment of school-age children, particularly as (i) it is increasingly recognised that subtle presentations of developmental disorders may escape professional notice until school age, (ii) these disorders are interweaving and overlapping, necessitating a truly holistic view and (iii) no another professional group is equipped to deliver a single diagnostic assessment encompassing cognitive, communication, social, emotional and physical domains.

However, assessment in the over-5s requires a different set of skills to the under-5s. The emphasis in this age group shifts from assessing developmental impairment, for example, a specific delay in walking or talking or a low developmental quotient, to assessing factors affecting the child's social or academic function. The paediatrician's task is to apply their knowledge of risks and vulnerabilities, using their experience in general and developmental paediatrics, paediatric neurology and child and adolescent mental health to identify environmental and/or biological factors affecting the child. The diagnostic focus that is a strength of paediatric practice needs to be tempered by a more flexible approach taking account of the child's strengths and difficulties. Finally, the clinician needs to decide if further assessment and investigations are required and make recommendations to help improve the outcome for the child.

In this paper, the author will set out the context for these assessments, and then guide the reader through a clinical approach that the author has found useful.

Introduction

This paper describes our practice in Lambeth, as well as arguing for a role for paediatricians in school-age developmental assessments. By developmental assessment, I mean the whole initial clinical encounter between doctor and family, which leads to the formulation of a developmental profile, suggestions for possible diagnoses and referral for further assessment. It does not cover definitive diagnostics.

Note that I have referred to the child throughout as 'she' in order to remind the reader of the ease with which these difficulties may be missed in girls.

What is the population need?

Many children enter school with undiagnosed developmental disorders.[1] However, these difficulties come to light as developmental expectations rise incrementally during the early school years. For this reason, this article focuses on the development of skills at primary school age (5–11). An appropriately trained paediatrician, working in a multidisciplinary context, can contribute a holistic integrated assessment of a child's development which can add unique value to the process of clarifying a child's needs and how to meet them.

Table 1 provides a list of the conditions that typically come to paediatric attention in the school-aged child. Three points need to be made. First, the figures shown are estimates of population prevalence: the *incidence* at school age will vary from condition to condition: on the one hand, most cases of severe global learning difficulties will be detected before school age, whereas specific learning difficulties are more likely to be detected once school has begun. Second, the conditions are common, and therefore services need to plan for large numbers of children presenting. Third, these conditions do not usually present in isolation, but more commonly as a combination of difficulties which constantly defy and confound neat classification. Therefore, for an assessment to be maximally useful it needs to be broad based, and take in cognitive, communication, social, emotional and physical domains.

Table 1 Typical conditions in the school-age child

Condition	Prevalence/1000
Language disorders	30–50
Severe learning difficulties	3
Mild/moderate learning difficulties	5–10
Specific learning difficulties	30
Dyspraxia/developmental coordination disorder	50
Attention deficit hyperactivity disorder	10–30
Autism spectrum disorders	10
Fetal alcohol syndrome	0.3 (unknown prevalence of fetal alcohol effect)
Syndromes	3 (approximately)
Abuse and neglect	?

Box 1 A selection of questionnaires: see further reading for weblinks

- Broad-based questionnaires
  - Strengths and Difficulties Questionnaire
  - Conner's Rating Scale – Long version
  - Pediatric Symptom Checklist
- Condition-specific questionnaires
  - Autism spectrum disorders
    - Social Communication Questionnaire
    - Children's Communication Checklist
  - Attention deficit hyperactivity disorder
    - Conner's Rating Scales – Short version
  - Anxiety
    - Spence Anxiety Scale
  - Mood
    - Mood and Feelings Questionnaire

What are appropriate developmental expectations in school-age children?

Unlike the assessment of preschool development, developmental milestones are of limited use in our age group. The demands of the national curriculum[2] and the social and behavioural expectations of teachers and peers provide a useful yardstick, and difficulties with functioning within the family may be traced (with caution) back to developmental issues.

So rather than check milestones, it is more useful to ask what functional expectations the child is failing to satisfy, and then which developmental deficits have led to these functional problems.

This usefully roots the assessment in the child's everyday experience, and identifies the task which sets the paediatrician apart from other professionals – the challenge is to spot the pattern in the detailed picture of strengths and difficulties that points towards one or more particular developmental domains (see the 'Putting it all together' section below).

How does paediatrics fit in?

Paediatric services form only one element of the 'assessment landscape' for school-age children, and assessments are usually multi-disciplinary and multi-step. As well as the usual contact with general practitioners, therapists and nursing professionals, the following relationships need careful management.

First and foremost among professional agencies, *schools* act as a focal point for developmental assessment, and of course intervention. No assessment can be said to be complete in this age group without the involvement of the school in some way. Information from the school is essential, and at times the assessment is best relocated there.

Each local education authority has a team of *educational psychologists*. The purpose of this team is "the application of psychology in the school environment" (L Hime, personal communication, October 2009). Like paediatricians, they are interested in developmental skills, but approach these from an educational rather than developmental perspective, and do not generally use a diagnostic approach. However, with close co-operation and open communication, the two services can be made to complement each other.

Child and Adolescent Mental Heath Services (CAMHS) and developmental paediatrics have many patient groups in common, and both have a unique contribution to make. CAMHS have greater expertise in examining emotional difficulties, family dynamics and self-harm, as well as mental health disorders per se. Paediatrics has a greater emphasis on developmental and physical issues, and is for many families a less stigmatising referral.

The relationship with therapists is particularly important, particularly for speech and language therapy (SALT) and occupational therapy (OT). Joint assessment should be considered in some cases.

Which children should paediatricians see?

A focus on the following groups is likely to be most useful:

1. Children with an uneven developmental profile, who are having difficulties which extend beyond the academic sphere
2. Children who are not making expected progress despite intensive school intervention
3. Children whose development is faltering or regressing
4. Children displaying behaviour problems thought to be possibly developmental in origin.

The school-age developmental assessment

A developmental assessment is a clinical encounter designed to elicit information for the purposes of forming a picture of a child's strengths and difficulties, also taking into consideration whether the child's difficulties fit into any known diagnostic categories.

The key clinical questions are as follows:

1. Is there a general cognitive deficit or a specific difficulty, for example, language deficit?
2. Does the child have any identifiable neurodevelopmental conditions (which for

Table 2 The Lambeth assessment battery: an example

Test	Purpose
Goodenough Draw-A-Man Test	Non-verbal cognition
	Visuo-motor planning
Beery visuo-motor assessment battery (shape copying)	Visuo-motor planning
	Fine motor co-ordination
Raven's continuous progressive matrices	Non-verbal cognition
	Visuo-perceptual skills
Crichton Vocabulary Scale	Verbal cognition
	Verbal fluency
Digit span	Working memory
Motor skills screening	Higher motor skills

the purposes of this article, we will deem to be the cluster of autism spectrum disorder (ASD), attention deficit hyperactivity disorder (ADHD), developmental coordination disorder (DCD) and related co-existing conditions), physical disability or sensory impairment?

3. Does the child have any unmet mental health needs?
4. Are there contributing or underlying psychosocial stresses?

Each question needs to be addressed independently, as each will yield important information in its own right. The clinician needs to ask whether the pattern of strengths and difficulties that emerges from asking these questions accounts for the child's impairments.

The assessment consists of four elements: information gathering, history taking, qualitative observation and quantitative assessment. Each element contributes to the three clinical questions addressed above.

Information gathering

A bewildering array of standardised forms and questionnaires are available for gathering information *formally* (see box 1). These can be useful in delineating the exact nature and extent of any difficulties, but on the other hand can prematurely guide enquiry in one direction, or mislead entirely.

The importance of *informal* information gathering cannot be over-estimated. A discussion with an experienced professional will often throw immediate light on a seemingly mysterious presentation. This may also be the best opportunity to pick up safeguarding concerns not yet escalated to social care. Caution needs to be exercised with informal information, however, as no-one's objectivity is perfect, and it is unfortunately the case that, sometimes, the school's attitude and behaviour towards the child can be part of the problem.

Existing *reports* from other professional groups including education and social care, will need to be gathered, preferably before clinic. This will need parental consent (most commonly obtained at referral).

Managing the clinical encounter

The section on history taking which follows specifies which information is important; it is equally important to know who should provide the information.

As children get older, they are more and more able to express themselves, but, paradoxically, are often more unwilling to do so. They must be given an opportunity to speak for themselves, if necessary without their carers. This is not merely respectful: children's views on their own difficulties are always illuminating. The carer must also have the opportunity to discuss issues with the paediatrician in private. Having the child in the room during some of the history-taking is a useful test of their social and communicative skills, and capacity for boredom. Their interruptions and interactions greatly enrich the resultant history.

History taking

In most aspects, the history differs little from that for the under-5s, except as regards *reported current abilities*. This part of the history will be our main focus in this section. We use a notes proforma in our service which can be accessed online as a supplementary file. Bear in mind that the history obtained from the parent will only be as good as the language skills of the informant, for example, a history of higher order language difficulties may not be elicited from an adult with similar difficulties. It is important to enquire about hearing and vision, and refer if appropriate for formal testing. General systemic enquiry, including bowel and urinary function, headaches and fits/faints/funny turns, is often revealing.

Communication

Difficulties here may be subtle – consider a SALT referral if concerned

- *Receptive language* – ask about the child's vocabulary and the need for simplification and repetitive speech, and about the processing and completion of multi-step instructions (and probe where the process breaks down!). Also explore the understanding of informal language such as jokes and sayings (have some available to try in clinic). Does the child take things literally?
- Most of our population have *expressive language* skills sufficient to produce sentences, but it is important to enquire whether the child can express herself adequately. Word finding difficulties may be present, and must be differentiated from deficiencies of vocabulary (I can't think of the word versus I don't know the word). Explore the quality of speech (loud, fast, monotonous), and its intelligibility.
- When asking about *non-verbal skills*, have in mind the abnormalities found in ASD. Particular emphasis should be given to eye contact and facial expression when making social contact (eg, being picked up from school), the use of gesture both for descriptive and conventional purposes, and the presence of 'second-

order' facial expressions such as embarrassment, guilt and disgust. Carefully probe the perception of others' emotions, including the taking of verbal and non-verbal hints.
- Discuss the appropriateness of speech and *conversational skills*. Are any non-sense words used? Are words used out of context? Does the child talk *with* or *at* the parent? Are events explained in a way that takes into account the listener's state of knowledge? Is there repetition, either of subject matter or of questioning? Do conversations depart on a tangent?

Look for a verbal/performance mismatch: is the child much better at maths and visual skills but struggles with language tasks?

Social relationships

Friendships should be explored, preferably both with the child and parent, and it is the pattern of friendships, rather than their number, which counts. Sibling relationships almost invariably involve conflict, but if they also involve empathy, this is reassuring. Finally, the child's relationship with the wider world is explored: do they cope at parties? Are they fearful of strangers, or disinhibited and tactless in public?

Chosen activities

In 21st century childhood, various sorts of screen time loom large. Even here, though, there are useful avenues to explore. Does the child play multiplayer games, either physically or online? Are the games varied? What exactly is done on the computer – is there any creativity? Is there flexibility over watching habits and the sharing of screen time with siblings?

Some children with ASD watch certain video sequences obsessively; others have an apparently irrational fear of particular scenes.

Play with toys may need to be specifically probed for, as this often happens out of parents' sight, but if possible accounts of imaginative and co-operative play should be sought. Co-operative pretend play ('I'm Batman!') becomes less common with time, so it is worth asking whether this has ever happened. As the child gets older, the arena of play expands outside the home; what does she get up to with her mates?

Behaviour

Focus initially not on unwelcome behaviour, but on an account of a normal day: how does getting to school go? Describe dinner time. What about going to the shops with her? What is bedtime like? This will give a rapid survey of everyday behaviour, which will inform further enquiry.
- *Attention span*: do not take ability to remain glued to a console for hours as evidence for good attention – it is best to find something not involving screens that can engage the child. As well as homework completion (a highly complex area for interpretation), it is worth asking whether simple household tasks can be completed, such as washing up or getting dressed. Distractibility is frequently reported but hard to interpret without observation. Forgetfulness (of school equipment, coat) is an important sign of attention difficulties but also of problems with organisational skills. In older children, it is useful to ask whether they can reliably be sent on a small errand (perhaps during a supermarket visit).
- *Hyperactivity and impulsivity*: the ability to stay still and not fidget or fiddle when required (mealtimes, haircuts) is obviously important, but it is also useful to ask about the noisiness of play. A visit to the shops is testing with an impulsive child, as is any journey near roads. Interrupting conversations is common to both the impulsive and the socially unaware, as is answering questions out of turn in class.
- All children (and adults) have a negative emotional reaction when their desires are thwarted; the important question here is what the child and family do with this emotion. Does she shout, whine or lash out? Does she smash toys or other items? Is she discriminating in her *aggression?* Most importantly, what does the parent do about it? Ask them to describe factually their strategies for unwelcome behaviour – it is always revealing.
- Routines and *rituals* which are stuck to with anxious tenacity, and resistance to change, are common in, but not specific to, ASD; they need to be asked about with care as many families (particularly those with only one child) have adapted so seamlessly to the child that they are unaware of her rigidity.
- Persistent *fears or interests*, unusual in subject or intensity, may indicate rigidity of thought.
- *Sleep* can be addressed here – bedtime is often fraught, and night-waking common in our clinic. Sleep deprivation is both caused by and exacerbates behavioural problems, and sometimes it is impossible to work out which came first. Sleep management should be discussed in any case.
- The ability to accept *changes to routine* is reassuring.

Sensory issues

Sensory needs are frequently overlooked in the school setting. Children may display a combination of over- and undersensitivity to sensory input. Common features are as follows:
- Tactile aversions: food textures, clothing (uniforms can be a problem), type of shoe, physical contact (dislike of light or firm touch)
- Avoidance of vestibular input (roundabouts, climbing frames)
- Sensitivity to noise.

It may be useful to have a questionnaire available to obtain extra information.[3]

Self-care skills

Questions on self-care skills give information not only on fine motor and executive function, but also on

mood (does she sleep in her own room?), social awareness (is she bothered by toilet accidents?) and sensory issues (are there certain clothes that she avoids?). The impact can be significant – if a child is unable to dress rapidly and with ease she may struggle after physical education (PE) in school and come home either in her PE kit or with it on underneath her uniform. Some children avoid PE due to anxieties about undressing and dressing.

Motor skills

Difficulties with low muscle tone, sequencing and co-ordinating movements may lead to impairments in academic work (especially literacy), social life (ability to participate in activities) and self-care (can she do up her buttons?). Frequent falls are more often the result of inattention, impulsivity or a lack of confidence than motor disability, but muscular or neurological problems should be considered.

Questions to ask:

- Can the child use a knife and fork, or are fingers preferred?
- Does she avoid using a pencil whenever possible and can she copy letters and numbers?
- Can she copy neatly, is she always slow or can she speed up and is this at the expense of neatness?
- Can she draw – if so, is it a familiar cartoon or an imaginative scene?
- Can she kick a ball?
- Can she catch a ball?
- Can she ride a bicycle?
- Is there disproportionate difficulty in writing?

Qualitative observation

The child's behaviour and interaction with both parent and clinician should be recorded, without resort to value judgement. If the child can sit still, keep an eye out for fidgeting and tics. It is useful to record eye contact, facial expression and any abnormality of vocal tone, tempo or prosody.

Borrowing from the Autism Diagnostic Observation Schedule (ADOS) assessment, it is very revealing to ask the child what she likes to do with friends, and why she has chosen particular people as friends. Also, the child's aspirations are often revealing, as well as their feelings about having a partner or marrying in later life. Many paediatricians find great value in asking the child what their 'three wishes' would be. Finally, one of the biggest mistakes made by clinicians seems to be neglecting to attempt to 'chat' informally with the child, to assess their abilities in informal, reciprocal conversation.

Quantitative assessment

It is important to do some direct assessment of the child, for no other reason than to provide qualitative information about interaction/attention. Many clinicians develop over time a non-standardised set of exercises that serve as indicators of particular cognitive, linguistic or motor problems, and inform further referral. Alternatively, there are a number of standardised tests of cognitive abilities, both global and specific, and some examples are given in table 2.

In the UK, such cognitive testing has traditionally been the preserve of clinical or educational psychologists. The advantage for paediatricians of performing some standardised tests is that they can inform the interpretation of other findings – it is unfair, for example, to expect a child's attention span to be in advance of her cognitive development. The tests may also be useful in guiding future intervention or assessment, and in attempting to explain impairment.

However, such tests must be used with caution, and never without training: many are very demanding of time and resources, both in the training required and in their administration and interpretation. Others are of limited scope, and the danger of over-interpretation must be borne particularly in mind.

Physical examination

It is, as always, important to weigh and measure children, and perform an examination of systems. The latter can often be brief, but should always include examination for neurocutaneous markers.

Neurological examination should focus on balance, co-ordination, sequencing and gait in particular.

Examination of the eyes and ears should include the quality of eye movements and convergence. The presence of dysmorphism may trigger genetic investigation.[4]

Detecting mental health problems

Paediatricians are not expected to provide full mental health assessments; however, it is part of paediatric competence to detect mental health problems by a combination of sensitive history taking and observation.

In primary school-age children, direct interrogation of their mental state is likely to be less useful than the detection of clues in the history and observation obtained. 'Atypical' presentations are common in this age group. Thus while many depressed children are withdrawn and unmotivated, with a flat affect in clinic, some will present with aggression and truancy.

Anxiety is an important symptom to elicit, but can be very difficult to distinguish from autistic symptomatology; both may cause repetitive, avoidant behaviour, impaired social interaction and lack of social communication. Fortunately, separation is often unnecessary: a suggestive developmental history should trigger a more detailed ASD assessment, while concerns about anxiety can be followed up by direct enquiry. The relationship between symptomatology and life events needs to be made as clear as possible.

Should a mental health problem be suspected, the child's negative thoughts and worries should be explored as well as their aspirations and wishes. This

Box 2 Sample formulation

The child is a cognitively able boy, with normal social communication skills in a one-to-one setting. He shows age-appropriate impulse control and levels of concentration, and normal use of language.
However, he seems to experience difficulties with the processing of sensory information, and so is easily overwhelmed by sensory experience, particularly tactile and auditory. This seems to be underlying his aversion to group activities at school, and fearful reaction to some social situations.
His anxiety about his difficulties, and the impact they have had on his academic progress, seem to have impacted upon his behaviour at home, which is more frequently angry than avoidant.

area of questioning causes some anxiety in paediatricians – in fact a combination of open questioning, active listening (including the use of silence!) and a few set-piece questions (such as asking for three wishes) will yield enough information to at least have a sensible conversation with local mental health services. Questionnaires may be used, but are typically not standardised for developmentally disordered children.

Putting it all together: formulation of strengths and difficulties

At the end of the assessment, the clinician will be in possession of a huge amount of information on the child, her family and the broader environment.

The first task is to analyse the pattern of functional difficulties to discern the underlying developmental deficits. Take for example the frequent parental complaint of a child who doesn't listen.

First, we must dismantle the act of listening to see where it has broken down in this case: is it getting the child's attention, or maintaining it? Is it understanding instructions, or retaining them? Are things taken literally and out of context? Is this a problem at both home and school?

Second, we must see where else the child's function is impaired: if she is distractible in all contexts, poor concentration is suggested; if she is socially isolated at school, poor social communication may be the cause of her not listening. Similar enquiries into other dysfunctions yield a pattern of developmental deficits (or difficulties) which exist in the context of compensatory strengths. It may be that this pattern is suggestive of a given diagnosis, but in many cases, the clinician will not be in a position to offer a firm diagnosis at the end of clinic. Many of the diagnostic possibilities that will be raised require in addition a combination of specialist direct assessment and detailed third party information. These will need to be performed and collated, and diagnosis is usually confirmed at a subsequent contact. On the other hand, the assessment described here should cover the majority of diagnostic issues. It will also provide the basis for a developmental profile, as recently recommended in the National Institute for Health and Clinical Excellence ASD guidance (unpublished but distributed in draft, and will appear at http://guidance.nice.org.uk/CG/Wave15/78 when published); indeed such a profile is essential for the management of any neurodevelopmental condition. A purely diagnostic model is both limited and limiting here. In our view, a formulation emphasising the developmental skills that a child has mastered fully, as well as those where she is struggling, will be more useful in guiding future intervention (see box 2 for a sample formulation). Of course, in some children such a formulation will not be possible even at the end of a long assessment, as the data gathered may be confusing and contradictory.

It is tempting to speculate on the antecedent factors underlying a developmental deficit; usually a combination of genetic inheritance, developmental input from carers and broader factors such as access to leisure and exposure to alcohol in all its forms. Teasing these apart in individual cases is often both difficult and futile, unless the factor in question is remediable (eg, exposure to domestic violence) or overwhelmingly likely to have directly caused difficulties (eg, birth trauma). Knowledge of the wider context can, however, inform recommendations.

Next steps

The three main tools at the clinician's disposal at this point are as follows:

1. *'Common-sense' recommendations*: these will emerge naturally from the findings of assessment, and are not to be underestimated. Thus the child showing signs of language dysfunction does not need to wait for formal language assessment before visual reinforcement of verbal instructions can be recommended, and the parent unable to impose consistent boundaries can be referred for parenting intervention before any diagnostic work.
2. *Onward referral*: this may be to therapists (SALT, OT, physiotherapy) for further assessment and intervention, or other clinical teams, for instance CAMHS or paediatric neurology. Many children will need formal hearing and vision assessment.
3. *Further information gathering*: Narrow-based questionnaires may be sent to schools, parents and other agencies in order to facilitate diagnosis (see box 1), and multidisciplinary meetings convened in complex cases.
4. *School visits*: The value of seeing the child in this familiar environment, and chatting with professionals who know her well, cannot be overestimated. Do it if you are unsure and can possibly spare the time.
5. *Further clinical assessment*: Individual clinicians may wish to develop particular skills in assessing certain developmental domains, such as working memory, visuo-perceptual skills and attention. This may be

particularly useful if assessing children who have previously been seen by more junior staff. However, such skills are beyond the scope of this article.

Conclusion

As the developmental skills acquired become ever more complex during the school years, so does their assessment. The relationships between developmental domains add an extra layer of complexity, and make a truly holistic assessment essential in developmental disorders. We hope that we have shown that, by offering an integrated assessment spanning cognitive, communicative, social, emotional and physical domains, paediatricians have a unique contribution to make in the management of this fascinating group of children.

Acknowledgements The author would like to thank Eve Rossor, Moira Dick and Ajay Sharma for their comments and support through earlier drafts.

Competing interests None.

Provenance and peer review Not commissioned; externally peer reviewed.

References

1. **Howlin P**, Asgharian A. The diagnosis of autism and Asperger syndrome: findings from a survey of 770 families. *Dev Med Child Neurol* 1999;**41**:834–9.
2. In the UK, Teaching in State Schools is Organised Around a Single National Curriculum. http://www.education.gov.uk (accessed 12 April 2011).
3. Sensory Checklist: Taken from Raising a Sensory Smart Child, © Biel & Peske, 2005. http://sensorysmarts.com/sensory-checklist.pdf (accessed 12 April 2011).
4. **Horridge K**. Assessment and investigation of the child with disordered development. *Arch Dis Child Educ Pract* 2011;**96**:9–20.

Further reading

The following are useful sources of further information.

General development

Dixon S, Stein M. *Encounters with Children: Pediatric Behavior and Development.* Philadelphia: Mosby, 2005.

Autistic spectrum disorders

Frith U. *Autism: Explaining the Enigma.* Oxford: Blackwell, 2003.
Attwood T. *The Complete Guide to Asperger's Syndrome.* London: Jessica Kingsley, 2008.

ADHD

Barkley R. *Attention-Deficit Hyperactivity Disorder.* New York: Guilford Press, 2006.
National Institute for Health and Clinical Excellence (NICE) guidance. Attention deficit hyperactivity disorder (ADHD). http://guidance.nice.org.uk/CG/Wave10/1 (accessed 5 April 2011).

Developmental coordination disorder

Kirby A. *Dyspraxia: Developmental Coordination Disorder.* London: Souvenir Press, 2006.

Mental health

Goodman R, Scott S. *Child Psychiatry.* Oxford: Blackwell, 2005.

Weblinks for questionnaires

Strengths and Difficulties Questionnaire, http://www.sdqinfo.org/ (accessed 5 April 2011).
Conner's Questionnaires, http://www.mhs.com; can be ordered in UK via http://www.psychcorp.co.uk/ (accessed 5 April 2011).
Pediatric Symptom Checklist, http://www.brightfutures.org/mentalhealth/pdf/professionals/ped_sympton_chklst.pdf (accessed 5 April 2011).
Social Communication Questionnaire, http://www.hogrefe.co.uk/?/test/show/64/ (accessed 5 April 2011).
Children's Communication Checklist, http://www.psychcorp.co.uk (accessed 5 April 2011) has version 2; original version at http://psyweb.psy.ox.ac.uk/oscci/dbhtml/CCC/ccc.htm (accessed 5 April 2011).
Spence Anxiety Scale, http://www.scaswebsite.com/ (accessed 5 April 2011).
Mood and Feelings Questionnaire, http://devepi.duhs.duke.edu/mfq.html (accessed 5 April 2011).

Developmental assessment in the over 5s

Max Davie

Arch Dis Child Educ Pract Ed 2012 97: 2-8 originally published online May 5, 2011
doi: 10.1136/adc.2010.208140