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

Initial Assessment Reference Manual

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ACKNOWLEDGEMENT
This Reference Manual is Prepared by Zohreh Zarnegar, Ph.D., & Los Angeles County Department of Mental Health Infant-Early Childhood and Family Mental Health Advisory Committee, with Special Contributions By William Arroyo, MD, Diane Cullinane, MD, Wendy Lee, PhD, Constance M. Lillas, RN, MFT, PhD, Marcia Moriarta, PsyD, Lisa Margolis, LCSW, Allison Pinto, PhD, Wendy Schultz, MFT, Jeanne Smart, RN, MSN, and Katherine Reuter, PhD.
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The resources used to prepare this document are as follows:


Washington, D.C.: Zero To Three: National Center for Infants Toddlers and Families

This document is revised in 2006, to include the changes made in DC: 0-3-R.

Please contact Zohreh Zarnegar, Ph.D., for any questions, comments, and suggestions for improvement of this draft at zzarnegar@babygazette.org

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INTRODUCTION

The assessment process is the first intervention conducted by the mental health professional in her/his interaction with families. A thorough assessment is the process of collecting information to identify an infant/child’s developmental strengths and risks, to make a diagnosis, or to plan infant/child interventions. For preverbal age/stage children, the emphasis is on a thorough clinical observation of the infant/child, of the relationship between the infant/child and the caregiver, and of their interactions with each other, in a variety of times and settings.

Psychological assessment of children and their families takes place in their natural setting and in their primary language. Assessment must also be strength-based, to assist the infant/child to develop his/her strengths, and the family to serve as the primary vehicle for services to the infant/child. Attention should be paid to both points, in positive and empowering terms, both about the infant/child and the infant/child’s caregiving source.

The Los Angeles County Department of Mental Health, Infancy, Childhood and Relationship Enrichment (ICARE) Initial Assessment form is a comprehensive, multi-disciplinary collaborative document. Needed information for this document should be obtained from a variety of sources available. Psychological assessment requires a face-to-face clinical evaluation of the infant/child and caregiver(s) through interview, observation, record review, and the use of as-needed behavior-based measures. It is performed by trained mental health professionals to determine whether the infant/child might benefit from mental health treatment, to set a treatment plan and to decide on further referral.
HOW TO USE THIS MANUAL

This “Initial Assessment Reference Manual” is an attachment to the Los Angeles County Department of Mental Health, “Infancy, Childhood & Relationship Enrichment (ICARE) Initial Assessment” form, developed to be used with families whose children are three years old and younger (birth to three). However, many of the LACDMH-ICARE mental health professionals administered it successfully with children birth to five years of age during the piloting period. When this Initial Assessment form is used with children birth to five years of age, it will replace any existing Initial Assessment form used with this age group.

The information collected in this 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.

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

(I) Developmental Milestones,
(II) Diagnostic Classifications (1) DSM IV-TR commonly used diagnoses, and (2) Zero To Three (DC: 0-3-R), and
(III) Service/Referral Settings.

Part two includes concepts that will assist the clinicians to complete the Initial Assessment form by providing cues for their observation and interview of the family with young children, as follows:

(IV) Risk/Mediating Factors, and
(V) Cross Cultural Competency.
I. DEVELOPMENTAL MILESTONES

This section is prepared to assist the clinician in considering multiple developmental milestones for children ages birth to thirty-six months. The information obtained in this section is responsive to pages 3-5 of the Initial Assessment form, collected by taking a detailed history from the caregiving sources, thoroughly observing the child as well as the interaction between the child and the caregiver and using evaluation measures. Considering the variability and complexity of developmental stages, the child should be observed more than once and in different natural settings.

Infant-Early Childhood experts, such as Lieberman and Zeanah (1995), believe that a thorough assessment should include between four to six visitations, using a variety of sources to gather comprehensive data regarding all aspects of the infant’s life.

In this document, each developmental stage includes the following constructs/domains:

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

By Three Months: Regulation and Shared Attention

**Socio-Emotional**
- Infant smiles in response to your smile
- Caregiver is beginning to identify what types of sensory stimulation brings his/her infant pleasure and joy
- Infant ceases crying when caregiver enters the room and recognizes familiar faces and objects
- Infant recovers from distress with help from caregiver within 20 minutes

**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 actively holds rattle and pulls at blanket and clothes
- Infant keeps hands open 75% of the time

**Sensory Skills**
- Infant turns head and looks in direction of a sound
- Infant’s eyes follow you as you move across the room
- 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: Engagement & Relating

**Socio-emotional**
- Infant responds to caregiver’s smiles with a big one of his/her own
- Infant initiates interactions with loving looks and smiles
- Infant makes sounds and/or moving mouth, arm, legs, or body in rhythm with caregiver in rhythm with him/her
- Infant looks at caregiver’s face with rapt interest
- Infant anticipates with curiosity and excitement the reappearance of caregiver’s face or voice
- Infant looks uneasy or sad when caregiver withdraws in the midst of pleasurable playing
- Infant recovers from distress, with caregiver’s help within 15 minutes

**Motor Skills (from gross to fine motor)**
- Infant rolls from back to stomach
- Infant pushing up on extended arms when lying on stomach
- Infant sits in high chair with back straight and head steady
- Infant adjusts position to see a toy
- Infant plays with his/her own hands and brings hands together
- Infant reaches for a toy
- Infant grasps and plays with small objects voluntarily

**Sensory Skills**
- Infant looks toward a sound
- Infant tolerates gentle roughhousing
- Infant bites and chews

**Language Skills**
- Infant regularly localizing the source of a voice with accuracy
- Infant vocalizes two different sounds
- Infant begins to imitate sounds
- Infant’s babbling contains sounds like: ma, mu, da, di, hi
- Infant responds to caregiver’s expressions and sounds with vocalizations
Cognitive Skills
- Infant focuses and pays attention for 30 or more seconds
- Infant looks and scans for objects and faces
- Infant smiles at his/her own face in the mirror
- Infant looks toward an object that moves out of her visual range
- Infant looks at his/her own hand
- Infant manipulates and plays with toys, such as a rattle or key ring

By Nine Months: Two-Way Intentional Communication

Socio-emotional
- Reaches out to be picked up by caregiver, or hugging caregiver back when hugged
- Smiling, vocalizing, putting a finger in caregiver’s mouth, taking a rattle from his/her mouth and putting it in caregiver’s mouth, touching or exploring caregiver’s hair
- Angry face, shouts, and squirming body clearly communicates his/her sense of protest or anger (i.e., pushing undesired food off a high-chair tray with an accompanying angry look, screaming when a desired toy is not fetched quickly enough, etc.)
- Showing caution or fear by turning away, clinging to caregiver’s leg, or looking scared when a stranger approaches too quickly
- Crying more deliberately and calming more deliberately (cries are more intentional in communicating anger or more plaintive when feeling helpless)
- Can usually calm down after a few minutes of gestural interaction with caregiver (such as gentle sounds, eye contact, or back rub)
- Purposefully expressing a range of emotions, from joy, anger, and fear to surprise and anticipation

Motor skills (from gross to fine motor)
- Sits upright with good balance
- Holds a toy while sitting
- 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
- Pulls self to a standing position and stands, holding onto furniture
Crawls or creeps on stomach or hands
Playfully bangs hands or toys
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

Sensory Skills
Feels and explores textures
Explores different foods; tolerates different textures with hands and mouth
 Notices when an object (such as a toy) is put on various parts of his body
Enjoys movement in space
 Selectively responds to some sounds and sights
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 (i.e., “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
Focuses and pays attention while playing with you or alone for five 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
Looks for a toy if she/he sees it being hidden
Pulls on a part of an object (such as a piece of cloth) to get the object closer

By Twelve Months: Complex, problem-solving gestures

**Socio-emotional**

- Shows emotions clearly with discrimination, such as anger, fear, affection, and jealousy
- With caregiver support, (i.e., empathic reading of infant’s types of communication and responding to them), the infant and caregiver can organize three or more circles of communication (a circle = one person in the dyad initiates, the other responds, the initiator responds to the response) in the following emotional themes:
  - Negotiating Closeness: 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, back and forth
  - Assertive Explorations: Infant and caregiver examine new toys and explore the house
  - 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 and remain organized while distressed by entering into complex gestural negotiation for what s/he wants (i.e., banging On door to go outside and play).

**Motor Skills (from gross to fine motor)**

- Walks holding onto furniture or with both hands held
- Organizes one-step motor planning sequence, such as pushing, catching, or throwing a ball
- Squats while playing
- Stacks two cube-shaped blocks
- Throws a ball in a forward direction
- Can hold crayon and make a mark on paper
- Feeds self finger foods

**Sensory Skills**
- Can follow rapidly moving toy with eyes
- Infant can organize three or more interactive circles of communication (a circle = initiator, responder, initiator responds to responder) using vocalizations, facial expressions, reciprocal touching, movement in space (rough-and-tumble play), and motor patterns (chasing, searching for objects, etc).
- 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)
- Infant is not sensitive to bright lights and sounds

**Language Skills**
- Says two or more words, besides “dada” and “mama.”
- Imitates animal sounds
- Understanding simple words like “shoe” or “kiss”
- Using sounds or a few words for specific objects
- Jabbering

**Cognitive Skills**
- Can focus and pay attention while playing on own for five or more minutes
- Understands simple verbal commands (i.e., “Give it to me,” “Show me your eyes”)
- Recognizes objects by name and understands the meaning of several words
- Copying simple gestures like “bye-bye” hand wave and “no-no” head shake
- Finding a toy under caregiver’s hand
- Trying to imitate fine motor tasks like a scribble
- Exploring how toys work and figuring out simple relationships (pulling a string to make a sound)
- Using a variety of sounds interactively
By Fifteen Months:

**Socio-emotional**
- Kisses and hugs you
- Toddler has temper tantrums
- Asks for objects of desire by pointing (intentional, gestural communication)

**Motor Skills (from gross to fine motor)**
- Walks without help
- Stands up without support
- Drinks from a cup without help
- Begins using a spoon but needs help
- Points and gestures to objects of desire
- Scribbles spontaneously
- Places a round object in a round hole

**Sensory Skills**
- Shows intense interest in pictures

**Language Skills**
- Says four to six words, including names

**Cognitive Skills**
- Imitates activities, such as sweeping, dusting, and folding clothes

By Eighteen Months:  **Organization of pre-symbolic self and behavioral elaboration**

**Socio-emotional**
- Caregiver & toddler can engage in long chains of interactions around toddler’s interests (30 or more circles of communication)
- Caregiver and toddler can engage and explore a range of feelings; pleasure, excitement, curiosity, closeness, anger, defiance, and limit setting
- Toddler can begin to show a few different feelings during play, not just one (i.e., from anger, to joy, to curiosity)
Caregiver can express a range of feelings during play that has congruent affect expression in facial expressions, body postures, and vocal tones.

Toddler can engage in more problem-solving games such as in hide-and-seek.

Caregiver can challenge toddler to communicate through gestures, rather than quickly responding to vocalization of grunts, etc, when the parent “knows” what the sounds mean.

Caregiver can engage in symbolic play that allows for affect expression, not simply play with blocks, puzzles, or toys that teach a skill.

Caregiver is not preoccupied with teaching toddler about discipline and controlling his/her behavior.

Motor Skills (from gross to fine motor)

- Walks up stairs with one hand held
- Throws ball overhand without falling
- Plans motor patterns involving two or more steps, like throwing a ball up in the air and trying to catch it
- Jumps in place with both feet
- Pulls and pushes toys
- Eats with spoon well
- Turns pages in book, two or three at a time
- Builds a tower with two or three blocks
- Takes off shoes, socks, gloves, and unzips
- Puts items in a cup, or toys in box
- Tries to imitate scribbling, or scribbling 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
- Comprehends some simple 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 while playing with you (combs hair with a toy comb, vocalizes while holding a toy telephone)
- Searches for a desired toy or hidden object in more than one place
- Plays with you 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 in interaction with you
Twenty-Four Months: Creating Emotional Ideas

**Socio-emotional**
- The child 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 or a sequence of motor gestures or facial expressions or touching or select a series of pictures to communicate a need, wish, intention, or feeling (i.e., “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 (i.e., dolls feeding each other and child says, “Want Mommy”)
  - Pleasure and excitement (i.e., child makes funny faces like a clown and laughs)
  - Assertiveness and exploration (i.e., cars are racing, child looks at a real car in wonderment and asks, “Car?”)
  - Cautious or fearful behavior (i.e., says, “Scared”)
  - Anger (i.e., dolls are hitting or fighting, says, “Me mad”)
  - Limit setting (i.e., 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 books of page one at a time
- 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 do pretend play alone
- Can search for favorite toy where it was the day before
- Can do 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: Elaboration of Emotional Ideas

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**
- Refers to self by appropriate pronouns (I, me, mine)
- Uses plurals
- Understands sentences with two or more ideas (i.e., “you can have a cookie when we get home”)
- Understands directions with two or more ideas
- Organizes sentences with two or more ideas (i.e., “want apple and banana”)

**Cognitive Skills**
- Names one color
- Can point to some picture from a verbal description
- Can name objects in a picture
By Thirty-Six Months: Emotional Thinking

Socio-emotional
- Now ideas dealing with complex intentions, wishes, and feelings in pretend play or other types of symbolic communication are logically tied to one another
- Differentiation 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
See “30 months”
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
Sensory Profile Descriptors:

**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

**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

**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

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

**Vestibular- avoidant**: avoids swings, merry-go-round, unstable surfaces, heights

**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

**Taste- seeking**: places objects in mouth, licks objects, prefers salty, sour and/or spicy foods.

**Taste- avoidant**: limited range of food preferences, prefers bland foods

**Smell- seeking**: smells food before eating, smells various items in environment

**Smell- avoidant**: aware of faint smells, distressed by smells.
II. DIAGNOSTIC CLASSIFICATIONS

1. DSM-IV-TR

- Adjustment Disorders (209.xx)
- Anxiety Disorder NOS (300.00)
- Asperger's Disorder (299.80)
- Attention Deficit/Hyperactivity Disorder–Predominantly Inattentive Type (314.00)
- Attention Deficit/Hyperactivity Disorder–Predominantly Hyperactive Type (314.01)
- Attention Deficit/Hyperactivity Disorder–Combined Type (314.01)
- Autistic Disorder (299.00)
- Bipolar I Disorder (296.xx)
- Bipolar II Disorder (296.89)
- Bipolar Disorder NOS (296.80)
- Childhood Disintegrative Disorder (299.10)
- Chronic Motor or Vocal Tic Disorder (307.22)
- Communication Disorder NOS (307.9)
- Cyclothymic Disorder (301.13)
- Depressive Disorder NOS (311)
- Developmental Coordination Disorder (315.4)
- Disorder of Infancy, Childhood or Adolescence NOS (313.9)
- Disruptive Behavior Disorder NOS (312.9)
- Dyssomnia NOS (307.47)
- Dysthymic Disorder (300.4)
DIAGNOSTIC CLASSIFICATIONS (cont.)

- Encopresis (787.6 or 307.7)—only diagnosis if child is at least 4 years old
- Expressive Language Disorder (315.31)
- Feeding Disorder of Infancy or Early Childhood (307.59)
- Gender Identity Disorder (302.6)
- Generalized Anxiety Disorder (300.02)
- Impulse Control Disorder NOS (312.30)
- Intermittent Explosive Disorder (312.34)
- Major Depressive Disorder (296.xx)
- Mental Retardation (317-319)
- Mixed Receptive/Expressive Language Disorder (315.31)
- Mood Disorder NOS (296.90)
- Neglect of Child (V61.21)
- Nightmare Disorder (307.47)
- Oppositional Defiant Disorder (313.81)
- Parasomnia NOS (307.47)
- Parent-Child Relational Problem (V61.20)
- Pervasive Developmental Disorder NOS (299.80)
- Phonological Disorder (315.39)
- Physical Abuse of Child (V61.21)
- Pica (307.52)
- Posttraumatic Stress Disorder (309.81)
- Primary Dyssomnia (307.42)
- Primary Hypersomnia (307.44)
- Reactive Attachment Disorder of Infancy or Early Childhood (313.89)
DIAGNOSTIC CLASSIFICATIONS (cont.)

- Relational Problem NOS (V62.81)
- Rett's Disorder (299.80)
- Rumination Disorder (307.53)
- Selective Mutism (313.23)
- Separation Anxiety Disorder (309.21)
- Sexual Abuse of Child (V61.21)
- Sibling Relational Problem (V61.8)
- Sleep Terror Disorder (307.46)
- Sleepwalking Disorder (307.46)
- Social Phobia (300.29)
- Stereotypic Movement Disorder (307.3)
- Stuttering (307.0)
- Tic Disorder NOS (307.20)
- Tourette’s Disorder (307.23)
- Transient Tic Disorder (307.21)
- Trichotillomania (312.39)
# 2. Diagnostic Classification: 0 – 3 - R

## AXIS I

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DIAGNOSTIC CLASSIFICATION: 0 – 3

AXIS I (cont.)

700 Disorders of Relating and Communicating: Multi-system
   Developmental Disorder and Pervasive Developmental Disorder

  701 Pattern A
  702 Pattern B
  703 Pattern C
### AXIS II: PARENT – INFANT RELATIONSHIP GLOBAL ASSESSMENT SCALE (PIR-GAS)

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<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>90-99</td>
<td>WELL ADAPTED-</td>
<td>relationships are mutually enjoyable and growth promoting</td>
</tr>
<tr>
<td>80–89</td>
<td>ADAPTED-</td>
<td>relationships frequently reciprocal and synchronous; good enough for both partners</td>
</tr>
<tr>
<td>70–79</td>
<td>PERTURBED-</td>
<td>relationships less than optimal- disturbance is limited to one domain and lasts from a few days to a few weeks</td>
</tr>
<tr>
<td>60-69</td>
<td>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</td>
<td></td>
</tr>
<tr>
<td>50-59</td>
<td>DISTRESSED-</td>
<td>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</td>
</tr>
<tr>
<td>40-49</td>
<td>DISTURBED-</td>
<td>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.</td>
</tr>
<tr>
<td>30-39</td>
<td>DISORDERED-</td>
<td>relationships involve stable maladaptive interactions, may be grossly inappropriate developmentally without overt conflict.</td>
</tr>
<tr>
<td>20–29</td>
<td>SEVERELY DISORDERED-relationships severely compromised, significantly distressed, rigidly entrenched, almost always conflicted.</td>
<td></td>
</tr>
<tr>
<td>10–19</td>
<td>GROSSLY IMPAIRED-</td>
<td>relationships dangerously disorganized; infant is in imminent danger of physical harm</td>
</tr>
</tbody>
</table>
### AXIS II: RELATIONSHIP DISORDER CLASSIFICATION

<table>
<thead>
<tr>
<th>Code</th>
<th>_description</th>
</tr>
</thead>
<tbody>
<tr>
<td>901</td>
<td>Overinvolved</td>
</tr>
<tr>
<td>902</td>
<td>Underinvolved</td>
</tr>
<tr>
<td>903</td>
<td>Anxious/Tense</td>
</tr>
<tr>
<td>904</td>
<td>Angry/Hostile</td>
</tr>
<tr>
<td>905</td>
<td>Mixed (Specify)</td>
</tr>
<tr>
<td>906</td>
<td>Abuse</td>
</tr>
<tr>
<td></td>
<td>a. Verbally Abusive</td>
</tr>
<tr>
<td></td>
<td>b. Physically Abusive</td>
</tr>
<tr>
<td></td>
<td>c. Sexually Abusive</td>
</tr>
</tbody>
</table>
DIAGNOSTIC CLASSIFICATION: 0–3

AXIS III: OTHER PHYSICAL, NEUROLOGICAL OR DEVELOPMENTAL DIAGNOSES

COMPONENTS
MEDICAL/PHYSICAL
SPEECH
SENSORY
NEUROLOGICAL
MOTOR
EDUCATIONAL

FUNCTIONAL EMOTIONAL DEVELOPMENT LEVEL
(CHILD’S CAPACITY TO ORGANIZE EXPERIENCE)

SUMMARY RATING FOR EACH LEVEL IN INTERACTION WITH EACH PERSON

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 CONSTRUCTED 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
**DIAGNOSTIC CLASSIFICATION: 0~3**

**AXIS III: OTHER PHYSICAL, NEUROLOGICAL OR DEVELOPMENTAL DIAGNOSES**

**FUNCTIONAL EMOTIONAL DEVELOPMENT LEVEL**

(Child’s capacity to organize experience)

A. **MUTUAL ATTENTION**: ability of dyad to attend to one another (all ages)

B. **MUTUAL ENGAGEMENT**: ability for joint emotional involvement seen in looks, gestures, etc. (3 = 6 months)

C. **INTERACTIVE INTENTIONALITY & RECIPROCITY**: ability for cause & effect interaction where infant signals & responds purposefully to another person’s signals; involves sensorimotor patterns & a range of emotional inclinations (6-12 months)

D. **REPRESENTATIONAL/AFFECTIVE COMMUNICATION**: capacity to use mental representations, as evidenced in language & play to communicate emotional themes (18-24 months.)

E. **REPRESENTATIONAL ELABORATION**: ability to elaborate a number of ideas in pretend play & symbolic communication that goes beyond basic needs & deals with more complex intentions, wishes, or feelings; ideas need not be logically connected (over 30 months.)

F. **REPRESENTATIONAL DIFFERENTIATION I**: ability to deal with complex intentions, wishes & feelings in pretend play & symbolic communication where ideas are logically related; knows what is real & unreal & switches between fantasy & reality (over 36 months.)

G. **REPRESENTATIONAL DIFFERENTIATION II**: ability to elaborate complex pretend play & symbolic communication characterized by three or more ideas logically connected & informed by concepts of causality, time & space (over 42 months.)
DIAGNOSTIC CLASSIFICATION: 0–3

AXIS III: OTHER PHYSICAL, NEUROLOGICAL OR DEVELOPMENTAL DIAGNOSES

FUNCTIONAL DEVELOPMENTAL LEVEL SUMMARY OF CHILD:

1. HAS FULLY REACHED EXPECTED LEVELS

2. AT EXPECTED LEVEL BUT VULNERABLE TO STRESS AND/OR WITH CONSTRICIONS:
   A. DOES NOT FUNCTION AT THIS LEVEL IN THE FULL RANGE OF AFFECT (e.g., closeness, assertion, anger, fear and anxiety)
   B. DOES NOT FUNCTION AT THIS LEVEL UNDER STRESS
   C. functions at this level only with exceptional support

3. HAS NOT ACHIEVED CURRENT EXPECTED LEVEL BUT HAS ACHIEVED ALL PRIOR LEVELS

4. HAS NOT ACHIEVED CURRENT EXPECTED LEVEL BUT HAS ACHIEVED SOME PRIOR LEVELS PARTIALLY

5. HAS NOT MASTERED ANY PRIOR LEVELS.
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. Clinical Psychologist
6. Developmental Specialist
7. Education
8. Family Practice
9. Marriage Family Therapy
10. Neurology
11. Nursing
12. Occupational Therapy
13. Pediatrics
14. PT
15. Social Work
16. Special Education
17. Speech/Language
IV. RISK/MEDIATING FACTORS

RISK ASSESSMENT

A key concept in epidemiology is efficient prevention and tracking of disorders. Risk factors are categorized into two diverse groups, based on the timing of their occurrences in relation to the onset of the symptoms. The first risk factor group is considered “unmodifiable” and cannot be changed or avoided. This includes factors such as age, social class, gender, ethnicity and family history of mental illness. The second risk factor group is considered “modifiable”, with events that occur early in life and increase the risk and vulnerability level. These events include early home environment, poverty, childhood trauma, injuries, abuse/neglect, and parents’ education and awareness about child rearing, which can be changed and/or avoided.

There are two important elements to consider when the risk factor has been determined to be “unmodifiable”, early intervention and societal/cultural influence. Early intervention is critical to offset risk factors. Awareness of and sensitivity to societal/cultural influences is crucial to reduce the effect of the risk factors and to empower the individual at risk.

There is a wealth of literature available to support the argument that each and every one of the factors listed here is indeed significant to a child’s total development, including physical, cognitive, social/emotional and linguistic.

The health of a society depends, in large part, on the health of its children. Child advocacy is a crucial first step toward developing healthier children. 

Child advocacy, as described by Westman (1979), is “asking questions that are important to children”. It requires harmonious cooperation of multi-agencies to change, modify, and prevent negative factors effecting developmental process. It requires knowledge of the child, the available resources, intervention possibilities and alternatives, and bridging the gaps among multiple professionals, agencies and systems in order to implement an effective prevention program.

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

- Baby Cried Quickly
- 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
- Premature baby
Self regulation level;
   ○ Well regulated,
     ○ High or low arousal level

Sex of the child

Social skills development

Temperament;
   ○ Responsivity,
   ○ Sociability,
   ○ Irritability

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
MATERNAL FACTORS DURING PREGNANCY (cont.)

- Exposure to second-hand smoking
- German Measles
- Infection, (e.g., rubella, VD, HIV, Flue Virus)
- Ingestion of medication
- Injuries
- Known threat of miscarriage
- Over-the-counter Medication
- Previous miscarriage
- Special diet/eating habit
- STDs
- Unusual bleeding
- Use of caffeine
- Use of Prescribed Medication
- Vaccinations
- Vomiting frequently

- Pregnancy due to a violent act
- Post-Partum Depression
- Stress and Anxiety
- Teen-age pregnancy
FAMILIAL FACTORS

- Active Social Support
- Affective engagement and responsiveness
- Cultural/linguistic concerns within the dominant society; minority status
- Custody issue
- Dyad relationship difficulties
- Familial conflicts/ Distress level
- Familial psychopathology
- Family cohesion
- Family stress
- Family violence
- Financial concerns and distress; poverty
- Legal problems
- Limit setting and control
- Maternal education level
- Number of children at home
- Parent/child relationships
- Parental history of drug use/abuse
  - Alcohol use (resulting 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: Father
- Single parenting
- Socialization elements
- Socio-Economic Status
- Stimulating factors
ENVIRONMENTAL FACTORS

- Community violence
- Community poverty
- Neighborhood violence
- Social support received following a traumatic event
- Community resources
- Unemployment
- Being on welfare
- Environmental distress
V. THE CROSS CULTURAL COMPETENCY

“Cultural competence is a set of congruent behaviors, attitudes, and policies that come together in a system or agency or among professionals that enable effective interactions in a cross-cultural framework.” T. Cross, et.al., 1989.

Cultural Competency is the acknowledgement of a complex and systemic nature. It is the ability of individuals and systems to respond respectfully and effectively to people of all social, class, racial, ethnic and religious backgrounds in a manner that recognizes, affirms, and values differences as well as similarities, and the worth of individuals, families, and communities, and protects and preserves the dignity of each.

Cultural competency is a developmental process. It includes acknowledgement and respect for differences among those for whom we care, in terms of their values, expectations, and experiences.

As the diversity of the populations we serve continues to grow, the importance of cultural competency or “cultural and linguistic appropriateness” in the effective delivery of mental health services is well recognized.

Infant-Early Childhood and Family Mental Health professionals place culture within the context of an interwoven network of relationships. They address broad cultural issues that impact the mental health of young children and their families. Through efforts such as – but not limited to - cultural competency trainings, socially conscious interpretations, inter-agency/inter-disciplinary collaborations, and community coalitions addressing language, tradition, history, and economics, the LACDMH IECFMH Pioneer Providers serve as a bridge between communities and those they serve to ensure full access to quality mental health care that is culturally and linguistically appropriate.
This document is revised in 2006, to include the changes made in DC: 0-3-R.

Please contact Zohreh Zarnegar, Ph.D., for any questions, comments, and suggestions for improvement of this draft at ZZARNEGAR@BABYGAZETTE.ORG

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