Los Angeles County Department of Mental Health
Infancy, Childhood and Relationship Enrichment
Initial Assessment Reference Manual

Los Angeles County Department of Mental Health
Infancy, Childhood and Relationship Enrichment (ICARE)
Initial Assessment Reference Manual

DISCLAIMER: The ICARE manual is to be used as a guide to assist in completing the ICARE initial assessment. It is not a substitute for attending an ICARE training.

Los Angeles County Department of Mental Health
Infancy, Childhood and Relationship Enrichment
Initial Assessment Reference Manual

FOREWORD

This version of the ICARE Assessment manual has been updated to reflect the use of the DC: 0–5™: Diagnostic Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood. The revision is intended to help with early identification of issues that may influence the trajectory of a young child's life. There are questions and prompts in the assessment form addressing important aspects of a young child's social life, the quality of the dyadic relationships, as well as possible considerations for referrals. One of the hopes is that this assessment tool will be used to slow down the clinical process and gather as much vital information to create quality treatment roadmaps for children and their families.

Ever more important during these times where we are facing a global pandemic and a civil movement, mental health professionals must do their very best to ensure that there is equity and access for infants, toddlers and their families. Implicit biases and systemic racism has an impact on the families we serve, who are often overrepresented from low socio-economic backgrounds and communities of color. Food insecurities, limited affordable housing and transportation, job instability, limited access to appropriate health care and generational trauma are just some of the social determinants of health that all continue to manifest themselves in poor outcomes for many young children. We as mental health professionals have an opportunity and an ethical responsibility to ensure that all children have access to quality education, health and mental health care, and food.

We know too many of our families of color face higher rates of poor access to maternal mental health and health care, experience higher rates of infant mortality, limited access to quality foods and education, and have higher rates of involvement in different systems, including the Department of Children and Family Services. There is a disproportionate rate of black and brown children that receive out of school suspensions in preschool in comparison to their white counterparts. These biases carry through to K-12 essentially funneling them out of the public school system and into the juvenile and criminal justice systems, a concept known by many as the pre-school to prison pipeline. Many of these children have undiagnosed learning disabilities and/or have been given inappropriate mental health diagnoses which fail to take into consideration traumatic experiences and how these manifest in their behaviors. Furthermore, at times there is a failure to consider culturally appropriate treatment and interventions.

We need to honor the diversity and strengths of the families and the communities that we serve with the goal of building healthy, strong, and empowered families. This becomes especially crucial given that our young children are amongst the most vulnerable and at risk for negative outcomes related to abuse, poverty, and trauma, to name a few.

Not only is the ICARE a mental health assessment tool created to determine if a child would benefit from mental health services, it is furthermore a mechanism by which we can advocate for needed resources and services to build the very best foundation for young children. The ICARE highlights the importance of a multi/intra/inter disciplinary approach and sets the foundation for

considering a child and family in their totality and to consider all that affects this child and family, including implicit biases, racism, poverty, and trauma.

In closing, consider the words of Dr. John B. King, Jr., *"The start that we give our children shapes how we end up as a society."* Let us be that change and set a foundation for our children and for our humanity.

I would like to offer special thanks to the following individuals who assisted with the development of this revision:

Amber Cárdenas, LCSW
DMH – Mental Health Clinical Supervisor, Long Beach Child and Adolescent Program
Verónica Chávez, PhD, IECMHS
DMH- Clinical Psychologist II, Prevention Services, Family and Community Partnerships
Emily C. Dossett, MD, MTS
DMH - Associate Medical Director, Women's Health and Reproductive Psychiatry
Assistant Clinical Professor, Keck School of Medicine, University of Southern California
Departments of Psychiatry and Biobehavioral Sciences and of Obstetrics / Gynecology
Allegra Klacsmann, PhD
Former DMH Employee
Lisa Schoyer, MFA
DMH – Medical Case Worker II, Prevention Services, Family and Community Partnerships
Mike Sherman, PsyD
DMH – Clinical Psychologist II, Child Welfare Division, MAT Program Administration
Marian E. Williams, PhD, RPM
Associate Professor of Clinical Pediatrics and Psychology, Keck School of Medicine, University of Southern California
President, CalAIMH (California Association for Infant Mental Health)
Lesli Yoshihara, LCSW, IECMHS
DMH – Psychiatric Social Worker II, Prevention Services, Family and Community Partnerships

And the countless other partners including, DMH - Quality Assurance Division, Legal Entity Providers and other key Birth to Five champions.

Thank you all for your work and for being that change for our children and families.

Carolyn L. Kaneko, LCSW
DMH – Mental Health Clinical Program Manager, San Fernando Child and Family Center
(formerly with Prevention Services, Family and Community Partnerships)

Los Angeles County Department of Mental Health
Infancy, Childhood and Relationship Enrichment
Initial Assessment Reference Manual

INTRODUCTION

The ICARE Initial Assessment Reference Manual is an attachment to the Los Angeles County Department of Mental Health <u>Infancy, Childhood & Relationship Enrichment (ICARE) Initial Assessment</u> Form recommended for use with children birth to five and their families.

The assessment process is the first intervention conducted by the mental health professional in her/his interaction with families. Building a relationship and gathering information are equally important, as a collaborative process with the caregiver will enhance the quality of the interviews resulting in a more strength based outcome (Zeanah, 2000, 2018). A thorough assessment is the process of collecting information to identify a child's developmental strengths, emphasizes the child's functional capacities, current competencies, and those that will promote developmental progression (Finello, 2005). The assessment also identifies weaknesses/challenges, symptoms, and risks. The assessment may or may not lead to a diagnosis. Clinical observation of the child, of the relationship between child and the caregiver(s), and of their interaction in a variety of times, situations, and settings (e.g., feeding, play), along with structured interviews with the family, will ensure a complete developmental evaluation.

Assessment of children and their families should take place in their natural setting (e.g., home, preschool, daycare) and in their primary language when it is more likely that families will engage in routine patterns of behavior. The assessment process is part of the "ongoing mutual negotiation aimed at finding a clinically compelling picture of the family situation, the presenting problems, and the infant's and caregiver's experiences." (Zeanah, 2000, 2018)

As a precaution, young children should not be challenged by being separated from their parents during the assessment or to be assessed by a complete stranger after only a brief warm up period. Separation can be particularly stressful for both the child and parent. (Zero To Three, 2016)

The Los Angeles County Department of Mental Health, Infancy, Childhood and Relationship Enrichment (ICARE) Initial Assessment form is a comprehensive, multi-disciplinary collaborative document. Information for the assessment should be obtained from a variety of sources, including caregivers, relatives, and other professionals as well as record review, behavioral measures and developmental screening tools. A thorough assessment of an infant or a young child should include between 4-6 sessions (Zeanah, 2000, 2018). The assessment tool is a useful tool for trained mental health professionals to determine whether the infant/child might benefit from mental health treatment, to develop a treatment plan, or to decide on further referral.

Los Angeles County Department of Mental Health
Infancy, Childhood and Relationship Enrichment
Initial Assessment Reference Manual

HOW TO USE THIS MANUAL

The ICARE Assessment was developed to be used with children age 0-5 and their families in lieu of the Child/Adolescent Assessment. A link to the Assessment can be found at: http://file.lacounty.gov/SDSInter/dmh/1069490_MH-645InfancyChildhoodAssessment2-20-20fillable.pdf.

The information collected in this ICARE Initial Assessment Reference Manual is to assist LACDMH mental health professionals in directly operated clinics and contract agencies who serve families with children five years of age and younger. The goal is to complete the Initial Assessment in a more thorough and informed manner given the vast knowledge available about the first years of life and to approach the assessment process systematically with a developmentally based perspective. The assessment tool is aligned with the DC: 0-5™: Diagnostic Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood. ***While it is preferable that clinicians attend an in-person ICARE training prior to doing an ICARE assessment, the Department believes it is best practice to utilize the ICARE form when assessing a child between the ages of birth to five. It is acceptable for a clinician to complete the ICARE if his/her supervisor has been trained in the ICARE and receives guidance from said supervisor. As soon as the clinician is able to attend an ICARE training, it is imperative that he/she attend.***   Training in the use of the DC:0-5 is *highly recommended* for clinicians assessing children under five years of age.

This Manual is divided into two major parts. Part one includes sections that parallel the Initial Assessment form, as follows:

   (I)   ICARE Initial Assessment Form Sections

        Section I: Identifying Information and Special Service Needs
        Section II: Reason for Referral/Chief Concern
        Section III: Mental Status History/Risks
        Section IV: Medications
        Section V: Physical Status/Medical History
        Section VI: Developmental History
        Section VII: Psychosocial History (Child Care / Specialty Services / Educational History)
        Section VIII: Current Family Systems Review
        Section IX: Relevant Past Family Systems Review
        Section X: Observed Caregiver – Child Interaction
        Section XI: Behavioral Observations & Interview with Caregiver
        Section XII: Mental Status / Behavioral Observations of Child
        Section XIII: Summary/Clinical Formulation/Diagnosis
        Section XIV: Disposition/Recommendation/Plan
        Section XV: Referrals Given Including Service/Referral Settings
        Section XV: Signatures

Part two includes mediating/risk factors clinicians should consider that may increase vulnerability to psychological disorders and resilience/protective factors that can contribute to positive outcomes and mitigate future psychological disturbances. Successful interventions will reduce risk factors and target multiple protective factors. (Zeanah, 2000, 2018)

Cultural competence is the awareness, understanding, and openness to continual learning with individuals of different cultural backgrounds. It is the key to effective and ethical interventions and central to meeting the needs of diverse communities.

- (II)   Risk/Mediating Factors
- (III)   Resilience/Protective Factors
- (IV)   Cultural Competence
- (V)   References and relevant birth to five resources for further reading

Los Angeles County Department of Mental Health
Infancy, Childhood and Relationship Enrichment
Initial Assessment Reference Manual

I. ICARE INITIAL ASSESSMENT FORM SECTIONS

SECTION I: IDENTIFYING INFORMATION AND SPECIAL SERVICE NEEDS
- While there are only two options for Gender (i.e., Male and Female), the clinician can ask whether any other pronouns (she/hers/he/his/they) are preferred and note it either on the "other names used" or "cultural considerations" free text field.
- The form currently provides space for 1 primary caregiver, however, the clinician is recommended to get as much information on the caregivers in the child's life.
- Additionally, it is important to consider that not all families are homogenous, and clinicians need to be sensitive to same sex couples who are also parents to the children with whom we work. It is best not to assume a family consists of a mother and father.

SECTION II: REASON FOR REFERRAL/CHIEF CONCERN
- Useful questions to consider in gathering as much information as possible.
- Why was the child referred? Why now? What type of help is the family hoping to receive? What does the caregiver perceive as concerning or problematic? If not self-referred, at whose recommendation did the caregiver decide to seek services?
- What are the current primary concerns? (Include the onset, triggers, duration, intensity, and frequency)
- Inquire about the history of the problem. Has this happened in the past? What helps address the difficulties? Any identifiable triggers? What makes the behaviors or symptoms worse? Is the problem specific to certain situations, contexts, environments, or caregivers or is it more global?
- What is the functional impairment? Clinicians should include such factors as the probability of not meeting developmental milestones, Probability of later deterioration in functioning, as well as the impact on the family
- In this section, it is also a good idea to gather information on the strengths of the: Child, Dyad, Family and highlight what is working for the family, what they are proud of.

SECTION III: MENTAL STATUS HISTORY/RISKS
- While epidemiological studies indicate that there is 16–18% prevalence rate of mental disorders among children aged 1 to 5 years, there is not much information on the rates of psychiatric hospitalizations for this age group. Even so, it remains important to inquire about individual children's history related to psychiatric hospitalizations.
  - Engage the caregiver by asking such questions as: has your child previously participated in therapy? Or have you and your child participated in mental health services together before? Has your child been hospitalized due to concerns for their own safety or potential harm to someone else?
- TRAUMA OR EXPOSURE TO TRAUMA: It is crucial to gather information on past trauma exposure, both from collateral contacts, as well as from records. In a thought-provoking article published in The Guardian, Dr. Lauren Devine makes the assertion that even a referral to Child Protective Services, whether it is conclusive or not, is enough to trigger a trauma

response in some children and their families (Tickle, 2016). Even if the child was not detained but if he or she was questioned by a social worker, it could be a potentially traumatizing event.

- Asking about exposure to medical trauma is also key. This may include such experiences as NICU stay when the child was born, any PICU stays, visits to the emergency room (e.g., catheter placement, blood draws, IV placement, child having to be held down by caregivers or medical personnel to name a few).

SECTION IV: MEDICATIONS
- In gathering information on medications used by the child, ask about 1) prescribed medications 2) medications bought in a pharmacy or online and 3) any home remedies used. Also ask WHY the medication is being used and for HOW LONG it has been used.
- Important to ask specifically about any medication effects on mental health/behaviors (e.g. steroids, albuterol, pain meds, anti-epileptic meds, psychotropic meds, over-the-counter dietary supplements). It is always practice to fill in the specific side-effects to any medications.
- SUBSTANCE EXPOSURE/Parental Substance Use: Note any prenatal or postnatal substance exposure, parental use including the toxic substance. (See below for further details on what/how to ask these questions).
  - Ask questions related to exposure to alcohol and keep in mind Fetal Alcohol Spectrum Disorder

SECTION V: PHYSICAL STATUS/MEDICAL HISTORY
- Consider asking about other medical conditions not noted on the ICARE form, please refer to the table below for additional medical conditions to consider in young children.

☐Ear infection(s) #:_____	☐Colic	☐Recurrent or chronic pain	☐Cancers/tumors
☐Endocrine (e.g., diabetes)	☐Gastrointestinal	☐ Growth trajectory problems *(pg. 151)	☐Genetic syndromes
☐Hematological/blood diseases	☐Respiratory, specifically asthma	☐ Infectious diseases, such as HIV	☐Neurologic conditions, including history of head trauma
☐Metabolic conditions	☐Vision concerns	☐Hearing impairment	☐Immunologic conditions
☐Dental concerns	☐Allergies	☐Congenital anomalies	☐None

- Also consider asking about any physical injuries or exposures (e.g., burns, bruises, injuries related to abuse, accidental ingestions) the child might have experienced and provide more details (child's age, duration, frequency, intensity, treatment received).
- Given the high rates of obesity in children, it is important to ask about/note whether the child appears overweight/underweight? Are caregivers concerned about the weight? Have medical professionals expressed any concerns to the caregivers?

SECTION VI: DEVELOPMENTAL HISTORY
Note that this section provides a lot of information on the experience of the birth parent(s) and it is included for clinicians' knowledge and to assist with information gathering. Not all this

information is pertinent to questions/prompts that appear on the ICARE assessment form. Should a clinician have concerns about the parent(s)/caregiver(s) mental health functioning, it is important to refer for services.

Prenatal/Perinatal Information

- Information gathered in this section is vital given that it can provide us invaluable information about the impact of environmental stressors on the developing fetus and help explain some of the difficulties a child may be having.
- Environmental stressors on a developing fetus can take several different forms. The primary three are:
  o Substance use or some medication exposures
  o Untreated physical or mental illness in the mother
  o Unresolved or negative social determinants of health, such as housing or food insecurity, intimate partner violence, or lack of social support.
- These stressors negatively affect the fetus in two primary ways.
  o The substance itself crosses the placenta and interrupts normal development (one example would be alcohol use).
  o The stress involved with illness or life circumstances causes the mother to have unregulated stress hormones (mostly cortisol) that cross the placenta and interrupt the fetus' own developing stress management system.
- Many questions about prenatal and early life stressors are sensitive and even embarrassing to parents and caregivers. It's important to ask questions in the following ways:
  o Normalizing questions before asking them: "While some of these questions may seem really personal, please know that we ask them to every parent and caregiver – they are important for helping us better understand your child and how we can best help him/her."
  o Without judgment: for instance, asking "How often did you drink alcohol when you were pregnant?" is much less judgmental than "You didn't drink alcohol when you were pregnant, did you?"
  o The above question is also an example of a "yes / no" question: avoid these!
  o Also avoid "why" questions: for example, asking "Why were you using depressed?" is less likely to yield information than "Please tell me about your depression."
- Good questions to ask to gather information about prenatal substance exposure:
  o How far along were you before you found out you were pregnant? How did you find out (e.g., missed period, home pregnancy test)? About how many weeks were you when your pregnancy was confirmed by a medical professional?
  o Before you knew you were pregnant, how often were you drinking alcohol, smoking tobacco, using marijuana, or using other drugs?
  o Once you knew you were pregnant, how often did you use the following substances?
  o Which ones, if any did, you continue using after the baby was born?

Los Angeles County Department of Mental Health
Infancy, Childhood and Relationship Enrichment
Initial Assessment Reference Manual

o Notes on using the charts below: ask specifically about alcohol, tobacco, and marijuana; if no to all these, then ask "any other street drugs?" If yes to alcohol, tobacco, or marijuana, then ask specifically about the other drugs.

Substance Use in **Pregnancy** (indicate if in mother, father, or both):

Please check all that apply	Alcohol	Tobacco	Marijuana / THC / Cannabis	Methamphetamine	Prescription Pills	Heroin	Cocaine / Crack Cocaine	Other
Frequency								
Duration								
Still using								
In recovery								

Substance Use **Up to One Year Postpartum** (indicate if in mother, father, or both):

Please check all that apply	Alcohol	Tobacco	Marijuana / THC / Cannabis	Methamphetamine	Prescription Pills	Heroin	Cocaine / Crack Cocaine	Other
Frequency								
Duration								
Still using								
In recovery								

- Postpartum psychiatric problems/ Maternal Mental Health Disorders definition: "Maternal Mental Health Disorders" (MMHDs) are any mental health disorder that affects women in pregnancy or up to one year after delivery. MMHDs can be 1) ongoing mental illness in a woman who then gets pregnant or 2) new-onset, with its development only during pregnancy or the postpartum. While we often think of postpartum depression as the only mental illness, the reality is that most women who struggle with MMHDs actually have a longer history of mental illness. Even women who have new-onset illness tend to develop the symptoms in pregnancy, not just the postpartum.

- What are common MMHDs?
    - o Postpartum Depression (PPD) is the most commonly known maternal mental health disorder (see below for rates in Los Angeles County). Most cases begin in the 3rd trimester or consist of ongoing or worsening symptoms in a woman who may have had depression for a long time. The symptoms of PPD are similar to other types of depression: low mood, decreased interest or pleasure, sleep disruption (too much or too little), appetite disruption (too much or too little), low energy, poor concentration, excessive feelings of guilt, physically moving or

sleeping slowly, or even suicidality (more on this below). In addition, many women with PPD have excessive anxiety.

o Anxiety in pregnancy and the postpartum is often underrecognized (in fact, there is no "official" term for it), but some studies show that it is even more common than depression. While some nervousness or anxiety is a natural part of having a new baby, some women have so much anxiety that it impacts their physical and emotional health. Signs of excessive anxiety may include difficulty sleeping, even when the baby sleeps; low appetite, even if breastfeeding; looping, anxious thoughts, often about the baby's health or wellbeing; panic or anxiety attacks; and too much concern about cleanliness or germs, to the point that a mother may not want anyone else touching or helping with the baby. These types of anxiety often exist together, along with depression.

o Perinatal Post Traumatic Stress Disorder (PTSD) is a specific type of PTSD. The traumatic event is childbirth. The actual mode of delivery (vaginal, C-section, vacuum assisted, etc.) is not as important as the experience of the woman. Specifically, feeling as if her pain is not addressed, as if no one is listening to her, and as if she or her baby are in real danger are the biggest triggers. Woman at higher risk for PTSD are those who have histories of depression, anxiety, trauma, or sexual abuse themselves. Rates are roughly 6% for short-term and 3% for long-term cases. The impact on mother-infant bonding can be negative, as the mother may avoid the baby because he/she is the reason the PTSD occurred. Other long-term negative effects can be worsening of her partner relationship because she does not want to get pregnant again and refuses any sexual activity that could lead to pregnancy.

o Bipolar disorder affects roughly 2-3% of all women of childbearing age, including women who are pregnant or postpartum. Bipolar disorder, by definition, means that a woman has days- or weeks-long episodes of "mania." Mania has the following characteristics: really good or high mood OR anger and irritability; decreased need for sleep (NOT insomnia); increased energy or productivity; disorganized thoughts or actions; uncharacteristic, risk-taking behavior, such as spending too much money or acting out sexually; or even psychotic symptoms like hearing voices or feeling paranoid. While depression isn't required for a diagnosis of bipolar disorder, the majority of people with bipolar disorder have episodes of depression, also, and in fact, tend to spend more time depressed than manic. For either type of episode, psychiatric medication is vital for stability. This can be difficult to manage in pregnancy, as medications can have their own risks. However, it is important, because the highest risk time for women to relapse into symptoms of bipolar disorder and become psychiatrically hospitalized is in the first four weeks after delivering a baby.

o Psychosis is not a diagnosis, but rather a set of symptoms that are present in many different diagnoses, in perinatal women as well as in the general population. Psychosis essentially means that one's thoughts are not in sync with reality. This can result in hearing voices (auditory hallucinations) or other types

of sensory hallucinations (like visual or somatic, which means bizarre feelings in the body). Other common psychotic symptoms are delusions, which are beliefs that the woman holds as complete truth, even if they don't make sense to anyone else or in reality overall. One example is the delusion that the CIA has installed tiny cameras in one's shower in order to monitor thoughts and behaviors. For any type of psychosis, the most common diagnoses to watch for in perinatal women are 1) schizophrenia or schizoaffective disorder 2) substance-induced psychotic disorder and 3) postpartum psychosis.

o Schizophrenia or schizoaffective disorders are chronic psychotic disorders that typically start in women between ages 25 and 35. Schizophrenia affects 1% of all women, and schizoaffective disorder affects about 0.3%. Schizophrenia includes psychotic symptoms, plus general withdrawal from relationships as well. Schizoaffective disorder is characterized by chronic psychosis, with episodes of either mania or depression occurring at times as well. Once a woman has schizophrenia or schizoaffective disorder, it should be considered a chronic illness that needs ongoing medication and psychosocial management for the rest of her life, including in pregnancy. The highest risk time for relapse is in the first four weeks after delivering a baby.

o Substance-induced psychotic disorder occurs when a woman has psychotic symptoms either because she is intoxicated on a substance that can cause them, is withdrawing, or has used so long that her brain has changed and she continues to have psychotic symptoms even after the substance use has stopped. The most common substance-induced psychotic disorder seen is methamphetamine-induced. However, even prescription medications, like steroids, can sometimes cause psychosis, though this is temporary.

o Postpartum psychosis is the ONLY psychiatric disorder that is exclusive to perinatal women. By definition, postpartum psychosis is a new psychotic episode that occurs after a baby's birth. Most cases occur in the first 10 days after delivery, and 90% occur in the first four weeks. The rate of PPP is 1 out of 1000 deliveries. PPP comes in two forms: 1) a new manic episode, with psychosis, in someone who has not had it before or 2) a more disorganized, withdrawn, almost depressed type of presentation. Either way, PPP should be considered an emergency because 4% of cases result in infanticide, or the mother killing the baby. This is typically because the mother has a delusion that she is actually helping her infant in some way by killing it, e.g., sending it on to heaven. Suicide rates are high as well.

o Prevalence, by race and ethnicity: Prevalence rates of depression are the most reliable rates we have. The following data is based on the Los Angeles County Department of Public Health's LAMB (LA Mothers and Babies) Survey.

	LA County Overall	Black	Latina	White	Asian
Pregnancy: Depressed Mood	25.0	35.8	27.5	18.6	19.3
Postpartum: Depressed Mood	25.2	28.3	26.4	22.6	23.9

- Why it matters: attachment
    - Effects on pregnant and postpartum women
        - Poor self-care, such as not attending prenatal care appointments, taking medications regularly, or engaging in regular exercise or healthy eating habits
        - Gestational hypertension (high blood pressure of pregnancy)
        - Higher rates of substance use, including alcohol and tobacco
        - Suicide / overdose: second leading cause of death in California

    - Effect on developing fetus
        - Excessive exposure to stress hormones, which in term leads to the fetus' own stress management system developing abnormally
        - Preterm delivery, which is the biggest risk factor for infant morbidity and mortality
        - Low birth weight, also associated with infant morbidity

    - Effect on newborn infant
        - Less breastfeeding
        - Poor bonding or attachment
        - More dysregulation / irritability / crying because of dysregulated stress management system

    - Effect on school-age child
        - Elevated rates of anxiety and depression
        - Decreased ability to manage stress
        - Worse school outcomes
        - Worse behavioral outcomes
        - Higher rates of Attention Deficit Hyperactivity Disorder

- How to evaluate:
    - Difficulty in assessment: Many women may not have been assessed for maternal mental health disorders when they were pregnant or postpartum, and so they are unable to easily say whether or not they had a diagnosis.
        - Obtaining medical records from their prenatal care provider or hospital stay, or even the child's pediatrician, may give some insight into the mother's mental health during the perinatal period.
        - If a mother is still in the year after delivery, screening for depression with the Patient Health Questionnaire-9 (PHQ9) and the Generalized Anxiety Disorder-

7 (GAD7) together can get a good picture of her depression and anxiety symptoms over the past week of her life. Another option is the Edinburgh Postpartum Depression Scale (EPDS) that assesses both anxiety and depression in pregnant and postpartum women.

- o Questions that might be helpful include the following:
  - Please describe for me what it was like for you to be pregnant. How did you feel when you first found out you were pregnant? Did those feelings change as the pregnancy progressed? How did you feel about the baby by the time you delivered? How do you feel about the baby now?
  - How were you feeling emotionally during pregnancy? Did your emotions change as the pregnancy went on?
  - What were your biggest challenges physically? How did they affect your mood?
  - Please describe what your mood was like during the pregnancy.
  - What about anxiety? It's normal for women who are about to have a baby to feel nervous or anxious. However, did you feel as if nervousness was overwhelming for you, caused your body to hurt (headaches, stomachaches, etc.), or kept you from doing what you needed to do, such as go to work or take care of other children?
  - What did the people around you say about how you were doing in pregnancy or in the first months after having your baby? Did they say you were acting or speaking strangely or seemed to be "not like yourself" in any way?
  - Did you ever have thoughts that frightened you, such as hurting yourself or your infant? If so, did you tell anyone about them?
  - At any point in your pregnancy or the first year postpartum, did you think that you needed help for any mental or emotional challenges? If so, did you seek help? From whom?
  - Did you have any talk therapy or counseling during pregnancy or the postpartum?
  - Did you take any medication for your mood, thoughts, or anxiety during pregnancy or the postpartum? If so, what was it and when did you take it? Are you still taking it now?
  - Did you go to an emergency room because of your moods, thoughts or anxiety? Did you have to stay in a psychiatric hospital?
  - Have you had any treatment for using alcohol or drugs during pregnancy or the postpartum? If so, where?

Birth History
- It is often the case that what a woman imagines their birth plan to be, does not end up being quite the reality they experience. Asking open ended questions will provide rich information.
- As you were preparing for your baby's birth, what did you envision? Did you have a birth plan in mind? What was your delivery like?

- If it was a C-section, it is important to ask if it was planned or it came about as an emergency? Was the baby in distress? Was it local or general anesthesia? If the baby was in the NICU, for how long, as how did it affect nursing etc.?

Gestational Age	Low Birth Weight
Very Premature (Before 32 weeks) Premature (before 37 weeks) Full Term (38-42 weeks)	Extremely Low Birth Weight: 2 ¼ lbs. (Under 1,000 grams) Very Low Birth Weight: Less than 3lbs. 4oz (1500 grams) Low Birth Weight: Less than 5 ½ lbs. (2500 grams)

- Parent/Caregiver Perceptions of Pregnancy and Birth: What went through your mind when you learned you would have a baby? Was it a surprise? What was your partner's reaction? What do you think they were thinking? Were they surprised? Supportive - If yes, was he supportive the entire time you were pregnant? Who else was important to you in your pregnancy? Anyone else supportive? Were there any other family members you shared this news with?
  - Also consider questions such as what were the first days at home like with your baby? Did you have support? Anyone staying with you as you recovered from childbirth?
- The sections on *Feeding, Sleep Patterns, and Temperament/Regulation* have several important prompts to gather information. The clinician should be sure to ask these questions from every caregiver (past and current) that can provide information. For instance, if the child is in foster care and the clinician has contact with foster parents and birth parents or relatives, ask each individual these questions.

Common Infant Sleep Schedules (Pantley, 2002)

Age	Number of Naps	Total length of naptime hours	Nighttime sleep hours*	Total nighttime & naptime sleep
Newborn***				
1 month	3 – 4	6 – 7	8 ½ – 10	15 – 16
3 months	3 – 4	5 – 6	10 – 11	15
6 months	2 – 3	3 – 4	10 – 11	14 – 15
9 months	2	2 ½ – 4	11 – 12	14
12 months	1 – 2	2 – 3	11 ½ – 12	13 ½ - 14
18 months	1 – 2	2 – 3	11 ¼ – 12	13 – 14
2 years	1	1 ½ – 3	11 – 12	13 – 13 ½
3 years	1	1 – 2	11 – 11 ½	12 – 13
4 years	0 – 1	0 – 2	11 – 11 ½	11 ½ – 12 ½
5 years	0 – 1	0 – 1	11	10 – 12

*These are averages, and they do not represent unbroken stretches of sleep.
**Newborn babies sleep 16-18 hours per day, distributed evenly over six to seven brief sleep periods.

Developmental Milestones
The information presented in this section is used with permission from Stanley I. Greenspan, MD. The section was compiled from Greenspan's (1996) and Greenspan & Meisels' (1996). As appropriate, clinicians may refer to the DC:0-5 Manual, Appendix A Developmental Milestones and Competency Ratings p. 161.

Every child develops in his own style and at his own pace. This section is to assist the clinician in examining multiple domains of development for children age birth to five. These developmental norms must be applied flexibly and consider the family's unique situation.

A detailed developmental history should be obtained through structured interviews with the caregiver(s), as well as observations of the child and of the interaction between caregiver(s) and child, and, if needed, developmental screening. It is important to be detailed in gathering this information, noting what the child is able to do and what they are not *yet* able to do and refrain from describing their development as "within normal limits/WNL."

Considering the variability and complexity of developmental stages, the child should be observed more than once and in different natural settings.

Each developmental stage includes the following domains:

- Socio-Emotional
- Motor Skills
- Sensory Skills
- Language Skills
- Cognitive Skills

This list is neither exhaustive or inclusive of all characteristics exhibited by infants and young children at each stage but presented as examples for age categories and domains.

Los Angeles County Department of Mental Health
Infancy, Childhood and Relationship Enrichment
Initial Assessment Reference Manual

The chart below is a brief compilation of developmental milestones. Below the chart, there is additional, more detailed information on developmental milestones across the 5 domains.

DEVELOPMENTAL SCREENING ADDENDUM		
By 3 months - Calms; smooth state transitions - Smiles back; coos - Imitates facial expressions - Follows people w/ eyes - Pushes up trunk when on stomach; holds head up	**By 6 months** - Shows range of emotions - Recovers from distress when comforted - Watches faces; social interactions - Babbles w/ consonants - Recognizes familiar people - Sits w/o support - Rolls over tummy to back	**By 9 months** - Preference for caregivers - Stranger wariness; protests separation - Mimics simple gestures - Imitates speech sounds - Mouths/bangs objects - Looks for things hidden - Stands with support - Crawls/scoots
By 12 months - Looks to caregiver to share emotional experiences - Offers objects/plays interactive games - Responds to name - Points/waves bye - Says a few words - Fills & dumps containers - Takes a few steps	**By 15 months** - Shows affection w/ kisses - Seeks attention - Parallel play w/ peers - Shakes head "no" - Integrates vocalization, gesture, eye contact - Points to show - Walks independently	**By 18 months** - Comforts self - Shares humor - Asserts autonomy - Uses at least 20 words - Follows one-step commands - Play sequences - Doll play - Stacks blocks - Walks up steps w/ help - Eats with spoon/drinks open cup
By 24 months - Exhibits empathy - Imitates complex actions - Enjoys other children - Names familiar people & body parts - Uses two words together - Sorts shapes/colors - Simple make-believe play - Runs - Kicks ball	**By 36 months** - Expresses full range of emotions - Shares w/o prompts - Asks "why" & "how" questions - Uses 2-3 sentences in conversation - Labels some colors - Thematic make-believe play - Attends to story 5 min - Climbs on structures - Pedals tricycle - Walks stairs alternating feet	**By 48 months** - Talks about self; speech understood by others - Counts to 5 - Elaborate make-believe play - Draws person 2-4 parts - Plays simple board games - Talks about right & wrong - Skips, hops - Catches large ball - Toilet trained during day
By 60 months - Increased confidence - Values rules in social interactions - Participates in group activities with different roles - Modulates voice for situation - Tells story sequentially - Names colors/counts things - Attends to group activity for 15 minutes - Stands on one foot 10 sec - Copies shapes, letters - Uses toilet independently		

By Three Months
Socio-Emotional
- Infant shows interest in caregivers (looking, listening, curiosity, pleasure)
- Caregiver is beginning to identify what types of sensory stimulation brings infant pleasure and joy
- Infant usually recovers from distress with help from caregiver

Motor Skills
- When lying on stomach, infant can raise head and shoulders by leaning on elbows

- Infant holds head upright on own
- Infant rolls from side to back to stomach to back
- Infant reaches for rattle or other toys

Sensory Skills

- Infant turns, looks, and listens to interesting sights and sounds
- Infant responds to touch (light or firm) with smile, vocalization or relaxation
- Infant follows objects in horizontal plane
- Infant follows objects in vertical plane
- Infant tolerates deep pressure touch

Language Skills

- Infant coos and babbles
- Infant watches lips/mouth of speaker
- Infant vocalizes one type of sound

Cognitive Skills

- Same as motor and sensory

 By Six Months:

Socio-emotional

- Infant smiles in response to smile
- Infant initiates interactions
- Makes sounds and/or moves mouth, arms, legs, or body in rhythm with caregiver in rhythm with infant
- Looks at caregiver's face with interest
- Anticipates with curiosity and excitement the reappearance of caregiver's face or voice
- Looks uneasy or sad when caregiver withdraws in the midst of pleasurable playing
- Recovers from distress with caregiver's help within 15 minutes

Motor Skills (from gross to fine motor)

- Rolls from back to stomach
- Pushes up on extended arms
- Sits with support
- Shifts weight on hands and knees
- Grasps objects with raking motion

Sensory Skills

- Looks toward a sound
- Tolerates gentle roughhousing/physical play
- Bites and chews various objects as a means of sensory exploration
- Is able to "get used to" certain undesired stimuli (ex. Bright lights, undesirable loud sounds, such as rattling)

Language Skills

- Regularly localizes the source of a voice with accuracy
- Vocalizes two different sounds

- Begins to imitate sounds
- Babbling contains sounds like: ma, mu, da, di, hi
- Vocalizes to caregiver's expressions and sounds

Cognitive Skills

- Focuses and pays attention for 30 or more seconds
- Looks and scans for objects and faces
- Smiles at his/her own face in the mirror
- Looks toward object that moves out of visual range
- Looks at own hand
- Manipulates and plays with toys, such as a rattle or key ring

By Nine Months:

Socio-emotional

- Reaches out to be picked up by caregiver, or hugs back when hugged
- Smiles, vocalizes, playful (e.g., puts finger in caregiver's mouth, takes rattle from his/her mouth and puts it in caregiver's mouth, touches or explores caregiver's hair)
- Angry face, communicates protest or anger (e.g., pushing undesired food off a high-chair tray with an accompanying angry look, screaming when a desired toy is not fetched quickly enough)
- Shows caution or fear by turning away, clinging to caregiver's leg, or looking scared when a stranger approaches too quickly
- Can recover from distress by being involved in social interaction

Motor skills (from gross to fine motor)

- Sits upright with good balance
- Reaches up in the air for objects while sitting
- Shifts from lying on back to a sitting position
- Goes from a sitting to a stomach position
- Crawls or creeps on stomach or hands
- Transfers objects from hand to hand
- Uses a thumb and finger to hold a block or toy
- Scoops a Cheerio or small object into palm of hand

Sensory Skills

- Feels and explores textures
- Notices when an object (such as a toy) is put on various parts of his body
- Enjoys movement in space
- Shows no particular sensitivity to bright lights
- Shows no particular sensitivity to loud noises, such as vacuum cleaners

Language Skills

- Responds to name and/or some simple requests (such as being told "no," "yes," "OK")
- Uses sounds to convey intentions or emotions (such as a pleasurable "mmmm")

- Vocalizes different sounds from front of mouth (e.g., "ba" or "ma" or "da") and causes these sounds to convey intentions or emotions, such as pleasure or satisfaction
- Responds to sounds with different vocalizations or with own selective behaviors
- Imitates a few sounds (tongue clicks or a "raspberry")

Cognitive Skills
- Focuses on toy or person for one or more minutes
- Explores and examines a new toy
- Makes sounds or creates visual sensations with a toy (cause & effect playing)
- Discriminates between different people (as indicated by different responses)
- Looks for a toy that has fallen to the floor
- Pulls on a part of an object (such as a piece of cloth) to get the object closer

By Thirteen Months:

Socio-emotional
- Shows emotions clearly with discrimination, such as pleasure, warmth, anger, fear, affection, and jealousy
- With caregiver support, (i.e., empathic reading of infant's communication and responding to them) the infant and caregiver can organize three or more circles of communication. A circle begins with infant behavior → caregiver responds → infant builds on caregiver's response using vocalizations, facial expressions, reciprocal touching, movement in space (rough-and-tumble play), or motor patterns (chasing, searching for objects, etc.) in the following emotional themes:
  - o Negotiating closeness and dependency: Infant gives caregiver a hug, and as caregiver hugs back in response, infant nuzzles and relaxes
  - o Pleasure and excitement: Infant and caregiver play together with an exciting toy or with caregiver's hair or toes, or infant's toes, in back and forth interaction
  - o Assertiveness and explorations: Infant and caregiver examine and explores new toys
    - ▪ Cautious or fearful behavior: Infant hides behind caregiver when in a new setting; negotiates degrees of protection needed with caregiver
    - ▪ Angry behavior: Infant can gesture angrily back and forth
    - ▪ Infant can recover from distress or remain organized while distressed by entering into complex gestural negotiation for what s/he wants (e.g., banging on door to go outside and play).

Motor Skills (from gross to fine motor)
- Walks/cruises holding onto furniture or with both hands held
- Can organize one-step motor planning sequence, such as pushing, catching, or throwing a ball
- Can squat while playing
- Stacks two cube-shaped blocks
- Throws a ball in a forward direction
- Can hold crayon and make marks on paper
- Feeds self finger-foods

Sensory Skills
- Can follow rapidly moving toy with eyes
- Comfortable climbing and exploring off the floor; on couches or table tops
- Explores and tolerates different textures with hands and mouth (i.e., willing to explore different texture, taste or color foods)
- Can tolerate bright lights and sounds

Language Skills
- Understanding simple words like "shoe" or "kiss"
- Using sounds or a few words for specific objects
- Jabs (ex. excited/rapid chatter that may not make sense)

Cognitive Skills
- Can focus and pay attention while playing on own for five or more minutes
- Copies simple gestures like "bye-bye" hand wave and "no-no" head shake
- Finds a toy under caregiver's hand
- Tries to imitate fine motor tasks like a scribble
- Explores cause and effect, such as how toys work and figures out simple relationships (pulling a string to make a sound)

By Eighteen Months:
Socio-emotional
- Comprehends, communicates via gestures basic emotional themes such as:
  - closeness and dependency: hugs, kisses, cuddles
  - pleasure and excitement: at simple games, giggles, smiles
  - assertiveness and exploration: explores independently but touches base with caregiver before venturing out
  - cautious/fearful: can signal to tell caregiver how to be protective
  - anger: hits, punches, yells, screams, lies on floor or angry gesture
- Imitates another person's behavior
- Can respond to limits
- Can use imitation to recover from stress
- Is able to disengage to regulate then re-engage to continue enjoying with caregiver

Motor Skills (from gross to fine motor)
- Walks up stairs with help
- Can plan motor patterns involving two or more steps, like throwing a ball up in the air and trying to catch it
- Builds a tower with two or three blocks
- Takes off socks
- Puts items in a cup or toys in box
- Tries to imitate scribbles or scribbles on own
- Holds crayon or pencil adaptively (gripping it in a way that makes scribbling possible)

Sensory Skills
- Enjoys or tolerates various types of touch, such as cuddling, roughhousing, different types of clothing material, tooth and hair brushing
- Comfortable with/tolerates loud sounds
- Comfortable with/tolerates bright lights
- Comfortable with/tolerates and finds comfort in moving through space

Language Skills
- Toddler says 10 or more words
- Asks questions
- Carries out simple directions ("Roll the ball here")
- Imitates simple words
- Uses words to make needs known ("Up!" "Kiss!")

Cognitive Skills
- Uses objects functionally during play (combs hair with a toy comb, vocalizes on a toy telephone)
- Searches for a desired toy or hidden object in more than one place
- Plays with caregiver or alone, in a focused manner, for 15 or more minutes
- Imitates behaviors just seen, or seen a few minutes earlier
- Recognizes familiar faces in family pictures
- Uses a stick or other tool to capture another object
- Uses long sound sequences and some words purposefully

By Twenty-Four Months:
Socio-emotional
- Creates mental representations of feelings and ideas that can be expressed symbolically through pretend play and words
- Can construct, in collaboration with caregiver, simple pretend play patterns of at least one "idea" (dolls hugging or feeding the doll)
- Can use words, sequence of motor gestures, facial expressions, touching, or select a series of pictures to communicate a need, wish, intention, or feeling (e.g., "Want that" "Me toy" "Hungry" "Mad")
- Can use pretend play or words employing at least one idea to communicate themes dealing with:
  - Closeness or dependency: dolls feeding each other and child says, "Want Mommy"
  - Pleasure and excitement: child makes funny faces like a clown and laughs
  - Assertiveness and exploration: cars racing, child looks at a real car in wonderment and asks, "Car?"
  - Cautious or fearful behavior: says "Scared"
  - Anger: dolls are hitting or fighting, says "Me mad"
  - Limit setting: child says to self, "No hit"
- Can use pretend play and/or words to recover from and deal with tantrums or distress

Los Angeles County Department of Mental Health
Infancy, Childhood and Relationship Enrichment
Initial Assessment Reference Manual

Motor Skills (from gross to fine motor)
- Catches a large ball from a few feet away using arms and hands
- Jumps with both feet off the ground
- Balances momentarily on one foot
- Walks up stairs placing one foot after the other on each step
- Can run fairly well
- Can stack more that four blocks (up to 6 or 7)
- Picks up toys without falling
- Kicks ball forward without losing balance
- Pulls people to show them something
- Dresses self in simple clothing
- Turns one page at a time in a book
- Turns doorknobs, unscrews lid

Sensory Skills
- Enjoys or tolerates various types of touch, including cuddles, roughhousing
- Enjoys or tolerates different types of clothing
- Brushes teeth or hair
- Comfortable with loud sounds, bright lights, movement in space

Language Skills
- Toddler has vocabulary of about 300 words
- Uses simple two or three words sentences ("More milk!" "Go bye-bye")
- Uses pronouns: I, me, you
- Refers to self by first name
- Talks constantly
- Verbalizes need for toileting, food, drink
- Understands simple questions ("Is Mommy home?")

Cognitive Skills
- Can attend or focus for more than 30 minutes
- Can engage in pretend play alone
- Can search for favorite toy where it was the day before
- Can put together simple puzzles of two or three shapes and can line up objects in a design (make a train of blocks)
- Can point to parts of a doll's body
- Can name some objects in a picture
- Can put round and square blocks in correct place on pegboard

By Thirty Months:
Socio-emotional
- Creates pretend drama with two or more ideas. Ideas need not be related or logically connected to one another (see emotional themes listed above or below).

- Uses symbolic communication (words, pictures, motor patterns) to convey two or more ideas at a time that express complex wishes, intentions, or feelings. Ideas need not be logically connected to one another.
- Pretend play or other symbolic communication can contain two or more ideas (emotional themes to look for: closeness or dependency; pleasure and excitement; assertiveness and exploration; cautious or fearful behavior; anger; limit setting; recovery from distress)
- Knows own sex

Motor Skills (from gross to fine motor)
- Walks up and down stairs
- Throws ball
- Stands on one foot momentarily
- Can walk on tiptoe
- Jumps a short distance with both feet
- Can make a tower of 8 or more blocks
- Can turn knob
- Can remove cap
- Can fold paper
- Moves fingers independently of each other
- Draws line with crayon or pencil
- Holds crayon with fingers rather than fist

Sensory Skills
- Enjoys or tolerates various types of touch (cuddling, roughhousing, different types of clothing, brushing teeth or hair)
- Comfortable with loud sounds, bright lights, movement in space

Language Skills
- Uses plurals
- Understands sentences with two or more ideas (e.g., "You can have a cookie when we get home")
- Understands directions with two or more ideas
- Organizes sentences with two or more ideas (e.g., "Want apple and banana")

Cognitive Skills
- Names one color
- Can point to some picture from a verbal description
- Can name objects in a picture
- Can make a train of blocks after seeing one in a picture
- Can repeat two or more numbers

By Thirty-Six Months:
Socio-emotional
- Ideas dealing with complex intentions, wishes, and feelings in pretend play or other types of symbolic communication are logically tied to one another
- Differentiate between real and not real

- Switches back and forth between reality and fantasy with little difficulty
- Pretend play and symbolic communication involves two or more ideas that are logically tied to one another (see list of emotional themes in previous milestones)
- Child can build upon adult's pretend play

Motor Skills (from gross to fine motor)
- Walks upstairs alternating feet
- Rides tricycle
- Catches big ball
- Kicks big ball
- Jumps forward
- Hops
- Daytime bowel and bladder control (may be later for boys)
- May or may not have nighttime bladder control (usually later for boys
- Feeds self completely
- Cuts paper
- Imitates simple designs like copying circles
- Buttons & unbutton buttons; almost completely dresses self, pulling on shoes

Sensory Skills
- Enjoys or tolerates various types of touch; comfortable with loud sounds, bright lights, movement in space

Language Skills
- Constantly asks questions
- Uses complete sentences of 3 to 4 words
- Understands and constructs logical bridges between ideas with full sentences
- Uses *but* and *because*
- Answers *who, what, and where* questions
- Comprehends actions/verbs
- Uses plurals
- Uses two prepositions

Cognitive Skills
- Pretend play has logical structure to it (pretend ideas are connected)
- Spatial designs are complex and interrelated (a house of blocks has connected rooms)
- Child identifies "big" and "little" as part of developing a quantitative perspective
- Can identify objects by their function as part of developing abstract groupings
- Begins to learn simple games and meanings of rules

By Forty-two to 48 months:
Socio-emotional
- Elaborates on complex, partially planned pretend play dealing with intentions, wishes, or feelings (how, why, when)
- Participates in reality-based conversation with intentions, wishes or feelings

- Distinguishes reality from fantasy
- Able to understand limits

Motor
- Skips, hops, rides tricycle, catches ball, bounces ball, show hand preference, copies cross, strings beads, cuts across a line

Sensory
- Enjoys or tolerates various types of touch
- Comfortable with loud sounds and bright lights
- Comfortable with movement in space

Language
- Comprehends complex "why" questions
- Can express ideas reflecting relative degree of feelings
- Can repeat 5 – 10 word sentence
- Can repeat 4 – 7 numbers

Cognitive
- Can identify similarities and differences among shapes and verbal concepts (triangle and rectangle; people and animals)
- Can recall and comprehend experiences from recent past

By 60 months:
Social/Emotional
- Wants to please friends and be like friends
- More likely to agree with rules
- Likes to sing, dance, and act
- Is aware of gender
- Can tell what's real and what's make-believe
- Shows more independence and increased confidence (for example, may visit a next-door neighbor by himself [adult supervision is still needed])
- Is sometimes demanding and sometimes very cooperative
- Uses toilet independently

Cognitive (learning, thinking, problem-solving)
- Names colors
- Counts 10 or more things
- Can draw a person with at least 6 body parts
- Can print some letters or numbers
- Copies a triangle and other geometric shapes
- Knows about things used every day, like money and food
- Attends to group activity for 15 minutes

Motor
- Stands on one foot for 10 seconds
- Hops; may be able to skip, can do a somersault

- Rides tricycle
- Catches, throws and bounces balls
- Show hand preference
- Copies shapes and letters, strings beads, cuts across a line
- Swings and climbs
- Uses a fork and spoon and sometimes a table knife
- Can use the toilet on her own

Sensory
- Enjoys or tolerates various types of touch
- Comfortable with loud sounds and bright lights
- Comfortable with movement in space

Language
- Speaks very clearly
- Tells a simple story using full sentences
- Uses future tense; for example, "Grandma will be here."
- Says name and address

Developmental Assessment Tools & Results
While the ICARE form only asks whether Ages and Stages Questionnaires (Squires & Bricker, 2009) were completed, the key is to make a developmental screener part of every clinician's assessment and data gathering process. Please refer to the ASQ – 3/ASQ-SE manuals for details regarding scoring.

Very briefly, the ASQ-3 is a developmental screening tool that can be used with children age 1 month to 5 ½ years.
- Helps identify needs for early intervention
- 10 to 15 minutes to administer
- Provides specific activities to do to enhance child's development

It is particularly important to complete a screening for possible developmental delays given that pediatricians and child health specialists fail to detect delays over 70% of time when relying only on clinical judgment (Glascoe, 2000). Many children who would benefit from early intervention are not identified until they start school, which means they have missed years of intervention services. Also important to keep in mind is that trauma can impact brain development and is often implicated in developmental delays in children.

Sensory Profile Descriptors
All children have a unique sensory processing profile. Children's responses to sensory stimuli occur along a continuum. Assessing children's biological challenges and strengths involves observations during play, in interaction with others, and observations over time. Some children have difficulty processing sensory input and regulating their responses. It is important to consider that "each sensory modality does not operate in isolation but in the context of the environment.

What triggers a strong reaction in one setting may trigger a smaller reaction in another." (Greenspan & Wieder, 2006)

Note that some populations are at higher risk to have sensory processing challenges, such populations include:
- Low birth weight
- Children who have experience trauma
- Children prenatally exposed to substances
- Children on the Autism Spectrum
- Children with ADHD

Signs to look for:
- Inability to tolerate sensory stimuli (such as bright lights, noise, or touch)
- Unresponsiveness to sensory stimuli (for example, does not react to extreme heat/cold, falls/bumps, etc. as expected)
- Clumsiness and lack of coordination (may bump into things regularly or have difficulty with motor skills)
- Difficult to engage in conversation or play
- Difficulty staying focused
- Slow to learn new activities and skills
- Difficulty reading or speaking

Children challenged biologically by sensory processing can exhibit some of the responses described below. Note that these are general descriptors, however, the DC: 0 – 5 does have classifications of sensory processing disorders within Axis I(see Zero to Three, 2016, pgs. 41-49).

Hypersensitive/overresponsive – children who are easily overwhelmed by sensory stimuli that are part of everyday life; responses to sensations that are more intense, quicker in onset, and longer lasting than children with typical responsivity under the same conditions

Hyposensitive/underresponsive – children who seem unresponsive to their environment; reflects failure to reach threshold of arousal

Sensory stimulation–seeking/impulsive – children who seem to need high level of sensory input

Mixed patterns are also observed in these children. Children may be hypersensitive in one category while being underresponsive in another. For example, some children may be hypersensitive to touch while being underresponsive to vestibular input; spinning, dancing, swinging, rocking, seeking out movement that provides vestibular input to the body.

Sensory Processing Domains

Auditory: Typical children can tolerate a wide variety of sounds from high pitched to low. Many children with special needs are over or undersensitive to sound. It is helpful to catalogue types of sounds that elicit favorable responses from a child. Sounds do not occur in isolation and may have a cumulative effect. Many children are sensitive to certain external sounds while seeking self-generated sounds or those listed below

Auditory-seeking: hums or talks to self, strongly attracted to music or musical toys

Auditory-avoidant: covers ears, afraid of loud noises or crowds, upset by unexpected background noises

Visual: Over or underresponsivity to bright lights, new or striking visual images such as colors, shapes or complex fields.

Visual-seeking: lines up objects, stares at lines, shadows, holds toys close to eyes, gets in odd postures to look, unusually drawn to visual detail

Visual-avoidant: seems to only notice what is directly in front of them, covers eyes or averts gaze with bright lights or direct social advances, prefers dim lighting

Tactile: Most children have preferences to light touch or firm pressure. Some children dislike being touched, others crave the sense of touch. Children with over responsivity to tactile sensations may have difficulties with dressing, bathing, stroking of arms, legs, trunk, "messy" textures, or pain. Oral hyperresponsivities include food textures, temperatures, aversion to things in or around the mouth, chewing, sucking, blowing, taking deep breaths.

Tactile-seeking: enjoys touching/ rubbing certain textures, rubs clothing, hair, places hands and objects to mouth, chews on objects

Tactile-avoidant: withdraws from light touch, avoids getting messy, dirty, dislikes hair brushing, teeth brushing, face washing, particular about feel of clothes

Proprioceptive: Proprioceptive refers to knowledge and awareness of where one's body is in space. Children challenged in this domain can exhibit symptoms such as bumping into things, fidgeting/squirming, fear of heights, climbing.

Proprioceptive-seeking: likes to jump, bounce, bump, roughhouse, hug, squeezes body into small spaces, hang upside down, pulls heavy objects, chews crunchy foods, likes to be wrapped tightly, walks on toes

Proprioceptive-avoidant: does not like to jump, bounce, roughhouse, will not try to pull or push with force

Vestibular: Vestibular processing involves sense of balance and movement. Children with vestibular difficulties can become distressed when their feet leave the ground.

Vestibular-seeking: loves to swing, spin, run in circles, rocks

Vestibular-avoidant: avoids swings, merry-go-round, unstable surfaces, heights, poor balance, hates having head moved out of upright position

Smell (olfactory): Under or overresponsivity to odors
  Smell-seeking: smells food before eating, smells various items in environment
  Smell-avoidant: aware of faint smells, distressed by smells, becomes distressed in certain environments (restaurants, cafeterias, certain rooms, around certain people).

Taste (gustatory): Food preferences, i.e. spicy, salty
  Taste-seeking: places objects in mouth, licks objects, preference for salty, sour and/or spicy foods.
  Taste-avoidant: limited range of food preferences, prefers bland foods

SECTION VII: PSYCHOSOCIAL HISTORY

As societal and cultural norms have shifted in tandem with economic trends, there is an increasing need for the traditional two-caregiver household to shift. Nowadays we hear more about multiple families living under one roof in order to make ends meet. With the need for more household members to work outside the home, there is a higher demand and need for childcare. While ideally families would have access to high quality and affordable childcare, this is not the reality. Childcare can range from informal (e.g., cared for at home by relatives who do not work outside the home) to more formal (e.g., licensed center based) and everything in between (e.g., unlicensed home based, licensed home based etc.).

With mounting evidence-based research indicating that access to high quality early childhood educational opportunities can have tremendous positive impact on a child's life, it is important to understand the child's early non-primary caregiver care and education environment. In gathering information in this section, the clinician needs to ask about several different possibilities that will shed light on who interacts with the child and in what capacity. Additionally, it is best practice to observe the child in the daycare/child care environment and gather information about the child's functioning.

If the child is attending Early Head start, Head Start or any other preschool gathering, information as to their functioning in these settings is also important. Given the importance of social development, it is also important to observe - at the very least - ask questions about the child's quality of interactions with both peers and with adults in the early school settings. Mounting evidence-based research indicates that access to high quality early childhood educational opportunities can have tremendous positive impact on a child's life.

This sections also offers important information about accessing services through the regional center and Special Education systems when there are concerns about developmental delays. As with any big system, it can be daunting for any family to navigate accessing services when there are concerns about developmental delays that may impact their social-emotional and educational success.

Los Angeles County Department of Mental Health
Infancy, Childhood and Relationship Enrichment
Initial Assessment Reference Manual

Cultural factors related to the client's presenting problems, psychosocial and caregiving environment, and relationship between parents/caregivers/teachers should be considered and briefly noted. It may be useful to refer to the DC:0-5 Manual section on Cultural Considerations in Diagnosing Infants/Young Children on page 9.

Disclaimer: This is an informational resource to guide referring a child for developmental disability services. The child's local Regional Center is the responsible agency for developmental disability services.

In California, anyone can refer a child who is suspected of having a developmental disability, for developmental assessment and disability services. Contact a Regional Center for an assessment. There are 21 independently-run Regional Centers throughout California. Each is a nonprofit, private corporation that contracts with the California Department of Developmental Services (DDS).
- paraphrased from http://www.dds.ca.gov

1. With each concerning behavior, determine (& document) if it is:
   - ☐ baseline/typical for developmental age (not chronological age)?
   - ☐ attributable to a developmental delay/disability?
   - ☐ attributable to a mental health concern?
2. With documentation in hand, approach appropriate service provider. Use language appropriate to the service seeking. Equivalencies, loosely based on order of usage:

DMH	Regional Center
Symptoms / Behaviors (Assessment)	Behaviors / Deficits (CDER)
Emotional Outbursts, Dysregulation	Tantrums, Aggression
Decompensation / Deterioration	Regression
Onset, Frequency, Duration	Number of Incidents
Assessment	Report / Evaluation
IBHIS Notes	ID Notes for CDER
Multiple State and Federally Funded Programs (i.e. via Medi-Cal, MHSA, etc.)	Regional Center-Funded Services (via State DDS); assistance identifying "Generic Resources"
Contracted Agency	Vendor
Staff: Liaison, Navigator, Community Health Worker, Medical Case Worker, Psychiatric Social Worker, LCSW, Psychologists and MDs	Staff: • Intake Coordinator • Service Coordinator (SC) • Specialists
Day Rehabilitation	• Services Delivered within the Natural Environment (0-3 years old) • Day Program (3+ years old) • Independent Living Skills (ILS) • Supported Living Skills (SLS)

Collateral	Circle of Support
Community Resource	Generic Resource***
"FUNCTIONAL IMPAIRMENT"	"SUBSTANTIAL DISABILITY"
"Meets diagnostic criteria"	"Qualifying conditions"
Client Treatment Plan	IFSP (Individual Family Service Plan) – for 0-3 IPP (Individual Program Plan) – for 3+ /IEP (Individualized Education Plan when referred to school district)
"Needs a higher level of care"	"Additional services and supports/hours"
"Early Start" CA MHSA term for certain Prevention and Early Intervention (PEI) programs	"Early Start" CA name for federal I.D.E.A. Part C services for children ages 0-3 (usually provided by Regional Centers)

*** Regional Centers are "payors of last resort". They are charged to find and connect the family to all available, appropriate services that matches the family's needs/wishes as laid out in the IFSP (Individual Family Service Plan) or client's IPP (Individual Program Plan) by first seeking "generic resources." Before requesting RC-funded service, bring proof that *generic resource* (i.e. health insurance, CCS, etc.) is not available, and provide justification based on needs.

Interagency Networking – Rosters and Contacts: https://dmh.lacounty.gov/our-services/developmental-disabilities/interagency-networking/

Note: The following 2 pages "Developmental Disability Referral Tip Sheet" is a useful resource that can be shared with caregivers to support them in requesting services from the regional centers.

Los Angeles County Department of Mental Health
Infancy, Childhood and Relationship Enrichment
Initial Assessment Reference Manual

DEVELOPMENTAL DISABILITY REFERRAL TIP SHEET

CHECK LIST and ACTIONS	

Before Calling the Regional Center collect this information →
 	
Don't know which Regional Center? Look up Los Angeles County Regional Center-by-zip code here:
 	
https://www.dds.ca.gov/ RC/regionMap.cfm? view=laCounty
	□ Address and zip code where the child lives: _____
	_____
	□ Child's Date of Birth and Age: _____
	□ Child's doctor's contact information: _____
	_____
	  – To help the Regional Center gather needed medical records
	□ Medical Insurance information, including the following
	– To be used later in the intake process
	  o Plan type: _____
	  o Explanation of Benefits (EOB) *– To be able to share what the insurance covers, how long it's covered for, what you have to pay for, and how much*
	  o Any denial letters for services related to the developmental delay/disability *– Regional Center may be a resource to pay for them*
	□ Results of any assessments and/or evaluations related to the developmental disability (DD)
	□ Medical records describing the developmental disability (DD), like a NICU discharge summary
	– To help the Regional Center's medical consultant determine eligibility
	  o Sign a consent form with child's doctor to share information with the Regional Center for when the Regional Center calls the doctor
	  o Medical insurance denial letters for services related to the developmental delay/disability
	    – Regional Center may be a resource to pay for them

What to Say:	*"I am calling to have my child **evaluated**. We are concerned because my child has the following **developmental concerns**: _____* _____ _____ *"* *(Write down DEVELOPMENTAL CONCERNS you and your doctor are worried about. Use separate paper if needed)*

Regional Center Contact's Information:
– so the family can follow up if there are concerns or to check in
	□ Regional Center Contact Name: _____
	□ Regional Center Contact Title: _____
	□ Regional Center Phone Number: (_____) _____ - _____ ext. _____
	If you get a voicemail message, write down:
	  o Date of call: _____
	  o Time of call: _____
	  o Name of the Regional Center person the message was left with: _____

Notes on the Conversation with Regional Center:	□ What did the Regional Center person say? *(Use separate paper if needed)* □ Schedule an appointment for the child to be evaluated. Date, Time Place: _____ _____ □ Is there additional information that the Regional Center needs to determine eligibility? If yes, what else: _____ _____ *(Use separate paper if needed)*
After the Evaluation:	□ Ask for a copy of the evaluation results to share with the child's doctor.

Los Angeles County Department of Mental Health
Infancy, Childhood and Relationship Enrichment
Initial Assessment Reference Manual

Services that Regional Centers Provide

EARLY START Services
For infants and toddlers (**0 to 36 months old**) who are
- at risk of having developmental disabilities or
- who has a developmental delay may qualify for services.

LANTERMAN ACT Services
For individuals ages **3 and older**

To be eligible, a person must have a disability that begins before the person's 18th birthday, be expected to continue indefinitely and present a substantial disability as defined in _Section 4512 of the California Welfare and Institutions Code_. Eligibility is established through assessment and diagnosis performed by regional centers.

Eligibility

Criteria for determining the eligibility of infants and toddlers are specified in _Section 95014 of the California Government Code_.

In addition, individuals at risk of having a child with a developmental disability may be eligible for genetic diagnosis, counseling and other prevention services.
For information about these services, go to
http://www.dds.ca.gov/Birth36Months/

Eligibility: 33% delay in at least 1 of the 5 following domains:

- Communication
- Cognitive
- Social/Emotional
- Self Help/Adaptive
- Physical

Eligibility

Eligible conditions are substantial disability from:
1. Cerebral palsy (CP)
2. Epilepsy
3. Autism
4. Intellectual Disability (ID) (was Mental retardation (MR)
5. Other conditions closely related to ID or that require similar treatment (known as "The 5th Category")

with functional impairments in 3 or more of the following areas:
(A) Self-care.
(B) Receptive and expressive language.
(C) Learning.
(D) Mobility.
(E) Self-direction.
(F) Capacity for independent living.
(G) Economic self-sufficiency.

Timeline
45 days from referral to evaluate and assess, and if eligible, develop the first Individualized Family Service Plan (IFSP).

Timeline
Intake to be done within 15 business days after calling the RC, and 120 days after intake to determine eligibility.

NOTE: Regional Centers are Payers of Last Resort
If there is another resource that can pay for the service that the Regional Center and the caregiver agree the child needs, the caregiver will be asked to use that resource first.

ALSO CONSIDER: (Federal) I.D.E.A. Part B
Low Incidence Specialized Services
Eligible Age Range: 0-22
Service Provider: Local Education Agency (LEA) (the child's School District)

California's eligible criteria: the following severe disabling conditions:
- Hearing-impaired
- Vision-impaired
- Severe orthopedic impairment/Medically and Physically Challenged (MPC)
- Any combination thereof

Sources: https://www.cde.ca.gov/fg/fo/profile.asp?id=2299 and
https://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?lawCode=EDC&sectionNum=56026.5.

Los Angeles County Department of Mental Health
Infancy, Childhood and Relationship Enrichment
Initial Assessment Reference Manual

SECTION VIII: CURRENT FAMILY SYSTEMS REVIEW

When it comes to a discussion or inquiring about any current or past history of homelessness, it is important to know that the definitions of homelessness are varied and plentiful. What is important to also consider is that homelessness does not only describe individuals and families who are living on the street in tents. Depending on the definition you are using, a person/child is considered homeless if they are sleeping on someone's couch, or renting a room in a non-family member's home. The U.S. Department of Education, for instance, defines homelessness in the following manner.

The term "**homeless children and youths**"—

A. means individuals who lack a fixed, regular, and adequate nighttime residence (within the meaning of section 11302(a)(1) of this title); and

B. includes—

> i. children and youths who are sharing the housing of other persons due to loss of housing, economic hardship, or a similar reason; are living in motels, hotels, trailer parks, or camping grounds due to the lack of alternative adequate accommodations; are living in emergency or transitional shelters; are abandoned in hospitals; or are awaiting foster care placement;

> ii. children and youths who have a primary nighttime residence that is a public or private place not designed for or ordinarily used as a regular sleeping accommodation for human beings (within the meaning of section 11302(a)(2)(C) of this title);

> iii. children and youths who are living in cars, parks, public spaces, abandoned buildings, substandard housing, bus or train stations, or similar settings; and

> iv. migratory children (as such term is defined in section 6399 of title 20) who qualify as homeless for the purposes of this subtitle because the children are living in circumstances described in clauses (i) through (iii).

The U.S. Department of Housing and Urban Development has slightly different definitions based on four categories.

Category 1: Literally Homeless
Individual or family who lacks a fixed, regular, and adequate nighttime residence, meaning:

> (i) Has a primary nighttime residence that is a public or private place not meant for human habitation;

> (ii) Is living in a publicly or privately operated shelter designated to provide temporary living arrangements (including congregate shelters, transitional housing, and hotels and motels paid for by charitable organizations or by federal, state and local government programs); or

> (iii) Is exiting an institution where (s)he has resided for 90 days or less and who resided in an emergency shelter or place not meant for human habitation immediately before entering that institution

Category 2: Imminent Risk of Homelessness
Individual or family who will imminently lose their primary nighttime residence, provided that:

> (i) Residence will be lost within 14 days of the date of application for homeless assistance;

> (ii) No subsequent residence has been identified; and (iii) the individual or family lacks the resources or support networks needed to obtain other permanent housing

Category 3: Homeless under other Federal statutes
Unaccompanied youth under 25 years of age, or families with children and youth, who do not otherwise qualify as homeless under this definition, but who:

> (i) Are defined as homeless under the other listed federal statutes;

> (ii) Have not had a lease, ownership interest, or occupancy agreement in permanent housing during the 60 days prior to the homeless assistance application;

> (iii) Have experienced persistent instability as measured by two moves or more during in the preceding 60 days; and

(iv) Can be expected to continue in such status for an extended period of time due to special needs or barriers

Category 4: Fleeing/Attempting to Flee Domestic Violence
Any individual or family who:

(i) Is fleeing or attempting to flee their housing or the place they are staying because of domestic violence, dating violence, sexual assault, stalking, or other dangerous or life-threatening conditions related to violence that has taken place in the house or has made them afraid to return to the house, including:
- Trading sex for housing
- Trafficking
- Physical abuse
- Violence (or perceived threat of violence) because of the youth's sexual orientation;

(ii) Has no other residence; and

(iii) Lacks the resources or support networks to obtain other permanent housing.

The main idea is to keep an open mind about what homelessness means and the possibility that given the housing crisis with rising rents in LA County, a large portion of the young children and families we assess may be homeless, have experienced homelessness or are imminently about to become homeless.

For DMH, the following is the definition being utilized:
"An individual, unaccompanied youth, or family (with our without minor children in their custody) who lack a fixed, regular, and adequate nighttime residence
- In a homeless shelter/car or RV/hotel
- On the street
- In a street encampment
- In an institution such as a hospital, jail/prison, or juvenile detention facility and will be homeless upon release"

For purposes of this section, it is important to list all family members (adults and children) who live in the child's current living situation. Many of the children and families we work with are involved with the Department of Children and Family Services (DCFS) and therefore may not be in custodial care of the Biological Parents. Information regarding foster parents/caregivers, biological family, and extended family who are caretakers of the child should be included in this section.

- If the child is adopted, it is important to gather as much pertinent information as possible about the approximate number of placements the child was in, what their experience was like in previous foster homes, reasons for placement changes.
- Be sure to ask about the specifics regarding the approximate dates the child was placed in the home? Do visitations still take place with the biological parent(s)? It is crucial to also ask about visitations/contact/placements of any siblings. If visits cease, when and for what reason? When was the adoption legally finalized?
- Important to highlight the strengths of the family – though this may be difficult to gather, all families have at least one strength and can prove to be an effective protective factor in times of need.

- Regarding support from DCFS, inquiring about contact/responsiveness and quality of caregiver/parent interaction with DCFS social workers is also important.

SECTION IX: RELEVANT PAST FAMILY SYSTEMS REVIEW

Specifically, for those children who are not in the care of their Biological Parents, it is important to gather information regarding the environment the child was living in prior to detainment/removal by DCFS (if applicable). For children placed in foster care, the foster parent(s) will likely not have information regarding the past living situation(s). For purposes of this section, it is highly recommended historical information be gathered from official court documents, such as Court Reports, Detention Reports/History, and Status Hearing Reports. These reports can be obtained by contacting the child's DCFS CSW (Children's Social Worker). If possible, an interview with the Biological Parents is ideal.

SECTION X: OBSERVED CAREGIVER – CHILD INTERACTION

Refer to the DC:0-5 Manual, Axis II Relational Context p. 139
This section should be completed by observing the child and caregiver interacting with one another (i.e. play). Provide descriptions of the following during your observation:
Refer to the DC:0-5 Manual, Table 1. Dimensions of Caregiving table on p. 142

Behavioral Observations
- Ensuring physical safety – how does the parent/caregiver monitor the child's play?
- Eye Contact/physical contact – is there mutual eye contact or gaze aversion, what is the proximity of the dyad, does the child or caregiver seek or avoid closeness?
- Affective Tone – what is the tone of the dyad's communication (soft, loving, calming, anxious, angry/hostile, etc.)?
- Enjoyment in Joint Play – does the dyad enjoy playing together, what is the quality of the back and forth communication ("Serve and Return") and joint attention?
- Teaching/providing structure/socialization – is there an even and appropriate amount of teaching during the interaction and narration of the child's play/experience?
- Supporting child's developmental capacity – does the caregiver have realistic expectations of the child's abilities based on the child's development, is the caregiver able to scaffold activities that may be more difficult for child to execute?

SECTION XI: BEHAVIORAL OBSERVATIONS & INTERVIEW WITH CAREGIVER

A separate session with the parent/caregiver should be conducted, without the child. If the parent/caregiver is married or has a partner, the spouse or partner should be involved with the interview as well. It is important to observe the parent/caregiver behaviors in the absence of the child – is this how the parent/caregiver is organically or does the parent/child relationship contribute to the parent/caregiver's behaviors? Take note of the following:

Behavioral Observations
- Make note of the parent/caregiver's appearance, social style, and mood/affect – does the parent/caregiver appear to be anxious, pre-occupied, flooded, etc.? How does the parent/caregiver relate to you as the clinician/therapist?

Caregiver's Perceptions and Expectations
- What is the parent/caregiver's view and expectations of the child and themselves as a parent/caregiver? What is the parent/caregiver's knowledge of typical child development?

Insight/Strengths/Challenges
- Is the parent/caregiver able to discuss their strengths and weaknesses? Does the parent/caregiver use hostile or angry language when talking about the child or themselves? How motivated is the parent/caregiver for mental health treatment?

Relationship Between Caregivers
- This is a new integration in the DC: 0-5. It speaks to the importance of how caregivers get along, work together, interact and how this impacts the child. Caregivers can be foster parents, biological parents, relatives, as well as non-relatives who are involved in the child's upbringing.

SECTION XII: MENTAL STATUS / BEHAVIORAL OBSERVATIONS OF CHILD
For purposes of this section, the observation should be focused solely on the child. It is important to note descriptions should NOT be recorded as "WNL" (Within Normal Limits), and the reader should have a thorough understanding and a clear picture of the child being assessed.

Appearance
- Take notice of the child's dress, grooming, and any unusual physical characteristics. Is the child dressed appropriately for the type of weather and does the clothing fit properly? Does the child appear disheveled or unkempt?

Behavior
- Observe the child's behavior during play and interaction with you as the clinician and the parent/caregiver. Does the child appear to have too much energy or is their energy level too low? What is the quality of the child's eye contact with the parent/caregiver or the clinician in relation to the child's culture? Does the child appear aggressive or impulsive?

Socio-Emotional/Mood/Affect
- What is the child's mood and how does the child relate to others? Is this typical for the child? Is the child slow to warm or does the child engage rather quickly? How regulated is the child and is this typical?

Risk to Self/Others
- Questions about risk to self/others can create anxiety in parents. Some parents may be opposed to their children being asked these types of questions. Clinicians should use their clinical judgment and consult with their supervisor with regard to this prompt.
- According to the Centers for Disease Control and Prevention, "suicide is the third-leading cause of death for children ages 5 to 14 in the United States" (as quoted in Weir, 2016).
- Weir (2016) also notes that "while death by suicide is less common in younger children than in adolescents, such deaths do occur—an average of about 33 per year in the United States in children ages 5 to 11, research suggests. The true number is probably higher, Jobes adds, since it's likely that some suicides in youth are misreported as accidents."

Thought Content
- Thought content relates primarily to three main categories, namely delusions, ideas of reference and obsessions. Given that young children are in a developmental stage where fantasy and reality often mix, it is important to tease apart what might be unusual thought content versus developmentally appropriate content (Ollendick & Schroeder, 2003).

Cognitive
- Is the child's attention span and problem-solving ability appropriate for the child's developmental age?

Communication/Language
- Is the child's verbal and nonverbal language typical for their developmental age? Can the parent/caregiver understand most of what the child is attempting to communicate? Does the child have problems with receptive (ability to comprehend what is being said) and/or expressive (verbally or nonverbally communicating to others) language?

Sensory Processing / Sensorimotor
- Does the child appear to have issues with their visual, auditory, tactile, vestibular (sense of balance and movement), proprioceptive (knowing where their body is in space), introceptive (ability to feel within their bodies), taste, or smell senses? Does the child appear to seek or avoid certain sensory input? Are they over-reactive? Under-reactive? Typical? What is their response/reaction to stimuli?

Gross Motor
- Does the child appear to have trouble moving their body in space? Does the child have trouble walking, standing up straight, can the child sit up right without support from the parent/caregiver?

Fine Motor
- Notice how the child handles small objects or toys. Does the child utilize a pincher grasp to obtain small objects? If age appropriate, notice how the child holds a pen/pencil/crayon/marker. Are any tremors observed?

Muscle Tone
- When discussing muscle tone, the main focus is on the intensity of tone, which can range between hypertonia (atypically high tone) and hypotonia (atypically low tone).
- Goo, Tucker & Johnston, 2018 note that "persistent hypertonia is problematic because it can restrict movement and lead to secondary impairments such as contracture, pain, limited motor development, and restricted participation. Persistent hypotonia produces other issues, such as poor joint stability, poor postural alignment, decreased activity tolerance, and delayed motor skill acquisition."
- Does the child's muscle tone appear low, floppy or tense? (See Pathways.org) for additional information to help determine muscle tone.

Adaptive Functioning
- Inquire about the child's ability for self care. Is the child toilet trained? Is the child able to dress themselves as developmentally appropriate? Is the child able to feed themselves, also as developmentally appropriate?

Play
- The famous Mr. Rogers is often associated with the following quote "Play is often talked about as if it were a relief from serious learning. But for children play is serious learning. Play is really the work of childhood." Children learn about the world, their immediate environment, and about themselves through play. Play is also believed to **"**foster and enhance language, cognitive, social and emotional development" (Xu, 2008). Research has typically identified six stages of play during early childhood: Unoccupied, Solitary, Spectator/Onlooker, Parallel, Associate, and Cooperative (Parten, 1932; Pathways.org).
- However, more recent research has questioned whether play follows this hierarchical process especially in light of the great influence that technology has on current day children (Xu, 2008).
  - Unoccupied Play (Birth to 3 months): Infants make a lot of movements with their arms, legs, hands, feet and the focus in on exploring and learning how their bodies move.
  - Solitary Play (Birth to 2 years): Children play alone and are not interested in playing with others.
  - Parallel Play (2+ years): Children may play alongside/near others but there is no interaction.
  - Associate Play (3 to 4 years): Children begin to interact, but the interaction is still limited. They may be engaged in a similar activity, but interaction is still limited (e.g., playing with blocks but each building their own creations).

    o Cooperative Play (4+years): Children play together, are interested in the same activity. (See Pathways.org)

Unusual Behaviors
- Are the child's behaviors age appropriate? Do they engage in repetitive behaviors? Head banging that is dangerous? Breath-holding?

Strengths
- Ask the parent/caregiver about the child's strengths – are the strengths age appropriate and realistic? Ask the child about what they think their strengths are if the child is able to verbalize this.

SECTION XIII: SUMMARY/CLINICAL FORMULATION/DIAGNOSIS

STRENGTHS OF THE CHILD AND FAMILY (to assist in achieving treatment goals)
- It is crucial to approach this summary section from a strength-based perspective. Of important note is that while "Strength-based approaches are frequently misunderstood to imply that staff members should concentrate only on the positive aspects of a situation or characteristics of a child or family. In fact, a strength-based approach refers to an interest in uncovering and recognizing potential resources, personal characteristics, and relationships that can be mobilized to support the growth and development of a child or family" (Heffron & Murch, 2010, pg. 13).
- In other words, what is going well for the family and what can be put into place in order to further improve areas of particular challenge.

CLINICAL FORMULATION
- Summarize/conceptualize all clinical information to determine the client's diagnosis and include initial proposal(s) for treatment. Identify any impairments in life functioning due to the client's diagnosis, if applicable, or how **Specialty Mental Health Services** can assist the client.
- Formulation should include risk factors as well as any significant strengths that can assist the client with treatment.
- Cultural factors related to the client's presenting problems, psychosocial and caregiving environment, and relationship between parents/caregivers should be considered, in addition to **probability of not meeting socio-emotional developmental milestones, likelihood of later deterioration in functioning** if not in services and the impact on family. It may be useful to refer to the DC:0-5 Manual section on Cultural Considerations in Diagnosing Infants/Young Children on page 9.

DIAGNOSIS
DC: 0-5 AXIS I: Major Diagnostic Clinical Categories, refer to the manual for specific diagnoses
Neurodevelopmental Disorders
Sensory Processing Disorders

Los Angeles County Department of Mental Health
Infancy, Childhood and Relationship Enrichment
Initial Assessment Reference Manual

Anxiety Disorders
Mood Disorders
Obsessive-Compulsive and Related Disorders
Sleep, Eating, and Crying Disorders
Trauma, Stress, and Deprivation Disorders
Relationship Disorder

Zero to Three has a crosswalk that may be helpful to refer to and is available by accessing the following link: https://www.zerotothree.org/resources/1540-crosswalk-from-dc-0-5-to-dsm-5-and-icd-10

AXIS II: Relational Context
Refer to the DC:0-5 Manual pages 139 - 148 for detailed description and for the tables referenced below

- First, a word of caution. Feedback received regarding this section is that it tends to be the more challenging to complete. Please refer to the DC: 0-5 Manual for detailed information to accurately complete this Axis.
- As a very basic summary, clinicians will complete this section based not only on direct observation of the child and caregiver(s) and in different natural settings but also include information gathered from collateral information, records review and any other pertinent information.
- Table 1 Dimensions of Caregiving and Table 2 Infant's/Young Child's Contributions to the Relationship are each completed in order to be able to complete the Levels of Adaptive Functioning – Caregiving Dimension Rating, which takes into account each caregiver with whom the child routinely interacts.
    - o Levels of Adaptive Functioning – Caregiving Dimension
        - Caregiver 1
            - Level 1 – Well-adapted to Good-Enough Relationships
            - Level 2 – Strained to Concerning Relationships
            - Level 3 – Compromised to Disturbed Relationships
            - Level 4 – Disordered to Dangerous Relationships
        - Caregiver 2
            - Level 1 – Well-adapted to Good-Enough Relationships
            - Level 2 – Strained to Concerning Relationships
            - Level 3 – Compromised to Disturbed Relationships
            - Level 4 – Disordered to Dangerous Relationships

- Table 3 Dimensions of Caregiving Environment is more focused on looking at the caregiving enviroment surounding the child regardless of whether the caregivers live together. This table will produce a rating on the Levels of Adaptive Functioning – Caregiving Environment.
    - o Levels of Adaptive Functioning – Caregiving Environment
        - Level 1 – Well-adapted to Good-Enough Caregiving Environment
        - Level 2 – Strained to Concerning Caregiving Environment

Level 3 – Compromised to Disturbed Caregiving Environment
Level 4 – Disordered to Dangerous Caregiving Environment

*Comments: Also consider *v/z-codes* from DSM-5/ICD 10 in the Comments section.

**In completing this section and gathering information to determine the ratings, if more than one rating is Level 2 or if any rating is Level 3/4, consider if likelihood for future developmental delay or mental health concerns warrant a finding of medical necessity for mental health treatment.

AXIS III: Physical Health Conditions and Considerations
This axis should be used for physical conditions and considerations not otherwise noted or described in Axis I. Additionally, information for this area are gathered from medical records, family report or consultation from a medical provider. It is important to note from where the information was gathered. See pages 149 – 151 of the DC: 0-5 for the "Physical Health Conditions and Considerations" for additional information.

AXIS IV: Psychosocial Stressors
See pages 154 – 158 Of the DC: 0-5 for the "Psychosocial and Environmental Stressor Checklist." Information on any stressors that apply needs to be completed, including the age of onset in months, and comments, especially those regarding duration and severity. The checklist includes challenges in the following areas:
- Child's family/primary support group
- Social environment
- Educational/childcare challenges
- Housing challenges
- Economic and employment challenges
- Infant/Child Health
- Legal/criminal justice challenges
- Other

The DC:0-5 enumerates three key factors inherent in the impact of any stressor:

1. Severity: intensity and duration, and the predictability

2. Developmental Level of Child: chronological age, social emotional history, biological vulnerability to stress and ego strength

3. Caregiving Adults: availability and capacity to serve as protective buffer and to help child understand/cope

Los Angeles County Department of Mental Health
Infancy, Childhood and Relationship Enrichment
Initial Assessment Reference Manual

It is important to note these three factors when discussing stressors in the child's life and how that affects their overall quality of life, socio emotional functioning and developmental functioning.

Axis IV lends itself to discussing other stressors impacting the communities that we serve throughout Los Angeles County. Consideration of adverse childhood experiences (ACEs) is vital given the families with whom we work. ACEs is the term used to describe potentially traumatic events that occur in childhood. For more detailed information, refer to the CDC website included in the references section of this manual. Also included in the references section is a California's First Surgeon General Dr. Nadine Burke-Harris' TED Talk on the ACEs.

Below is a table that encompasses various ACEs commonly seen in the families we serve. It is a useful tool to consider and remind clinicians of the various negative experiences that can impact a young child and their family.

☐Acculturation or language conflicts	☐Birth of a sibling	☐Change in primary caregiver
☐Criminal activity within the household	☐**Death of a parent or important caregiver***	☐Death of another important person
☐Death of other family member	☐**Domestic violence***	☐**Emotional abuse***
☐Family social isolation	☐Father or mother absence	☐Inadequate social support for the family
☐**Incarceration of family member***	☐Child has been adopted	☐**Child neglect***
☐**Child physical abuse***	☐Child placed in foster care	☐Child placed in institutional care
☐Reunification w/ parent after prolonged separation	☐**Child sexual abuse***	☐Medical illness of caregiver:☐Acute
☐Medical illness of household member	☐**Mental health problems of household member***	☐Chronic
☐New child in home (not by birth)	☐Other trauma to significant person in child's life	☐New adult in household
☐Parent or caregiver divorce or separation	☐Parent or caregiver remarriage	☐Parent or caregiver conflict (nonphysical)
☐**Parent or caregiver separation from child***	☐**Parent or caregiver substance abuse***	☐Removal of other child from home
☐Severe discord or violence with sibling	☐Substance abuse by household member	☐Teenage parent
☐Unpredictable home environment	☐Unstable family constellation	
CHALLENGES WITH THE SOCIAL ENVIRONMENT:		
☐Discrimination or racism is experienced by family	☐Immigrant status	☐Inadequate access to health care
☐Child experiences bullying	☐Child witnessed community violence	☐Refugee status
☐Unsafe neighborhood		
EDUCATIONAL OR CHILD CARE CHALLENGES:		
☐Multiple changes in childcare provider	☐Low parent or caregiver literacy	☐Poor quality early learning environment
☐Poor quality out-of-home care		
HOUSING CHALLENGES:		
☐Eviction of home or foreclosure	☐Homelessness	☐Inadequate, unsafe, or overcrowded housing
☐Multiple moves		
ECONOMIC AND EMPLOYMENT CHALLENGES:		
☐Dangerous or stressful parental work conditions	☐Food insecurity	☐Heavy indebtedness
☐Military deployment or reintegration	☐Parental unemployment or job instability	☐Poverty or near poverty
INFANT/YOUNG CHILD HEALTH CHALLENGES:		
☐Child accident or injury	☐Child hospitalization	☐Child medical illness: ☐Acute
☐Painful or frightening medical procedure	☐Pregnancy-related stressors	☐Chronic
LEGAL OR CRIMINAL JUSTICE CHALLENGES:		
☐Child protective services involvement	☐Custody dispute	☐Child is a victim of crime
☐Parent is a victim of crime	☐Parental arrest	☐Parental deportation
☐Parental incarceration or return from incarceration	☐Undocumented immigration status	
OTHER CHALLENGES:		
☐Abduction: ☐by family member	☐Disaster	☐Disease epidemic
☐Terrorism ☐by other	☐War	☐Other (specify:_____)

Los Angeles County Department of Mental Health
Infancy, Childhood and Relationship Enrichment
Initial Assessment Reference Manual

Adverse Childhood Experiences (ACEs)

Notable information regarding psychosocial stressors marked above:

If a child with an ACE score of 4 or more is **not** found to meet medical necessity for mental health treatment, please provide rationale:

Impact of Environmental/Psychosocial Challenges on the Child:

The environmental/psychosocial stressors and ACEs have impacted the development of the child and are causing a:

☐ Current delay in meeting developmental milestones   ☐ Regression in previously met milestones or area of life functioning

☐ Probability of future deterioration in functioning (anticipated regression)   ☐ Probability the child will not develop as individually appropriate

☐ No current deficits in functioning nor probability of future deterioration of developmental milestones or functioning

Describe all items checked above:

* Denotes ACEs included in the original ACEs study

AXIS V: Developmental Competence

Please refer to the DC: 0-5 Manual to complete the Competency Domain Rating Summary Table

Axix V focuses on considering young children's developmental competencies and the interconnetion of these with their mental health functioning. Rating on this axis can be informed through a variety or sources, including direct observation, caregiver report, developmental screening tools results, as well as in depth developmental testing standard scores (Zero to Three, 2016).

Competency Domain Rating	Emotional	Social-Relational	Language-Social Communication	Cognitive	Movement and Physical
Exceeds developmental expectations	☐	☐	☐	☐	☐
Functions at age-appropriate level	☐	☐	☐	☐	☐
Competencies are inconsistently present or emerging	☐	☐	☐	☐	☐
Not meeting developmental expectations (delay or deviance)	☐	☐	☐	☐	☐

SECTION XIV: DISPOSITION/RECOMMENDATION/PLAN

- Consider collaboration between systems and providers and its impact on the child and family
- If the clinician has enough information to recommend a specific modality/treatment/EBP, it is important to note that in this section.

SECTION XV: REFERRALS GIVEN

☐ Community Mental Health Clinic   ☐ Court Ordered Referral   ☐ Early Head Start Program

☐ Department of Social Services/CalWorks ☐ Department of Children & Family Services

☐ Early Intervention Specialist   ☐ Foster Care Agency   ☐ Head Start Program

☐ HMO   ☐ Hospital - In-patient   ☐ Hospital - Out-patient

☐ Medical School - In-patient   ☐ Medical School - Out-patient   ☐ Private Practice Office

☐ Public Health Clinic   ☐ Special Education Program

<u>Professional Discipline</u>

☐ Adult Psychiatry	☐ Child Development	☐ Child Life
☐ Child Psychiatry	☐ Psychology	☐ Developmental Specialist
☐ Education	☐ Family Practice	☐ Marriage Family Therapy
☐ Neurology	☐ Nursing	☐ Occupational Therapy
☐ Pediatrics	☐Physical therapy	☐ Social Work
☐ Special Education	☐Public Health Clinic	☐ Speech & Language/Speech Pathologist

SECTION XVI: SIGNATURES

Assessor's signature refers to the clinician conducting the ICARE assessment, while the Co-signature refers to the supervisor reviewing the assessment. This will depend on whether the assessing clinician is licensed/unlicensed and whether individual agencies and clinics have requirements about supervisors reviewing and co-signing.

II. RISK/MEDIATING FACTORS

RISK ASSESSMENT

"Environment plays an important role in shaping development from the newborn period through adolescence. Many individual environmental risk factors may impinge on development (poverty, mental illness, minority status, and many others), but the most detrimental effects are caused when multiple risk factors act on a single infant." (Sameroff, 1998)

Risk factors "are those characteristics or hazards that increase the possibility of the occurrence, severity, duration, or frequency of later psychological disorders." Risk factors can be located within the child or within the parent child relationship, from characteristics of the parent or family unit, life events, or family ecology. Risk factors often co-occur, are additive, and each exposure to a new risk may increase the vulnerability exponentially. However, risks do not fully determine outcome. (Zeanah, 2000, 2018)

A thorough assessment can determine a child's strengths and weaknesses and level of developmental functioning, as well as caregiver, family, and environmental factors mediating the child's developmental processes.

Social Determinants of Health that Can Impact Pregnancy

<u>For Mother</u>
☐ Experience of loss or trauma
☐ Incarceration or justice-involved
☐ Exposure to pollutants (lead, mercury, etc.)
☐ Pregnancy due to a violent act
☐ Teen-age pregnancy
☐ Physical disability

☐ Lack of social support
☐ Custody issue
- African-American race
- Homelessness or Housing insecurity
- Food insecurity
- Poverty
- Other social determinants? ACES?

For Family

☐ Familial conflicts/ distress level

☐ Lack of family cohesion

☐ Family violence

☐ Legal problems

☐ Financial concerns and distress; poverty

☐ Maternal education level

☐ Paternal education level

☐ Parenting style conflict

☐ Number of children in home

☐ Parent/Child relationships

☐ Single parenting

In Environment

☐ Community violence

☐ Community poverty

☐ High unemployment in community

☐ Lack of community resources

☐ Stress in physical environment (e.g., toxins, lack of green space, etc.)

Physical Health During Pregnancy

☐ Chronic illness; please name: _____-

☐ Gestational Diabetes

☐ Elevated blood pressure

☐ Exposure to second-hand smoke

☐ Special diet/eating habit

☐ Sexually transmitted disease - STDs

☐ Vaccinations, including flue

☐ Infections (e.g., Rubella, venereal disease, HIV, flu virus)

Medication used: please list all prescribed, over the counter, and herbal / supplemental / home remedies:

(If any of the following applies, please explain in the Initial Assessment form's appropriate section).

Birth Complications

☐ Breech birth	☐ Cesarean delivery	☐ Convulsions
☐ Cord around neck	☐ Forceps	☐ Hemorrhage
☐ Infections	☐ Multiple birth	☐ Cyanosis (Blue Baby)
☐ Exchange transfusion	☐ Feeding difficulties	☐ Jaundice (Yellow Baby)
☐ Oxygen needed for baby	☐ Paralysis (cannot move)	☐ Premature separation of placenta

Child Characteristics

☐ Biological vulnerability; health status   ☐ Birth weight   ☐ Brain injury
☐ Exposure to pollutants (lead, mercury, etc.)   ☐ Coping style   ☐ Prematurity
☐ Cognitive development   ☐ Interaction/responsivity level
☐ Cognitive appraisal of the traumatic event   ☐ Language development
☐ Compromised health; infectious diseases; HIV   ☐ Sex of the child
☐ Social skills development   ☐ Eye contact/In-utero exposure to toxic
☐ Self-regulation level: Well-regulated   solvent
☐ Self-regulation level: High or low arousal
☐ Attention focus level (reported and observed)
    ☐ At home   ☐ At school   ☐ In session
☐ Temperament
    ☐ Activity level   ☐ Approach-withdrawal   ☐ Adaptability
    ☐ Mood or Irritability   ☐ Attention span/persistence☐ Distractibility
    ☐ Rhythmicity/regularity   ☐ Intensity of reaction
    ☐ Threshold of responsiveness

III. RESILIENCE/PROTECTIVE FACTORS

Protective factors are "those conditions that increase resilience under conditions of adversity and increase resistance to later disturbances." "Protective factors, akin to risks, also exist in multiple domains. They may exist within a child, as with intelligence or skills in self-regulation, or within the parent, as commitment and sensitivity to the needs of the child and appropriate discipline, monitoring, and supervision. A close attachment with an effective parent or parent figure has been found to be a universal protective factor for children growing up under adversity." (Zeanah 2000, 2018)

Recent research in the area of child abuse and resilience suggest that protective factors reduce risk of abuse, build family capacity, and foster resilience. The following is a list of protective factors that include child factors, parent and family factors, social and environmental factors.

Child Factors

☐ Close attachment to parent figure   ☐ Positive self-concept
☐ Ability to deal with change   ☐ Easy temperament

Los Angeles County Department of Mental Health
Infancy, Childhood and Relationship Enrichment
Initial Assessment Reference Manual

☐ Positive disposition   ☐ Problem solving skills
☐ Communication skills   ☐ Social and emotional competence
☐ Positive peer relationships   ☐ Self-regulation
☐ Cognitive functioning   ☐ Temperament
☐ Balance between autonomy and help seeking behaviors

Parental Factors
☐ Attachment with children   ☐ Stable marital relationship
☐ Good health   ☐ Knowledge of parenting and child development
☐ Extended family or social support   ☐ Basic necessities (parental employment, income, food, shelter)
☐ Parental education
☐ Appropriate expectations   ☐ Family expectations of pro-social behavior
☐ Parental monitoring of children ☐ Parental self-esteem (positive attitude, creative problem solving skills)

Community Factor
☐ Access to health care and social services   ☐ Competent schools/good childcare
☐ Safe neighborhood   ☐ Family religious faith participation
☐ Socioeconomic status   ☐ Community support (social connections)
☐ Concrete support in times of need/resources
☐ Supportive adults outside family who serve as role models/mentors

IV. CULTURAL AND LINGUISTIC COMPETENCE

Cultural and linguistic competence have continued to emerge as essential requirements in the delivery of effective mental health services and supports to young children and their families. Continuously growing ethnic, cultural, and linguistic diversity is reflected in recent demographic data indicating a 5 million increase in U.S. immigrant populations since the 2000 census and approximately 50 million persons who now speak a language other than English at home. In Los Angeles County there are well over 30 primary languages, including 13 "threshold" languages, spoken among 2.5 million Medi-Cal beneficiaries.[1]

Cultural competence includes the ability to think, feel, and act in ways that respect and effectively respond to diverse peoples (Lynch, & Hanson, 2004, 2011). Cultural competence mirrors the growth of infants and young children in that it is an active, developmental, and ongoing process that evolves over an extended period of time. However, within service delivery systems, culturally competent policies, procedures, structures, and practices must keep pace with and

[1] A "threshold language" is defined as the primary language of 3,000 beneficiaries or five percent of the Medi-Cal beneficiary population (whichever is lower) in an identified geographic area.

adapt to the diversity and cultural contexts of the clients and communities they serve. This includes linguistic competence, which is defined as the capacity of an organization and its personnel to communicate effectively and convey information in a manner that is easily understood by diverse audiences (Bronheim, Goode, & James, 2006).

Improving the cultural and linguistic competence of early childhood systems rises to a high priority on the national healthcare agenda if persistent racial and ethnic health disparities are to be reduced and ultimately eliminated (Sareen, Russ, Vicensio, & Halfon, 2004).

ASSESSMENT GUIDE
In the assessment of children age 0-5 years, clinicians should consider symptoms, as well as developmental and sensory characteristics in arriving at an Axis I diagnosis.

7 Symptom Domains
Behavior
Affect
Thought
Sleeping
Feeding
Crying
Developmental lags

7 Developmental Domains
Sensory   (see below)
Motor   (gross, fine, oral)
Language   (receptive, expressive)
Cognition   (attention, information processing, memory)
Social   (with parents/caregivers, siblings/peers, strangers)
Emotional   (range for positive and negative feeling states, flexibility, containment, soothing)
Self-help   (feeding, bathing, dressing)

7 Sensory Domains
Auditory   (sound, hearing)
Visual   (sight, light)
Tactile   (touch)
Proprioceptive(deep pressure, vibration, muscle, joint)
Vestibular   (movement, gravity)
Olfactory   (smell)
Gustatory   (taste)

-*From Allison Pinto: "DC:0-3R: A Framework for Recognizing and Responding to the Mental Health Needs of Children from Birth – Age 3" DC:0-3R Training. June 19, 2006*

V. REFERENCES

Bronheim, S., Goode, T, and Jones, W. (Spring 2006). *Policy Brief: Cultural and Linguistic Competence in Family Supports.* Washington, DC: National Center for Cultural Competence, Georgetown University Center for Child and Human Development. Retrieved from https://nccc.georgetown.edu/documents/FamilySupports.pdf

Finello, K. M. (2005). *The Handbook of Training and Practice in Infant and Preschool Mental Health*. San Francisco, CA: John Wiley & Sons.

Glascoe, F. P. (2000). Evidence-based approach to developmental and behavioural surveillance using parents' concerns. *Child: Care, Health and Development, 26*(2), 137-149. doi:10.1046/j.1365-2214.2000.00173.x

Goo, M., Tucker, K., & Johnston, L. M. (2018). Muscle tone assessments for children aged 0 to 12 years: A systematic review. *Developmental Medicine & Child Neurology, 60*(7), 660-671. doi:10.1111/dmcn.13668

Greenspan, S. I. (1996). Assessing the Emotional and Social Functioning of Infants and Young Children. In S. Meisels & E. Fenichel (Eds.), *New Visions for the Developmental Assessment of Infants and Young Children* (pp. 231-266)*.* Washington, DC: Zero to Three National Center for Infants, Toddlers, and Families.

Greenspan, S. I., & Meisel, S. J. (1996). Toward a New Vision for the Developmental Assessment of Infants and Young Children. In S. Meisels & E. Fenichel (Eds.), *New Visions for the Developmental Assessment of Infants and Young Children (pp. 27-52).* Washington, DC: Zero to Three National Center for Infants, Toddlers, and Families.

Greenspan, S. I., & Wieder, S. (2006*). Infant and early childhood mental health: A comprehensive developmental approach to assessment and intervention.* Washington, DC: American Psychiatric Publishing, Inc.

Heffron, M. C., & Murch, T. (2010). *Reflective supervision and leadership in infant and early childhood programs.* Washington, DC: Zero To Three Press.

Lynch, E.W., & Hanson, M. J. (Eds.) (2011) *Developing cross-cultural competence: Working with children and their families* (4th ed.). Baltimore, MD: Paul H. Brookes.

Lynch, E.W., & Hanson, M. J. (2004) *Developing cross-cultural Competence: A framework for working with children and their Families* (3rd ed.). Baltimore, MD: Paul H. Brookes.

Ollendick, T. H., & Schroeder, C.S. (2003). (Eds). *Encyclopedia of clinical child and pediatric psychology*. New York, NY: Kluwer/Plenum.

Pantley, E. (2002). *The no-cry sleep solution: Gentle ways to help your baby sleep through the night*. New York, NY: McGraw-Hill Education.

Pathways.org. (n.d.). How kids learn to play: 6 stages of play development. Retrieved from https://pathways.org/kids-learn-play-6-stages-play-development/

Pathways.org. (n.d.). What Are Hypertonia and Hypotonia. Retrieved from https://pathways.org/what-are-hypertonia-and-hypotonia/

Parten, M. B. (1932). Social participation among pre-school children. *The Journal of Abnormal and Social Psychology, 27*(3), 243-269. doi:10.1037/h0074524

Sameroff, A. J. (1998). Environmental risk factors in infancy. *Pediatrics, 102*; 1287-1292.

Sareen H, Russ S, Visencio D, Halfon N. The Role of State Early Childhood Comprehensive Systems in Promoting Cultural Competence and Effective Cross-Cultural Communication. In: Halfon N, Rice T, and Inkelas M, eds. Building State Early Childhood Comprehensive Systems Series, No. 8. National Center for Infant and Early Childhood Health Policy at UCLA; 2004.

Squires, J., & Bricker, D. (2009). *Ages & Stages Questionnaires®, Third Edition (ASQ®-3): A Parent-Completed Child Monitoring System*. Baltimore, MD: Paul H. Brookes Publishing Co., Inc.

Tickle, L. (2016, April 15). *Rise in referrals to social services causing trauma to families, expert says.* Retrieved from https://www.theguardian.com/society/2016/apr/15/rise-in-referrals-social-services-trauma-families-child-protection

Weir, K. (2016). Research on suicide overlooks young children; psychologists are working to change that. *CE Corner, 47 (11).* Retrieved from https://www.apa.org/monitor/2016/12/ce-corner

Xu, Y. (2010). Children's social play sequence: Parten's classic theory revisited. *Early Child Development and Care, 180*(4), 489-498. DOI: 10.1080/03004430802090430

Zeanah, Jr., C. H. (Ed). (2018). *Handbook of infant mental health* (4th ed.). New York, NY: The Guilford Press.

Zeanah, C. H., Jr. (Ed.). (2009). *Handbook of infant mental health* (3rd ed.). New York, NY: The Guilford Press.

Zero to Three. (2016). *DC: 0-5™: Diagnostic classification of mental health and developmental disorders of infancy and early childhood*. Washington, DC: Zero To Three Press.

Relevant Birth to Five resources for further reading

American Academy of Pediatrics. Developmental milestones. www.aap.org (Search: "*developmental milestones"*)   Link below to "*Developmental milestones*" Excerpted www.aap.org (Search: "*developmental milestones"*)   Link below to "*Developmental milestones*" Excerpted from Caring for Baby and Young Child: Birth to Age 5. Bantam. 1999. https://healthychildren.org/English/ages-stages/Pages/default.aspx Retrieved December 6, 2019.

Ames, L. B., Gillespie, C., Haines, J., Ilg, F.G. (1979). *The Gesell Institute's Child from One to Six: Evaluating the Behavior of the Preschool Child*. New York, NY: The Gesell Institute.

Burke-Harris, N. (2014, September). *Nadine Burke-Harris: How childhood trauma affects health across a lifetime.* [Video file]. Retrieved from https://www.ted.com/talks/nadine_burke_harris_how_childhood_trauma_affects_health_across_a_lifetime

Center for Disease Control and Prevention. (2020, April 20). Child abuse and neglect: Risk and Protective Factors. Retrieved from https://www.cdc.gov/violenceprevention/childabuseandneglect/riskprotectivefactors.html

Center for Disease Control and Prevention. (2019, December 06). *All Checklists*. Retrieved from https://www.cdc.gov/ncbddd/actearly/pdf/checklists/all_checklists.pdf

Center for Disease Control and Prevention. (2019, December 06). Adverse Childhood Experiences (ACEs). Retrieved from https://www.cdc.gov/violenceprevention/childabuseandneglect/acestudy/index.html.

Center for the Study of Social Policy. (2020, April 04). About Strengthening Families and Protective Factors Framework. Retrieved from https://cssp.org/resource/about-strengthening-families-and-the-protective-factors-framework/

Child Welfare Information Gateway. (2018). *Preventing child abuse and neglect.* Washington, DC: U.S. Department of Health and Human Services, Children's Bureau. Retrieved 04.20.2020. https://www.childwelfare.gov/pubPDFs/preventingcan.pdf

Cove, E., Eiseman, M., Popkin, S. (2005). *Resilient Children: Literature Review and Evidence from the HOPE VI Panel Study*. Washington, DC: The Urban Institute Metropolitan Housing and Communities Policy Center. Retrieved from

https://www.urban.org/sites/default/files/publication/51961/411255-Resilient-Children.PDF

CrossRoads Institute. (2006, September 01). *Sensory Programs*. Retrieved from
www.crossroadsinstitute.org

Georgetown University Center for Child and Human Development: National Center for Cultural
Competence: https://nccc.georgetown.edu/

Greenspan, S. I., DeGangi, G., & Wieder, S. (2001). *The Functional Emotional Assessment Scale
(FEAS) For Infancy and Early Childhood: Clinical and Research Applications*. Bethesda,
MD: Interdisciplinary Council on Developmental and Learning Disorders.

Interdisciplinary Council on Developmental and Learning Disorders. *(*2005). *Diagnostic Manual
for Infancy and Early Childhood Mental Health, Developmental, Regulatory-Sensory
Processing, Language and Learning Disorders.* Bethesda, MD: Author.

Interdisciplinary Council on Developmental and Learning Disorders Clinical Practice Guidelines
Workgroup. (2003). *Clinical Practice Guidelines: Redefining the Standards of Care for
Infants, Children, and Families with Special Needs*. Bethesda, MD: Author.

Jellinek, M., Patel, B., & Froehle, M. (Eds.). (2002). *Bright Futures in Practice: Mental Health.
Vol. II. Tool Kit.* Arlington, VA: National Center for Education in Maternal and Child
Health.

Jones, S.M., Zaslow, M., Darling-Churchill, K.E., & Halle, T.G. (2016). Assessing early childhood
social and emotional development: Key conceptual and measurements issues. *Journal of
Applied Developmental Psychology*, *45*, 42-48. doi: 10.1016/j.appdev.2016.02.008

Lipkin, P.H., & Macias, M. M. (2020). Promoting optimal development: Identifying infants and
young children with developmental disorders through developmental surveillance and
screening. *Pediatrics*, 145, 1-19. doi: 10.1016/j.appdev.2016.02.008

Meisels, S., & Fenichel, E. (Eds). (1996). *New Visions for the Developmental Assessment of
Infants and Young Children.* Washington, DC: Zero to Three National Center for Infants,
Toddlers, and Families.

Mozolic-Staunton, B., Donelly, M., Yoxall, J., & Barbaro, J. (2020). Early detection for better
outcomes: Universal developmental surveillance for autism across health and early
childhood education settings. *Research in Autism Spectrum Disorders*, *71*, 101496. doi:
10.1016/j.rasd.2019.101496

Public Broadcasting System. (2019, December 06). The Whole Child. Retrieved from
www.pbs.org/wholechild/

Sameroff A. Early Resilience and Its Developmental Consequences. In: Tremblay RE, Boivin M,
Peters RDeV, eds. Masten AS, topic ed. *Encyclopedia on Early Childhood
Development* [online]. http://www.child-encyclopedia.com/resilience/according-
experts/early-resilience-and-its-developmental-consequences Updated October 2013.
Accessed April 20, 2020.

U.S. Department of Health and Human Services Office of Minority Health. (2020, April 15).
Improving Cultural Competency for Behavioral Health Professionals. Retrieved from
https://thinkculturalhealth.hhs.gov/education/behavioral-health

U.S. Department of Health and Human Services Office of Minority Health. (2020, April 15).
Culturally and Linguistically Appropriate Services (CLAS) Report and Toolkit from OMH.
Retrieved from https://minorityhealth.hhs.gov/omh/browse.aspx?lvl=1&lvlid=6

Yates, T. M. F. Resilience at an Early Age and Its Impact on Child Development: Comments on
Luthar and Sameroff. In: Tremblay RE, Boivin M, Peters RDeV, eds. Masten AS, topic
ed. *Encyclopedia on Early Childhood Development* [online]. http://www.child-
encyclopedia.com/resilience/according-experts/resilience-early-age-and-its-impact-
child-development-comments-luthar Updated October 2013. Accessed April 20, 2020.

Zero To Three. (2020, July 15). Healthy from the Start. Retrieved from
https://www.zerotothree.org/resources/352-healthy-from-the-start

Zero To Three. (2020, April 15). Parent Favorites: A collection of our highest trending resources
for parents. Retrieved from https://www.zerotothree.org/resources/series/parent-
favorites

Zero To Three. (2019, December 06). Brain Wonders: The Magic of Everyday Moments. Video.
Retrieved from https://vimeo.com/103169425

Zero To Three. (2019, December 06). Crosswalk from DC:0-5™ to DSM-5 and ICD-10
Retrieved from https://www.zerotothree.org/resources/1540-crosswalk-from-dc-0-5-to-
dsm-5-and-icd-10

Telehealth with Young Children

Clinical Guidance re: Assessing and Treating the 0-5 Population during COVID-19
http://file.lacounty.gov/SDSInter/dmh/1074407_ClinicalGuidancereAssessingandTreatin
g0-5PopulationduringCovid-19.pdf

Donisch, K., Inscoe, A. B., Tunno, A. M., Asarnow, J. R., & Goldston, D. B. (2019). Trauma-informed telehealth considerations for youth with suicidal and self-harm ideation and behaviors. UCLA-Duke ASAP Center for Trauma-Informed Suicide, Self-Harm, & Substance Abuse Prevention and Treatment. Available at: https://www.asapnctsn.org/wp-content/uploads/2020/05/Pediatric-Telehealth-Recommendations.ASAP-Center.05.16.2020-Final.pdf

Apps and other Web-based Resources

Vroom: 5 minutes of fun, free, developmentally appropriate activities and psychoeducation about development. "Every parent has what it takes to be a brain builder." Vroom turns shared moments into brain building moments to nurture our children's growing minds.

Staying on track app: Early development network, Babies can't wait. There is no one measure to identify delays as development is interactive and affected by many factors. This app provides guidelines to help determine how a child's development compares with most children their age.
 MotherToBaby: brings accurate, evidence-based information to pregnant and breastfeeding women. Providing information and research about the risks of medications, vaccines, chemicals or diseases during a woman's pregnancy.

The Word Gap: By age 3, children from low-income families are likely to hear 30 million fewer words creating a huge "word gap." This app provides resources in English and Spanish to help parents bridge this gap and interact with their babies in a new way.
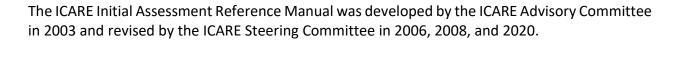
The FAMILIA text messaging program: focuses on family planning, active living, improving nutrition, reducing stress, and addressing abuse. Messages link to the FAMILIA website, for information, apps, blogs, and videos related to that topic in Eng./Span.

Father Source: "Everything You Need to Serve Fathers" the National Fatherhood Initiative® equips professionals with knowledge, skills, and resources to effectively engage fathers in their children's lives. Free resources for father's and professionals.

PTSD Coach app: VA sponsored app for adults, provides education about PTSD, tools to help manage the stresses of daily life such as: relaxation sessions, positive self-talk & anger management. Users can customize tools and integrate personal contacts, photos, and music.

Pathways: Free educational materials and resources for parents and professionals addressing the importance of early detection and early intervention. This website offers information by age, games to improve areas of development and other tools

Los Angeles County Department of Mental Health
Infancy, Childhood and Relationship Enrichment
Initial Assessment Reference Manual

The ICARE Initial Assessment Reference Manual was developed by the ICARE Advisory Committee in 2003 and revised by the ICARE Steering Committee in 2006, 2008, and 2020.

DISCLAIMER: The ICARE manual is to be used as a guide to assist in completing the ICARE initial assessment. It is not a substitute for attending an ICARE training.