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

INTRODUCTION

The ICARE Initial Assessment Reference Manual is an attachment to the Los Angeles County Department of Mental Health Infancy, Childhood & Relationship Enrichment (ICARE) Initial Assessment 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). 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, 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 (eg., feeding, play), along with structured interviews with the family, will ensure a complete developmental evaluation.

"Watching a baby or young child do something he or she enjoys with someone he or she trusts should be the most important part of the developmental assessment. A developmental assessment is the time to learn about how a child uses his or her abilities to interact with people and objects in the environment." (The Zero To Three New Visions for Parents Work Group)

Assessment of children and their families should takes 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)

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. (The Zero To Three New Visions for Parents Work Group)

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

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 and if needed, behavioral measures or developmental screening tools. A thorough assessment of an infant or a young child should include between 4-6 sessions (Zeanah, 2000). 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.

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://dmh.lacounty.gov/documents/cms1_046533.pdf

The information collected in this ICARE Initial Assessment Reference Manual is to assist LACDMH mental health professionals, who serve families with children five years of age and younger, to complete the Initial Assessment in a more thorough and informed manner given the vast knowledge now 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 Diagnostic Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood: Revised Edition (DC:0-3R). The ICARE 0-5 Initial Assessment should only be used by staff who have completed Department training in conducting assessments for the 0-5 population which includes documentation for the ICARE 0-5 Initial Assessment form (*DMH Clinical Records Bulletin 2007-02 December 2007).* Training in the use of the DC:0-3R 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) **Developmental Milestones**
Sensory Profile Descriptions

(II) **Diagnostic Classifications:**
(1) **DSM IV-TR Commonly Used Diagnoses**
(2) **DC: 0-3R Clinical Disorders (Diagnostic Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood: Revised Edition)**
(3) **ICARE/DMH DC:0-3R Crosswalk**

(III) **Service/Referral Settings**

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)

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.

(IV) **Risk/Mediating Factors**
(V) **Resilience/Protective Factors**
(VI) Cultural Competence

To read more about assessment of infants, toddlers and preschoolers:

Finello, Karen. (Ed). (2005). *The Handbook of Training and Practice in Infant and Preschool Mental Health.* San Francisco: Jossey-Bass.

Meisels, Samuel, & Fenichel, Emily. (Eds). (1996). *New Visions for the Developmental Assessment of Infants and Young Children.* Washington, D.C.: Zero To Three National Center for Infants, Toddlers, and Families.

New Visions: A Parent's Guide to Understanding Developmental Assessment. Zero To Three New Visions for Parents Work Group. Zero To Three National Center for Infants, Toddlers, and Families. www.zerotothree.org

ICDL Clinical Practice Guidelines: Redefining the Standards of Care for Infants, Children, and Families with Special Needs. The Interdisciplinary Council on Developmental and Learning Disorders.

Zeanah, Jr., Charles. (Ed). (2000). *Handbook of Infant Mental Health*. 2nd Ed. New York: The Guilford Press.

I. DEVELOPMENTAL MILESTONES

The information presented in this section is used with permission from Stanley I. Greenspan, MD. The section was compiled from:

Greenspan, Stanley I. "Toward a New Vision for the Developmental Assessment of Infants and Young Children." In Meisels and Fenichel's *New Visions for the Developmental Assessment of Infants and Young Children*. (1996).

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 forty eight months. These developmental norms must be applied flexibly and consider the family's unique situation.

A detailed developmental history should be obtained though 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.

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.

Additional references on developmental milestones are provided at the end of this section.

DEVELOPMENTAL MILESTONES

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

Sensory Skills

- Looks toward a sound
- Tolerates gentle roughhousing
- Bites and chews

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:
  - Negotiating closeness and dependency: Infant gives caregiver a hug, and as caregiver hugs back in response, infant nuzzles and relaxes
  - 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
  - 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 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 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

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 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: jokes, giggles
  - 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

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

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

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

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

References on developmental milestones:

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

Greenspan, Stanley I. (1996). "Assessing the Emotional and Social Functioning of Infants and Young Children." In Meisels, S., Fenichel, E. (Eds.) *New Visions for the Developmental Assessment of Infants and Young Children.* Washington, D.C. Zero To Three National Center for Infants, Toddlers, and Families.

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.

Web based links:

American Academy of Pediatrics. http://www.aap.org/
AAP Parenting Corner http://www.healthychildren.org

ZeroToThree. *The Magic of Everyday Moments.* www.zerotothree.org

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 2006)

Children challenged biologically by sensory processing can exhibit the following responses: *(See DC:0-3R pages 28-34)*

Hypersensitive/overresponsive – children who are easily overwhelmed by sensory stimuli that are part of every day 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 (Olfactory)**: 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 (Gustatory):** places objects in mouth, licks objects, preference for salty, sour and/or spicy foods.
> **Taste- avoidant**: limited range of food preferences, prefers bland foods

Introduction to Sensory Processing Concepts

References:

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

Greenspan, Stanley, Wieder, Serena. (2006*). Infant and Early Childhood Mental Health: A comprehensive developmental approach to assessment and intervention.* Washington, D.C.: American Psychiatric Publishing, Inc.

II. DIAGNOSTIC CLASSIFICATIONS

1. DSM-IV-TR

(296.xx) Bipolar I Disorder

(296.xx) Major Depressive Disorder

(296.80) Bipolar Disorder NOS

(296.89) Bipolar II Disorder

(296.90) Mood Disorder NOS

(299.00) Autistic Disorder

(299.10) Childhood Disintegrative Disorder

(299.80) Asperger's Disorder

(299.80) Pervasive Developmental Disorder NOS

(299.80) Rett's Disorder

(300.0) Anxiety Disorder NOS

(300.02) Generalized Anxiety Disorder

(300.4) Dysthymic Disorder

(300.29) Social Phobia

(301.13) Cyclothymic Disorder

(302.6) Gender Identity Disorder

(307.0) Stuttering

(307.3) Stereotypic Movement Disorder

(307.9) Communication Disorder

(307.20) Tic Disorder NOS

(307.21) Transient Tic Disorder

(307.22) Chronic Motor or Vocal Tic Disorder

(307.23) Tourette's Disorder

(307.42) Primary Dyssomnia

(307.44) Primary Hypersomnia

(307.46) Sleep Terror Disorder

(307.46) Sleepwalking Disorder

(307.47) Dyssomnia NOS

(307.47) Nightmare Disorder

(307.47) Parasomnia NOS

(307.52) Pica

(307.53) Rumination Disorder

(307.59) Feeding Disorder of Infancy or Early Childhood

(309.21) Separation Anxiety Disorder

(309.xx) Adjustment Disorders

(309.81) Posttraumatic Stress Disorder

(311) Depressive Disorder NOS

(312.9) Disruptive Behavior Disorder

(312.30) Impulse Control Disorder NOS

(312.34) Intermittent Explosive Disorder

(312.39) Trichotillomania

(313.9) Disorder of Infancy, Childhood, or Adolescence NOS

(313.23) Selective Mutism

(313.81) Oppositional Defiant Disorder

(313.89) Reactive Attachment Disorder of Infancy or Early Childhood

(314.00) Attention Deficit/Hyperactivity Disorder – Predominantly Inattentive Type

(314.01) Attention Deficit/Hyperactivity Disorder – Predominantly Hyperactive Type

(314.01) Attention Deficit/Hyperactivity Disorder – Combined Type

(315.4) Developmental Coordination Disorder

(315.31) Expressive Language Disorder

(315.31) Mixed Receptive/Expressive Language Disorder

(315.39) Phonological Disorder

(317-319) Mental Retardation

(787.6 or 307.7) Encopresis – *only if child is at least 4 years old*

(V61.8) Sibling Relational Problem

(V61.20) Parent-Child Relational Problem

(V61.21) Neglect of Child

(V61.21) Physical Abuse of Child

(V61.21) Sexual Abuse of Child

(V62.81) Relational Problem NOS

2. DIAGNOSTIC CLASSIFICATION: 0 – 3 REVISED (DC:0-3R)

Below are highlights and descriptions from the DC:0-3R. For complete descriptions, please refer to the respective DC:0-3R sections and categories.

AXIS I: CLINICAL DISORDERS

100 Traumatic Stress Disorder

150 Deprivation/Maltreatment Disorder

200 Disorders of Affect

210 Prolonged Bereavement/Grief Reaction

220 Anxiety disorders of Infancy and Early Childhood

- 221 Separation Anxiety Disorder
- 222 Specific Phobia
- 223 Social Anxiety Disorder
- 224 Generalized Anxiety Disorder
- 225 Anxiety Disorder NOS

230 Depression of Infancy and Early Childhood

- 231 Type 1: Major Depression
- 232 Type 2: Depressive Disorder NOS

240 Mixed Disorder of Emotional Expressiveness

300 Adjustment Disorder

400 Regulation Disorders of Sensory Processing

410 Hypersensitive

- 411 Type A: Fearful/Cautious

412 Type B: Negative Defiant

420 Hyposensitive/Underresponsive

430 Sensory Seeking/Impulsive

500 Sleep Behavior Disorder

510 Sleep Onset Disorder (Protodyssomnia)

520 Night Walking Disorder (Protodyssomnia)

600 Feeding Behavior Disorder

601 Feeding Disorder of State Regulation

602 Feeding Disorder of Caregiver-Infant Reciprocity

603 Infantile Anorexia

604 Sensory Food Aversions

605 Feeding Disorder Associated with Concurrent Medical Condition

606 Feeding Disorder Associated with Insults to the Gastrointestinal Tract

700 Disorders of Relating and Communicating

710 Multisystem Developmental Disorder

800 Other Disorders (*DSM-IV-TR or ICD 10*)

ICARE/DMH DC:0-3R CROSSWALK

L.A. County's ICARE Steering Committee provides this DC:0-3R Crosswalk as a guideline for L.A. County DMH 0-5 providers to translate the DC:0-3R to DSM-IV-TR general categories. Treatment planning should address specific symptomatology as reflected in the DC:0-3R diagnosis.

Axis	DC:0-3R Code	DC:0-3R Definition	DSM IV TR Code*	DSM IV-TR Definition
I	100	Post Traumatic Stress Disorder	309.81	Post Traumatic Stress Disorder
I	150	Deprivation/Maltreatment Disorder	313.89	Reactive Attachment Disorder of Infancy and Childhood: Inhibited or Disinhibited Type
I	200	Disorders of Affect	296.90	Mood Disorder NOS
I	300	Adjustment Disorder	390.9	Adjustment Disorder Unspecified
I	400	Regulation Disorders of Sensory Processing	313.9	Disorder of Infancy, Childhood & Adolescence NOS
I	500	Sleep Behavior Disorders	313.9	Disorder of Infancy, Childhood & Adolescence NOS
I	600	Feeding Behavior Disorder	307.59	Feeding Disorder of Infancy
I	700	Disorders of Relating and Communicating	299.80	Pervasive Developmental Disorder NOS
I	800	Other Disorders (DSM-IV-TR or ICD 10)		

Use the appropriate DSM-IV diagnosis code if applicable

AXIS II : The Parent-Infant Relationship Global Assessment Scale (PIR-GAS)	
Relationship Problems Checklist (RPCL)	
Overinvolved Underinvolved Anxious/Tense Angry/Hostile Verbally Abusive Physically Abusive	*Code if appropriate on Axis I- DSM IV*** V61.20 Parent-Child Relational Problem V61.21 Neglect V61.21 Physical/Sexual Abuse of Child V62.81 Relational Problem NOS
AXIS III: All relevant medical problems as in DSM IV-TR	
AXIS IV: Psychosocial Stressors	
AXIS V: Functional Emotional Developmental Level	

*Refer to "Medi-Cal Included Diagnosis" in the Organizational Provider's Manual
**Not Medi-Cal included diagnosis

AXIS II: PARENT – INFANT RELATIONSHIP GLOBAL ASSESSMENT SCALE (PIR-GAS)

(See DC:0-3R pages 42-45 for detailed description)

Adapted Relationship

91-100	**WELL ADAPTED** - relationships are mutually enjoyable and growth promoting
81-90	**ADAPTED** - relationships frequently reciprocal and synchronous; good enough for both partners

Features of a Disordered Relationship

71-80	**PERTURBED** - relationships less than optimal- disturbance is limited to one domain and lasts from a few days to a few weeks
61-70	**SIGNIFICANTLY PERTURBED** - relationships strained but are still largely adequate, disturbance is limited to one or two problematic areas, and lasts no longer than one month
51-60	**DISTRESSED** - relationships more than transiently affected, but still some flexibility and adaptive qualities; experience some distress; developmental progress likely to be impeded, but overt symptoms unlikely
41-50	**DISTURBED** - relationships at significant risk for dysfunction and problematic features overshadow, disturbance is more than transient and adversely affects the subjective experience of one or both partners.

Disordered Relationship

31-40	**DISORDERED** - relationships involve stable maladaptive interactions, may be grossly inappropriate developmentally without overt conflict.
21-30	**SEVERELY DISORDERED** - relationships severely compromised, significantly distressed, rigidly entrenched, almost always conflicted.
11-20	**GROSSLY IMPAIRED** - relationships dangerously disorganized; infant is in imminent danger of physical harm.
1-10	**DOCUMENTED MALTREATMENT** - neglect or physical/sexual abuse.

AXIS II: RELATIONSHIP PROBLEM CHECKLIST

Relationship Quality	**No evidence**	**Some evidence; *needs further investigation**	**Substantial evidence**
Overinvolved: parent manifests overinvolvement both physically and/or psychologically			
Underinvolved: parent shows only sporadic, infrequent involvement or connectedness			
Anxious/Tense: tense and constricted interactions with little enjoyment/mutuality			
Angry/Hostile: interactions are harsh and abrupt, often lacking in emotional reciprocity			
Verbally Abusive: severe abusive emotional content, unclear boundaries, and overcontrol by the parent.			
Physically Abusive: severe physical abuse, unclear boundaries, and overcontrol by the parent.			
Sexually Abusive: a lack of regard for physical boundaries and extreme sexualized intrusiveness.			

Each quality of the caregiver relationship is described in terms of: (1) characteristic behavioral quality, (2) affective tone, and (3) psychological involvement. See DC0-3R, pages 46-52 for detailed descriptions under each Relationship Quality.

The following format is suggested to note the quality of relationships with multiple caregivers.

Relationship Quality	No Evidence	Some evidence*	Substantial evidence
Overinvolved			*Mother (Mo). Grandmother (GrMo)*
Underinvolved		*Father (Fa)*	
Anxious/Tense			*GrMo; Mo*
Angry/Hostile		*Fa*	
VerballyAbusive	√		
PhysicallyAbusive	√		
SexuallyAbusive	√		

*Needs further investigation

AXIS III: MEDICAL AND DEVELOPMENTAL DISORDERS AND CONDITIONS

"Medical, neurological and developmental diagnoses made using other diagnostic and classification systems should be noted here. These systems would include DSM-IV-TR (2000), ICD-9 (1977) or ICD-10 (1992), as well as systems used by speech pathologists, occupational therapists, physical therapists, special educators and primary health care providers."

"If the child meets criteria for DSM-IV-TR or ICD-10 psychiatric disorder, the disorder should be coded on Axis I as an 800 disorder." [See page 53, DC:0-3R]

AXIS IV: PSYCHOSOCIAL STRESSORS

See pages 56-59 of the DC:0-3R 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 primary support group
- Social environment
- Educational/child care challenges
- Housing challenges
- Economic challenges
- Occupational challenges
- Health-care access challenges
- Health of child
- Legal/criminal justice challenges
- Other

The DC:0-3R enumerates three key factors inherent in the impact of any stressor:

1. Severity: intensity and duration, suddenness of initial stressor and the unpredictability of its reoccurrence.
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

AXIS V: EMOTIONAL AND SOCIAL FUNCTIONING

Reflects child's emotional and social functioning with important caregivers, in relation to expectable patterns of development. See DC:0-3R pages 61-64 detailed description.

Rating Scale

1. age appropriate level under all conditions and with full range of affect states
2. age appropriate level but vulnerable to stress and/or with constricted range of effects
3. has the capacity, but not in keeping with age expected forms of the capacity (e.g., relates but is immature)
4. needs some structure or sensorimotor support to evidence capacity; otherwise manifests capacity intermittently/inconsistently
5. barely evidences this capacity even with support
6. has not reached this level

Emotional and social functioning capacities with **each** of the significant caregivers in the child's life *(check all that apply)*	**1.**	**2.**	**3.**	**4.**	**5.**	**6.**	**n/a**
Attention and regulation: (0-3 mos.) ability to sense and attend to what is going on in the world with sufficient regulation without over- or under-reacting							
Forming relationships/mutual engagement: (3-6 mos.) ability to relate to supportive caregiver, and experience range of emotion while staying engaged.							
Intentional two-way communication: (4-10 mos.) use of gestures and affect, start and engage in reciprocal communication.							
Complex gestures and problem solving: (10-18 mos.) use of motor and language skills to get what is needed or wanted, eventually using words.							
Use of symbols to express thoughts/ feelings: (18-30 mos.) use of imaginative play, role playing to express ideas, thoughts, feelings.							
Connecting symbols logically/ abstact thinking: (30-48 mos.) use interconnected ideas and language to talk about daily events and imaginative stories; understands abstract thoughts, reflects on feelings, articulates lessons learned from experience.							

III. SERVICE/REFERRAL SETTINGS

1. Community Mental Health Clinic
2. Court Ordered Referral
3. Department of Children & Family Services
4. Department of Social Services/CalWorks
5. Early Head Start Program
6. Early Intervention Specialist
7. Foster Care Agency
8. Head Start Program
9. HMO
10. Hospital - In-patient
11. Hospital - Out-patient
12. Medical School - In-patient
13. Medical School - Out-patient
14. Private Practice Office
15. Public Health Clinic
16. Special Education Program

Professional Discipline

1. Adult Psychiatry
2. Child Development
3. Child Life
4. Child Psychiatry
5. Psychology
6. Developmental Specialist
7. Education
8. Family Practice
9. Marriage Family Therapy
10. Neurology
11. Nursing
12. Occupational Therapy
13. Pediatrics
14. Physical Therapy
15. Social Work
16. Special Education
17. Speech & Language/Speech Pathologist

IV. 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)

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.

(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
- ❑ Cyanosis (Blue Baby)
- ❑ Exchange transfusion
- ❑ Feeding difficulties
- ❑ Forceps delivery
- ❑ Hemorrhage
- ❑ Infections
- ❑ Jaundice (Yellow Baby)

- Multiple birth
- Oxygen needed for baby
- Paralysis (cannot move)
- Premature separation of placenta

CHILD CHARACTERISTICS

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

MATERNAL FACTORS DURING PREGNANCY

- Alcohol use/abuse
- Distress level
- Experience of loss or trauma
- Exposure to pollutants (lead, mercury, etc.)
- Exposure to radiation
- Exposure to glue/or paint thinner
- Incarceration
- Malnutrition during pregnancy
- Maternal "sniffing" of solvent-based paint glue, etc.
- Mental health status (maternal depression, psychopathology)
- Mixed use of illicit drugs
- Nutrient deficiency
  - Vitamin B
  - Vitamin A
  - Folic Acid
- Parent/child relationships; parent/child role reversal
- Physical disability
- Physical health concerns:
  - Anemia
  - Chronic illness
  - Diabetes
  - Edema (swelling)
  - Elevated blood pressure
  - Exposure to second-hand smoke
  - German Measles
  - Infection, (e.g., Rubella, venereal disease, HIV, flu virus)
  - Ingestion of medication
  - Injuries
  - Known threat of miscarriage
  - Over-the-counter medication
  - Previous miscarriage
  - Special diet/eating habit
  - Sexually transmitted disease - STDs
  - Unusual bleeding
  - Use of caffeine
  - Use of prescribed medication

- Vaccinations
- Vomiting frequently

- Pregnancy due to a violent act
- Post-partum depression
- Stress, anxiety
- Teen-age pregnancy

FAMILIAL FACTORS

- Lack of social support
- Affective engagement and responsiveness
- Cultural/linguistic concerns within the dominant society; minority status
- Custody issue
- Dyadic relationship difficulties
- Familial conflicts/ distress level
- Familial psychopathology/parental or caregiver mental illness
- Lack of family cohesion
- Family stress
- Family violence
- Financial concerns and distress; poverty
- Legal problems
- Limit setting and control
- Maternal education level
- Number of children in home
- Parent/child relationships
- Parental history of drug use/abuse
    - Alcohol use; Fetal Alcohol syndrome (FAS)
    - Alcohol-Related Birth Defects (ARBD)
    - Alcohol use – father
    - Amphetamines and Methamphetamines
    - Cocaine use
    - Marijuana
    - Phencyclidine Hydrochloride (PCP)
    - Smoking
- Parenting style conflict
- Paternal education level
- Physical disability of parent/caregiver
- Single parenting
- Socio-economic status

ENVIRONMENTAL FACTORS

- ❑ Community violence
- ❑ Community poverty
- ❑ Neighborhood violence
- ❑ Lack of support following a traumatic event
- ❑ Lack of community resources
- ❑ Unemployment
- ❑ Welfare
- ❑ Environmental distress

V. 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)

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.

<u>CHILD FACTORS</u>

- Close attachment to parent figure
- Positive self concept
- Ability to deal with change
- Easy temperament
- Positive disposition
- Problem solving skills
- Communication skills
- Social and emotional competence
- Positive peer relationships
- Balance between autonomy and help seeking behaviors
- Self regulation
- Cognitive functioning
- Temperament

<u>PARENTAL FACTORS</u>

- Parental self esteem (positive attitude, creative problem solving skills)
- Attachment with children
- Stable marital relationship
- Basic necessities (parental employment, income, food, shelter)
- Appropriate expectations/parental monitoring of children

- Knowledge of parenting and child development
- Good health
- Extended family or social support
- Family expectations of pro-social behavior
- Parental education

COMMUNITY FACTORS

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

References:

A Protective Factors Approach: Strengthening Families through Early Care and Education. Center for the Study of Social Policy. http://www.cssp.org/doris_duke/protective.html

Cove, Elizabeth, Eiseman, Michael, Popkin, Susan. *Resilient Children: Literature Review and Evidence from the HOPE VI Panel Study*. December 2005.

Risk and Protective Factors for Child Abuse and Neglect. Child Welfare Information Gateway http://www.childwelfare.gov

Sameroff, Arnold J. (1998) *Environmental Risk Factors in Infancy*. Pediatrics. 1998; 102; 1287. www.pediatrics.org

Sameroff, Arnold, MacKenzie, Michael. *A Quarter Century of the Transactional Model: How Have Things Changed?* Zero To Three. September 2003.

Luthar SS. Resilience at an early age and its impact on child psychosocial development. In: Tremblay RE, Barr RG, Peters RDeV, eds. *Encyclopedia on Early Childhood Development* [online]. Montreal, Quebec: Centre of Excellence for Early Childhood Development; 2005:1-6. Retrieved from http://www.child-encyclopedia.com/Pages/PDF/LutharANGxp.pdf

Zeanah, Jr., Charles. (Ed).(2000). *Handbook of Infant Mental Health*. 2nd Ed. New York: The Guilford Press

VI. 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” (1) languages, spoken among 2.5 million Medi-Cal beneficiaries.

Cultural competence includes the ability to think, feel, and act in ways that respect and effectively respond to diverse peoples (2). 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 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 (3).

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 (4).

References:

(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.

(2) Lynch, E.W., & M.J. Hanson (Eds.) (2004) *Developing Cross-cultural Competence: A Guide for Working with Children and their Families* (Third Edition) Baltimore: Paul H. Brookes.

(3) Bronheim. S., Goode, T. & James, W. (Spring 2006). *Policy Brief: Cultural and Linguistic Competence in Family Supports*. Washington, DC: National Center for Cultural Competence, Georgetown University Center Child and Human Development.

(4) Sareen, H., Russ, S., Vicensio, D., & Halfon, N. (2004) The Role of State Early Childhood Comprehensive Systems in Promoting Cultural Competence and Effective Cross-cultural Communication. In N. Halfon, T. Rice,& M. Inkeles (Eds.) *Building State Early Childhood Comprehensive Systems Series, No. 8.* National Center for Infant and Early Childhood Health Policy @ UCLA.

Resources:

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

U.S. Department of Health & Human Services
Human Resources and Services Administration
http://www.hrsa.gov/culturalcompetence

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.

<u>7 Symptom Domains</u>

- Behavior
- Affect
- Thought
- Sleeping
- Feeding
- Crying
- Developmental lags

<u>7 Developmental Domains</u>

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)

<u>7 Sensory Domains</u>

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*

Los Angeles County Department of Mental Health
Infant-Early Childhood/Family Mental Health
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.