The LSP is a summary that a home visitor uses to sort and organize information gathered from visits, screening tools, and observation of the family. The first four pages summarize a parent’s skills in relationships, education and employment, health and medical care, mental health and substance use, and basic essentials. The fifth page focuses on the developmental and psychosocial characteristics of an infant or toddler. The LSP is not a developmental screening tool but instead gives a succinct summary of developmental screening results and, when delays are present, captures whether early intervention services are needed. It does not describe whether nutrition, education/early intervention services, or medical care is effective, because those outcomes are the primary responsibility of those disciplines. The focus of most home visitation services and of the LSP is on the growth of parental life skills needed for a good, healthy, and successful life; on parenting abilities; and on the child’s cognitive, motor, psychosocial, and regulatory development.

USING THE LSP

Home visitation services play a unique and collaborative role in parent education, family needs identification, referral to community resources, and developmental screening. Because the relationship between the family and home visitor is intimate, based on trust, and dedicated to building strengths, the LSP was not designed to be used in an interview form with a list of questions for a parent to answer. If used that way it could interfere with establishing a trust relationship. It is intended to help a visitor reflect on complex family issues in a way that facilitates a clear understanding of family needs, strengths, and issues and results in more effective visitation services. The caseload data generated are useful for a variety of purposes: supervision, training, program planning, and demon-

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strating outcomes for funding purposes. **Agencies using the LSP are responsible for its safe and confidential use and are responsible for the training and supervision of staff regarding high-risk and reportable situations such as child abuse, domestic abuse, suicide/depression, homicidal threats, and mental illness/depression.**

**Format**

The LSP is generally printed as a five-page form, which takes a trained and experienced home visitor about 5 minutes to complete. Scoring consists of circling pertinent information listed in each of the scale columns and entering the resulting scores in the score column for later data entry. Some programs provide comprehensive support services and find that they will use all data from all of the scales in the LSP. Other programs have a more specific focus and only some LSP scales will be used to demonstrate targeted outcomes. **Each scale is scored separately,** and there is no total LSP score similar to an IQ. Programs can use all or just some scales.

The LSP is generally completed in the office or car after a visit and it is filed in the family or medical record. Use one LSP for each individual parent (pp. 1–4) and child (p. 5) served (e.g., if a single parent has two children, one parent form would be used and two infant scales would be completed). If both parents and more than one child are being served, keep copies of extra parent and child scales available. Because a completed LSP contains highly confidential information, it needs to be protected by all staff, specifically by the visitor, data clerk, and supervisor. The LSP, as with other program data, should be included on a signed informed parental consent form.

**Frequency of Use**

Most programs want to capture baseline data that shows the family characteristics at intake—before services have made a difference—and the progress over time. The first few home visits generally are needed to establish a trusting relationship, describe services, complete intake forms, and gather basic information about the parent(s) and child or children. An experienced visitor usually can gather enough information to complete the first LSP scales within the first two visits.

Waiting longer than the first two visits to do the initial LSP, programs run the risk of diluting later outcomes. Ongoing LSPs are usually completed every 6 months and at closure. If a parent’s initial LSP is begun in pregnancy, it is recommended that the next ongoing LSP be delayed until the infant’s can be done using a developmental screening tool such as the ASQ at age 4 or 6 months. This prevents doing two separate LSPs at different dates on the parent and child. Use of the LSP in 6-month increments allows programs to note not only how scoring changes over time but also when changes happen relative to the length of time in the program.
HEADING INFORMATION

The basic data in the heading at the top of the first page is needed to sort data into meaningful reports. LSP data usually are not the only data collected by programs. All of the data listed below are essential in order to produce accurate sequential data reports. Some programs have the mistaken idea that because the same data are collected in other places or systems, it is redundant to do so for the LSP. However, in the absence of certain LSP data, changes cannot be linked to any other categories, such as differences between changes seen in different ethnic groups. In one situation, because dose indicators were deleted, no comparison could be calculated between amount of service and change seen. Because it generally takes less than 5 minutes to complete or enter the entire form and because the LSP is only completed 2–3 times per year, the cost to enter all of the data is not prohibitive. It is important for program managers to understand conceptually the differences between simple numerical counts of some characteristics (e.g., age distribution) and multiple variable analyses, correlations, or relationship-table analyses.

Parent/Guardian Heading Data

Parent (top, Page 1) includes:

- Family record identification number
- Individual number (usually two digits)
- Web database identification number (if applicable)
- Client’s name (last name and first name)
- Client date of birth (DOB; 6 digits)
- Sex
- Race and ethnicity (optional)
- Medical codes (optional)
- Type and dates of LSP: initial, ongoing (with number, e.g., 1, 2, 3), and closing
- Next LSP due: date
- Months of service
- Number of attempted visits
- Number of completed visits
- Home visitor (initials or number)
- Agency/program or site designator
**Child Heading Data**

Child (top, Page 5) includes:

- Family record/index number
- Individual number (usually two digits)
- Web ID number
- Child’s name (last name and first name)
- Date of birth (DOB; 6 digits)
- Age (years/months)
- Type and dates of LSP: initial, ongoing (with number, e.g., 1, 2, 3), and closing
- Parent’s months of service

This heading information allows an agency to sort data by age, sex, race/ethnicity, medical code, visitor, and program and to generate caseload reports by programs and by individual visitors depending on the software used for data management (see Chapter 7, Section 2).

Because the LSP is designed to be scored sequentially every 6 months, heading data include the type of the LSP being scored (e.g., Initial, Ongoing by number, and Closing). The information summarized on any LSP applies only to the 6-month period immediately preceding the LSP date. It does not capture historically significant information such as a parent’s own history of physical or sexual abuse as a child. This serves to keep the LSP data focused on current behavior, attitudes, and skills. As a result, the LSP is able to capture progress and change. For example, if child abuse occurs and the child is placed and then returned to the parent who is now off drugs and learning to parent well, all of these changes can be captured by sequential scoring of the LSP.

A third type of heading information collected is the “dose” or amount of services received by the family. This refers to the months of service (MOS) and the number of attempted and completed visits. Without the dose of service contact being tracked, the sequential scale scores are nearly worthless and outcomes may be incorrectly assigned to program effects. Some programs are required to carry unavailable clients due to welfare reform requirements; thus it would be important to note how much or little progress is made for a client who has been open to service for 12 months but who had only two completed visits. Most programs only count face-to-face visits as completed visits, regardless of the place. Phone calls do not “count” for a visit on the LSP. In some cases in which families have been lost to follow-up and updated information is unavailable, the data will need to be closed and only data from the last LSP will be resubmitted under the closing date as the final score.

One of the most difficult factors to manage in home visitation programs is the issue of a parent who is unavailable for anticipated visits. Some “not-home” or “failed” visit rates reportedly run as high as 50%, which is costly for staff utilization and program costs and impact and is quite problematic if funding is based on completed visits (Gomby, 2003). Some critics of home visitation suggest that missed visits reflect the client’s lack
of value for the service, and for some families this may be true; however, this is a simplis- 
tic view because there are multiple causes for not-home visits. The reasons for failed 
visits vary depending on the stage of parental involvement with the visitor, the parent’s 
organizational skills, the amount and type of family crisis and family support, the impact 
of education and information provided to the parent, and the parent’s life skills or cir-
cumstances (e.g., use of a calendar or availability of a phone or transportation). Later, 
even parental success such as working and going to school can affect a parent’s availabil-
ity for visits. In addition to dose-related data, parental involvement is measured by Scale 
9, Relationship with Home Visitor.

In most LSP databases, the heading data and scale scores for parents and infants are 
entered separately, linked only by the Family Record Number. The heading data at the 
top of the child’s form (Page 5) are intentionally minimal. The parent’s months of service 
are repeated on the child’s form, including children for whom service began during the 
mother’s pregnancy. The number of visits for the infant would be redundant informa-
tion. The child’s LSP status (Initial, Ongoing, or Closing) is tracked independent of the 
parent’s status.

**GENERAL SCORING INSTRUCTIONS**

1. Each scale stands alone and is scored individually across a range of 0–5 points, using 
   0.5-point increments, as indicated by the number values across the top of the 
columns.

2. Behaviors or skills described in the columns that apply to an individual are circled, 
   and the numbers are entered in the Score column. Either whole numbers (0–5) or 
   decimals (e.g., 1.5, 2.5) are entered as scores. If some of a parent’s or child’s character-
   istics are circled in more than one column, a split score is the result—meaning that 
two or more columns have circled information in them. These split scores are aver-
ged, using the column numbers and decimal points (e.g., 1.5, 2.5) that appear over 
the lines. This number will be the score that will be entered in the Score column 
(e.g., items circled in both Columns 1 and 2 would be scored as 1.5 in the Score 
column).

   Circled characteristics show strengths and needs at a glance and are useful for 
reflective supervision. Numerical scores are useful for data purposes.

3. Scores range on a continuum from Inadequate (1) to Competent (5), reflecting the 
   characteristics, development, and/or learning curve of the parent or child. Assign a 
score of 1 for violent behaviors and reportable conditions such as child abuse or 
   domestic violence that occurred in the last 6 months.

4. Zero (0 = NA) is used for scales with No Answer, that were Not Asked or Not applic-
able. A zero score is preferred if a visitor is uncertain of an answer; the score can be 
   changed on subsequent LSPs as information is available. However, frequent use of 
zeros may indicate that a visitor has training or supervision needs.
5. The LSP is specific to an individual parent or child (use one form per parent and child). There is no “family” score and there is no cumulative score for all of the scales, because each of the scales contains very different characteristics and the scores are used for both clinical purposes and data analysis. For example, on Page 1, a mother who is a victim of domestic violence would score 1 on Scale 2, but if that is averaged with the other scales and all the other relationship scales have scores of 4 or 5, the score that indicates violence would be lost. Some evaluators will use an average of the mean scores of the larger measurement groupings (e.g., Relationships or Education) for statistical analysis rather than for clinical purposes.

6. Although the LSP was designed primarily for work with mothers, all of the LSP scales can be scored for fathers, with the exception of Scale 17, Prenatal Care.

7. Some LSP scales (e.g., Scale 1, Family/Extended Family; Scale 2, Boyfriend, Father of the Baby, or Spouse; and Scales 5–7, Nurturing, Discipline, and Support of Development) are more likely than others to have split scores. This allows the scores to reflect more than one relationship, such as parenting differences by a mother with both an infant and a 3-year-old. Any scale can have split scores.

8. Scores should apply only to skills, behaviors, or attitudes occurring currently or over the last 6 months. This interval captures changes and keeps the profile of parent skills and child development current.

9. Some scales are not always scored.

The following scales are not scored if the parent is pregnant and not parenting a child age birth to 3 years:

- Parent Scales 5–8
- Child Health Scales 20–23
- Scale 35, Child Care
- Infant/Toddler Scales 36–43

Scale 4, Attitudes to Pregnancy, is scored only during pregnancy and up to 1 month after delivery.

Scale 12, Language, is scored only for parents for whom English is a second language.

Scale 15, Employment, is not scored for teens unless they are employed.

Scale 16, Immigration, is scored only for parents who are not U.S. citizens by birth.

Scale 17, Prenatal Care, is not scored for fathers or for mothers if it has not been an issue within the past 6 months.

Scale 22, Child Dental Care, is scored only after an infant has teeth.
BASIC DATA INSTRUCTIONS

Family Record and Individual Identification Number

The Family Record Identification Number is the agency case number. Numbers for the family and individual are treated as two separate entries. This unique individual identifier allows for anonymous data reports, which can be separated by individual parent and child scores. Some programs find it useful to always designate a father as 01, a mother as 02, the oldest child 03, the next child 04, so that data can be identified clearly. A parent and a child or another child should never have the same individual number. Some programs are part of larger chart numbering systems and must use the designated coding system. Software should be able to handle either numeric or alphanumeric record identifiers, but it is essential that the individual code be used as a separate entry even if it is part of a larger case number. For example, “GON1247902” would become Family Record ID Number “GON12479” and Individual Number “02,” if “02” was the individual client identifier.

Client Name

Consistent use of last name followed by first name is recommended for accurate, alphabetically listed data reports. If family score groupings are needed, family and individual numbers provide a way to sort these, because last names of family members seldom match. Middle names are not used because record and individual numbers are reliable unique identifiers. Programs will need to provide instructions to staff on handling culturally linked names, for example, Maria Guadalupe Gonzales, is Ma. Guadalupe Gonzales, a.k.a. “Lupe,” so the instructions for LSP entry might be to use Guadalupe Gonzales as the first and last name. Inconsistent name entry makes for erroneously inflated case-loads and data reports.

Databases can and should be programmed to avoid duplicate entry based on case numbers and LSP dates. Even with safeguards, programmers, staff, and data clerks need to enter names consistently to ensure clean data and avoid errors.

Race and Ethnicity

This information is optional, because many programs either capture this demographic data in another database or no longer collect this information because of the growing number of multietnic individuals. However, if programs want to link outcome data with race and ethnicity, such as programs monitoring disparity trends in access to care, these categories would need to be completed. Using the race or ethnicity list of choice, programs would assign a one- or two-digit code for each of the categories they want to track; staff would enter the applicable number on the line for Race or Ethnicity.
Medical Codes

Use of medical codes is also optional. Programs needing to track specific medical conditions for either parent or child can use either ICD-9 (National Center for Health Statistics, 2005), DSM-IV (APA, 1994), or DC:0-3 (Greenspan et al., 1994) codes or their own numeric code for the condition list of choice.

Type of LSP

Check one box to indicate which LSP is being done: Initial, Ongoing with number (e.g., Ongoing 1, 2), or Closing (whenever it occurs). This item is crucial and is required to measure sequential change for individuals or caseloads.

Date

The date entered is the date the LSP was done, not the scoring date. This will allow programs to have reports of LSPs done between specific dates, such as a funding or fiscal year, and for the useful “reminder lists” that indicate which clients have an ongoing LSP due next month. The date can also be used in a database to prevent duplicate LSP entries.

Months of Service

Enter the total number of completed months a parent has been open to service. This is important because outcomes have a relationship with length and frequency of service. The Initial LSP could show “0,” “1,” or “2” months of service depending on when the LSP was done.

Number of Attempted and Completed Visits

Enter the cumulative number of attempted and completed visits. Attempted visits are those that were scheduled and the visit made but the parent was not home at the appointed time. Visits that have been canceled and rescheduled do not count as attempted visits. Completed visits are face-to-face encounters, not necessarily done in the home, but phone visits are not counted as a completed visit.

Visitor Identification (ID)

Enter the home visitor’s initials and/or number. Smaller agencies will find that it is easier to read and sort data if initials are used to identify staff. Larger agencies may need to use employee numbers. Visitor ID data allow for caseload reports to be generated by individual staff and for the next-LSP-due lists to be sorted by visitor.
Agency/Program

Enter the agency and/or program name (usually initials). In agencies with multiple programs, ensuring that a list of program initials are available for staff and clerks is useful so that entries will be consistent. Data can be “lost” in the computer when a new clerk has entered the program initials incorrectly and the report query uses the standard designation. In some communities where the LSP is used by all visitation programs and data go to a shared database, consistent program designators can allow for data comparison across multiple agencies. This can be done with or without a shared database. Shared databases require legal agreements and confidentiality precautions. For small, single-program agencies, only one program name is necessary.

Next LSP Due

Next LSP Due is a month/year date when the next 6-month LSP update is due. The date can be used to generate monthly reminder lists for visitors and supervisors. LSPs frequently cannot be done exactly when planned, due to family availability or crisis, but outstanding LSP lists are useful to staff and supervisors.

Data entry staff should be trained to return any incomplete LSP to staff for completion and to notify supervisors if they see unusual scoring errors or patterns being generated by an individual or group. For accurate data, clerks should never guess at the missing answer. Route slips with prewritten lists to check off items that are missing or incorrect and/or the use of a highlighter on the LSP are two strategies data clerks use to communicate what edits are needed. Some programs have a supervisor review every LSP submitted for data entry to avoid incorrect data entry. The latter is recommended.

SCALE SCORING INSTRUCTIONS

The information summarized applies ONLY to events, skills, and relationships that have occurred within the last 6 months.

PARENT SCALES

Relationships with Family, Spouse, and Friends (Scales 1–3)

This section describes the parent’s primary support system, the parent’s relationship/parenting skills with his or her child or children, and the parent’s relationship with and ability to use the home visitor, information, and resources.

1. Family and/or Extended Family

The quality of support available to parents varies greatly and has serious implications for parental success and identity. Because the functional definition of family often includes extended family or in-laws, this item can be used to summarize relationships with either or both family types by circling which relationship is being described. Scale 1 describes
the quality of family relationships and Scale 30 describes housing circumstances. The parent may or may not live with the family.

**Column 1** reflects *physically violent and abusive* family relationships with overt hostility.

**Column 2** indicates that there is a *loss of contact or physical separation* from the family, so that useful support is not available when needed. This includes both emotional estrangement and loss of contact due to immigration.

**Column 3** describes relationships in which there is *verbal conflict or frequent arguments* but some tangible support is available for the parent and baby.

**Column 4** captures families whose relationships offer *conditional or inconsistent support*. This includes situations in which the parent has physical support but not does not feel close to or cared for by the family.

**Column 5** reflects a *loving, supportive* family.

### 2. Boyfriend (BF), Father of the Baby (FOB), or Spouse

Circle boyfriend, FOB, or Spouse, and circle more than one, if applicable. Boyfriend implies an intimate sexual relationship with someone who is *not* the FOB. FOB is specific for a child or the pregnancy. Spouse applies to legal marriage or long-term common-law marriage relationships. Some young mothers may have relationships in all three categories within a 6-month period. This scale can be used for fathers by interpreting BF to be Girlfriend (GF), and FOB to be Mother of the Baby (MOB).

If more than one relationship is applicable, it may result in split scores, meaning that items in more than one column are circled and averaged. Domestic violence is captured by a score of “1,” by circling items in the first column. Reporting and referral for domestic violence should follow state law and agency protocol; the visitor should assess carefully the severity of continuing risk, parental depression and suicide risk, and the impact of observed violence on the child.

The logic for the ordering of scoring Column 2, Separated or no contact, as a lower score than Column 3, Conflicted relationship with limited support, is that the potential exists for working with a couple to support improvement in a relationship (e.g., teaching communication skills and anger management, effects on children), whereas there is no potential for improvement in ended relationships.

**Column 1** captures *physically violent relationships* with domestic partners and is used for women with *multiple sexual partners*. One example is when the mother is uncertain of the child’s paternity versus when the father is known. Women with multiple sex partners or violent relationships may have a history of physical or sexual abuse and may show symptoms of drug use, depression, and low self-esteem.

**Column 2** indicates that the relationship with the significant man has *ended and contact is lost*. This includes those couples separated due to immigration issues. The partner is not present to support pregnancy or parenting or to create a family life.

**Column 3** indicates that the couple has *frequent verbal fights*, but the relationship continues and there is some support for the mother and baby.
Column 4 indicates that the relationship is stable with one partner but lacks the quality of a truly loving and supportive commitment. FOB may have other sexual relationships. They may or may not live together. Inconsistent support or conditional support is scored here.

Column 5 indicates a loving, committed, and mutually supportive couple and includes traditional “spouse” or common-law marriage relationships in which caring and support are present.

3. Friends and Peers
This scale describes the parent’s peer support network. In talking about their friends, most parents seem to give answers that fall in only one column. However, for clients in transition, such as when a parent leaves a gang or drug-using friends, or returns to school, split scores may occur. Social isolation due to immigration, rural circumstances, or chaotic lifestyles is common for low-income parents. As parents develop their goals, support networks, and parenting skills, isolation scores may also show positive change. Scores on this scale often improve after parents return to school or work or participate in parenting classes.

Column 1 includes gang-linked relationships in which drugs, sexual initiations, or violence is a characteristic; the violence influences the quality of the group identity and support. Score this column if the FOB is a gang member and is still involved with the mother.

Column 2 indicates social isolation, regardless of the cause.

Column 3 indicates that friendships are brief and casual and lack depth or permanence or involve frequent verbal fights, leaving the parent feeling lonely, unsure of support, or that she is without close friends.

Column 4 indicates that the parent can name a few close friends who are available to talk with and offer support.

Column 5 indicates that the parent has an identified group of close or long-term friends with whom to share life and have as a support network. The parent feels supported by friends.

Relationships with Children (Scales 4–8)

Scales 4–8 apply to how the parent relates to all of his or her children, not just the most recent infant. Split scores can be common because of different parenting skills for different ages and needs of the children. If a parent is in the first pregnancy, Scales 5–8 are scored “NA” or “0.” If a child is in foster placement because of abuse or neglect, score the scales on the parent’s characteristics over the past 6 months, and if the child is adopted, the case and chart would generally be closed and the final LSP scored.
4. Attitudes to Pregnancy

This scale can be scored for either mother or father. Check “NA” and score “0” if the parent or couple is not currently pregnant. This scale is only scored during pregnancy and up to 1 month after delivery, after which “NA” is used until there is another pregnancy. Low scores for this scale may indicate that the mother may need extra support to establish reciprocal attachment and nurturing after the baby is born. Low scores are common for some substance-abusing mothers, some very young teens, denied pregnancy situations, and some rape-linked pregnancies, and for some parents with developmental delays or mental illness. Scale 19 is a separate scale for Family Planning.

Column 1 indicates a truly unwanted pregnancy. A therapeutic abortion or adoption may be wanted or planned. The parent’s attitude is primarily hostile or indifferent to the baby compared with Column 2 (e.g., unwanted versus unplanned).

Column 2 indicates an unplanned pregnancy, characterized by fearfulness or ambivalence. Alternatively, the pregnancy may be kept in response to expectations from self, family, the FOB, or peers.

Column 3 indicates that although the pregnancy was unplanned, it is accepted.

Column 4 indicates that the pregnancy was planned and accepted but the parent is unprepared.

Column 5 indicates that the pregnancy was planned and wanted, and the parent was/is prepared for the baby.

5. Nurturing

For parents with both an infant and other children, differences in nurturing abilities may result in split scores. For example, a woman in recovery who has several children currently in placement for abuse or neglect may show very different behavior with a new baby due to changes in her drug use. The split score average would reflect that her nurturing ability is changing or that there are differences in how she cares for different children. Screening tools such as the NCAST–Feeding Scale or the Family Infant Relationship Support Training (FIRST) can be used to pinpoint parent responsiveness to cues and nurturing skills with infants younger than 1 year old.

Column 1 is used to describe the rare parent who appears unable to nurture or love; these parents often fail to notice or respond to infant cues and avoid holding and caressing. Empathy is lacking. The parent may meet DSM-IV-TR diagnostic criteria for personality disorders or other mental illness.

Column 2 indicates that nurturing is affected by the mother’s own flatness, apathy, and seeming indifference. These behaviors are often seen with depression or significant developmental delays. Further screening for depression or developmental delay may be needed.

Column 3 describes a parent who confuses nurturing and responsiveness with “spoiling” or who lacks information about appropriate and necessary nurturing but responds to the information with positive changes. Responses are sometimes appropriate to intense...
infant cues and the state transitions described in the Keys to Caregiving and NCAST materials.

**Column 4** indicates that the parent–infant relationship shows some visible evidence of reciprocal attachment/bonding, but the parent’s responses to the child are inconsistent and may be influenced by immaturity, stress, and coping ability.

**Column 5** indicates that the parent shows loving, nurturing responses to even subtle cues; she or he touches, responds, holds, comforts, and delights in the child. Reciprocal connectedness is present.

### 6. Discipline

“NA” may be used and may be appropriate for young infants who are not mobile, unless inappropriate discipline is observed or reported; however, it is important to remember that most child abuse occurs to children younger than age 1 year. Split scores are needed if a spectrum of discipline is noted or if discipline varies inappropriately across children of different ages. **Physical punishment means the use of hitting, spanking, slapping, pinching, or shaking.** Physical abuse should meet the current legal definitions and may be indicated by bruises or more severe physical damage. Discipline tends to have roots in family experiences, environmental norms, and cultural practices. These practices may not match what is currently known to have positive effects on the infants involved and may be damaging to the child. Appropriate intervention includes culturally sensitive parental education. Scoring should reflect the scale criteria listed in the instructions and should not be influenced by the presence of cultural components.

If the visitor files a child abuse report on either parent, or if there has been a known report filed by anyone in the last 6 months, circle the items that apply and enter a score of “1,” regardless of whether other parenting abilities are present. If children are or have been in foster placement within the last 6 months, score a “1.” If the children are permanently placed without reunification options, or have been adopted, scores should only reflect the status in the past 6 months. Some programs may shift services to the adoptive parent and score that parent’s ability on the LSP.

**Column 1** identifies a parent who has a history of reported or suspected child abuse/neglect in the past 6 months.

**Column 2** describes parenting characterized by frequent criticism or verbal abuse of child(ren) or who use physical punishment described above for children (birth to 3 years old) who are scored on the LSP.

**Column 3** characterizes parents with a mixed range of abilities, who sometimes show angry/critical discipline and who also use some age-appropriate teaching discipline.

**Column 4** indicates that parenting is more benign, lacking in boundaries, and ineffective than angry or critical. Limits are sometimes inconsistent or fail to teach appropriate behavior. The discipline style may be linked to parental issues such as depression or low self-esteem.

**Column 5** describes a parent who consciously seeks to use age-appropriate discipline and sees
it as a means of teaching appropriate behavior. The parent uses distraction, redirection, houseproofing, or, later with toddlers, short time-outs to teach; the parent explains expected behavior and praises appropriate behavior.

7. Support of Child Development

This scale involves parental values and behaviors that support a child’s physical and cognitive development. Split scores may be necessary for parents with children of different ages and developmental needs. The scale also reflects the parent’s receptiveness to learning and incorporating new information about development, which may be influenced by the culture and values of the extended family. Parental activities that support development are scored here as a separate issue from the child’s actual development (see Scales 36–39), because developmental delays can occur from organic causes such as genetic conditions or parental neglect. However, a combination of low child developmental scores and low parental developmental scores is strongly suggestive of environmental causes in the absence of other conditions. Developmental observations summarized on the LSP about parents and children should be based on standardized screening or assessment tools, such as the ASQ, Denver II, BSID-II, or NCAST–Teaching.

Column 1 indicates that the parent has markedly inappropriate or unrealistic expectations of the child and/or fails to provide for or has a limited knowledge of developmental needs. The parent lacks information and resists or rejects information on development. Attitudes may indicate the presence of an underlying mental illness or substance use or abuse.

Column 2 indicates that the parent shows limited knowledge of the child’s need for developmental support and fails to provide a developmentally supportive environment. Parenting has passive, unresponsive, and language-poor characteristics. This is sometimes seen in very poor, overcrowded families with limited education.

Column 3 indicates that the parent lacks developmental information but responds to information by using some of the new ideas. The parent provides a few age-appropriate toys and is open to new resources and information.

Column 4 indicates that the parent actively seeks information on development and applies the information provided. The parent notices and comments on the child’s development and new abilities and interests.

Column 5 indicates that the parent is informed about the current and coming developmental stages, incorporates information, and anticipates developmental needs. The parent uses resources like libraries, toy exchanges, parent education, or parent support groups. The parent enjoys and takes time to play with and read to the infant or toddler.

8. Safety

Protecting an infant or child from environmental harm requires both knowledge and action on the part of a parent. Accidents account for a large part of health care costs and may result in permanent damage to a child. If an infant or child has sustained permanent damage or required hospitalization due to an unintentional injury or ingestion in the past 6 months, circle items in Column 1, and regardless of other items circled in other
columns, score the item as “1.” A sudden infant death syndrome (SIDS) death, or near-
SIDS after which recommended precautions such as “Back to Sleep” have not been used,
would also be scored a “1.” Parental safety skills are age specific and the safety needs
change as a child grows; as a result, split scores may be needed. Home safety precautions
may be complicated by living in shared, crowded housing or by cultural issues (e.g., lead
exposure from folk medicines).

**Column 1** is used for children who have been *hospitalized for treatment* of an uninten-
tional injury and/or who have sustained *permanent damage* in the past 6 months.

**Column 2** indicates that the child had *outpatient or emergency treatment* of an uninten-
tional injury in the past 6 months but sustained *no permanent damage*.

**Column 3** is used for children who have had *no recent history* of unintentional injury but
whose *home and/or car is not safe* or childproofed.

**Column 4** indicates that there is *no recent history* of unintentional injury but home is
*only partially safe* or childproofed. Family has and uses a car seat and accepts safety
information.

**Column 5** indicates that *home and car are safe* and the child is protected. The parent
teaches safety and adapts the *environment for safety as child’s age changes*. The parent talks
with the child about safety.

### Relationships with Supportive Resources (Scales 9–11)

#### 9. Relationship with Home Visitor

Often, progress is seen in the relationship with the home visitor as trust develops. Split
scores can be used if needed. In a 6-month period, leaps forward (or backward) in trust
may be noted. Setbacks can happen if a child abuse report is filed. Scale 9 is one indica-
tor of a parent’s ability to accept and effectively use outside resources, which is a basic
life skill. Visitors have an opportunity to support parents in actively learning resource use
in a way that is consistent with parental goals for themselves and their children, such as
using classes, libraries, and health or vocational resources. The relationship with a home
visitor may be the first trusting experience with resources or “strangers” from outside the
family.

**Column 1** indicates that a parent is *hostile, defensive, and avoids or refuses services*.

**Column 2** indicates that a parent is very *guarded and not trusting*; he or she frequently
*breaks appointments*.

**Column 3** indicates that a parent *passively accepts information and visits* but shows little
active participation. He or she keeps most appointments for visits but does not call or
ask for assistance.

**Column 4** describes a parent who *seeks and uses information* and the home visitor to meet
needs. The parent *calls with questions and to ask for help* and calls to cancel and resched-
ule appointments.
Column 5 indicates that a parent is open to visits, is welcoming and trusting, and uses and enjoys the visits.

10. Use of Information
The ability to identify and use needed information from reliable resources is an important life skill that is learned from life and educational experiences. Some families are distrustful of health resources. Some have limited education or literacy, and making use of written information is difficult. Some rely heavily on family and friends for information that may sometimes be incorrect and may disregard information provided by health or educational resources, particularly when it is not culturally compatible. The ability to seek out and use new information may be one of the most important characteristics that can help free families from poverty.

Column 1 indicates that a parent refuses information from the home visitor or health care resources, such as physicians or clinic staff, nutritionists, and so forth.

Column 2 is scored when the parent relies on inaccurate information from informal sources, rather than seeking accurate information from reliable sources.

Column 3 indicates that a parent passively accepts information from the home visitor or health care resources.

Column 4 indicates that a parent accepts and uses most of the information provided by the home visitor or health care resources.

Column 5 indicates that a parent actively asks for and uses information from the home visitor and health care resources.

11. Use of Resources
The ability to identify family or individual needs, and to locate and access the resources likely to meet those needs, is a crucial skill that can be learned with experience, support, and positive reinforcement. The ability to use a calendar, a phone, or transportation may be a skill that needs to be taught in order for the parent to access resources effectively. Parental ability to use resources also may be complicated by language issues.

Column 1 describes a parent who is hostile, distrustful, or fearful of using resources or who generally refuses resource referrals.

Column 2 indicates a parent who passively accepts referrals but misses appointments or shows limited follow-up.

Column 3 indicates a parent who will use resources if access is facilitated or who sometimes keeps appointments. The ability to access resources independently is not yet established and may be complicated by lack of other resources such as transportation.

Column 4 is scored for the parent who can identify needs with assistance, who accepts referrals to meet the need, and who keeps most appointments.

Column 5 is used for a parent who can identify needs independently, who seeks out and uses resources, and who keeps or reschedules appointments.
**Education and Employment (Scales 12–16)**

This section, Scales 12–16, includes issues related to Language, Education (one scale more useful for teens and the second more useful for adults), Employment, and Immigration.

12. **Language**

*This scale is scored ONLY for a parent whose primary language is not English.* Use a “0” and check NA if the parent’s first language is English and he or she is not bilingual in any combination of English and another language. Bilingualism may expand job or educational options. This scale can be used to measure the percentage of the caseload that has significant English as a Second Language (ESL) challenges, and the data can document the changes families make.

**Column 1** is used for a parent who does not speak English and has no or low literacy in any language. A parent who is preliterate in any language may not have developed visual symbolization skills, making it difficult to teach a child the alphabet or to read. This parent may need translators or same-language staff for home visits or provider use.

**Column 2** is used to score a parent who is fluent and literate in his or her primary language. This parent needs translators.

**Column 3** indicates that a parent sees the need for learning English and is taking English classes. The parent has some usable verbal skills in English that would allow for entry-level employment. The parent manages some conversations, bills, and applications without translation or assistance in English.

**Column 4** indicates a parent who continues English classes and/or has some useful written English capability. The parent can manage most bills, applications, and written instructions in English.

**Column 5** is used for a non–English-speaking parent who has become fully bilingual or speaks multiple languages including English.

13. **Less Than 12th Grade Education**

*(Adolescents age < 19 years and some adults)*

This scale is used for teens who, because of age, should still be enrolled in school. Some programs choose to use Scale 13 to track adults who are working toward a General Education Development (GED) diploma. The sequence reflects enrollment, grade-level status, attendance, and type of diploma targeted. Scale 14, Education, can give the total percentage of the caseload that has not graduated from high school in Column 1 when it is used for both teens and adults. Job skills programs are described in Scale 14, Education.

**Column 1** describes students who are not enrolled in school or who have dropped out.

**Column 2** captures students who are enrolled but who have limited attendance and who are not at grade level for their age.

**Column 3** is used for students who are enrolled and attending any program regularly but who are not at the expected grade level. This includes those who had previously dropped
out but returned to school.

Column 4 reflects students who are enrolled in independent study or adult schools, attend regularly as required, and are at grade level. Their goal is a GED diploma.

Column 5 is for students enrolled in and regularly attending high school (regular or alternative) who are at grade level. The goal is to graduate with a high school diploma.

14. Education (Adults and teens)
The Education scale is used for adults and teens to capture the percentage of the caseload that has less than a 12th grade education. In addition to scoring, it may be helpful to add written comments such as “10th gr. in Mexico.” Scoring is based on actual educational accomplishments. High school graduation is necessary for employment in most jobs that are not agricultural or manual labor and thus have potential for job growth and stability.

Column 1 indicates that a parent has completed less than 12th grade in any country.

Column 2 indicates that a parent has graduated from high school or has a GED diploma.

Column 3 indicates that a parent is enrolled or obtaining job training.

Column 4 indicates that a parent attends or has recently graduated with a 2-year degree from a community college.

Column 5 indicates that a parent attends or has recently graduated from a 4-year college program and/or is studying for an advanced degree.

15. Employment
Checking “NA” and scoring “0” would be appropriate for younger parents for whom employment is not a goal; however, scoring is appropriate for teen parents who are working. “NA” would not be used for a parent who has chosen not to work in order to stay home with a young or sick infant, because the scale indicates skill or experience and type of employment for the past 6 months. Written comments would add perspective, such as “by choice,” “cultural issue” or “on Workers Comp.”

Column 1 is used for a parent with no work experience or job skills or who is unemployed. Column 1 is scored even if unemployment is by choice to parent an infant or because of cultural values (e.g., women not working outside the home).

Column 2 indicates a parent who has occasional entry-level jobs or seasonal employment.

Column 3 indicates a parent who has stable employment in multiple and/or low-income jobs.

Column 4 is scored for a parent who is regularly employed in a job with adequate salary and benefits.

Column 5 identifies a parent who is working in his or her career of choice with a good salary and benefits and options for promotion. These jobs are often linked to job training or college education. Individuals on maternity or paternity leave are scored here.

16. Immigration
This scale applies only to those parents who are immigrants and not U.S. citizens by
birth. Check “NA” and score “0” for a parent who is a U.S. citizen by birth. The word “Migrant” appears in several columns because the frequency of moves for migrant families adds a layer of complexity and disruption of education and services. Circle “Migrant” when appropriate in the column that matches the parent’s immigration status. For two-parent families, score only the primary parent who is the focus of this LSP; usually it is the mother.

Column 1 is used for the undocumented, migrant parent, without a work permit or card, who frequently or annually returns to the country of origin. Often for these families, immigration and citizenship is not a goal. Moving often disrupts the continuity of the child’s health and medical care and educational opportunities.

Column 2 identifies a parent who is legally here with a valid work permit or card. The parent may be migrant or in the United States less than 5 years. He or she plans to return to country of origin to live.

Column 3 identifies a parent who is legally here with a valid work permit or card. The parent may be migrant or in the United States more than 5 years. He or she plans to live in the United States.

Column 4 identifies a parent who has a work permit or card or who is “documented” with a temporary visa. He or she is applying for citizenship and/or plans to live permanently in the United States.

Column 5 identifies a parent who has U.S. citizen status.

Health and Medical Care (Scales 17–23)

This section is divided into parent and child health care issues.

17. Maternal Prenatal Care
Check “NA” and use a score of “0” if the parent being scored is the father. This is the only scale that is not appropriate for use with males. As with other scales, behavior is indicated but use of health care also reflects attitudes; information; ability to access services, organizational skills, support network, transportation, phones, and culture. These factors may all need to be included in assessment for referral to prenatal care and for other support purposes. Prenatal care means medical care; prenatal dental care would be a secondary referral by the medical care provider and is not included for scoring (although dental care is certainly important, recommended and prenatal treatment can prevent caries in the infant).

Column 1 is used for the mother who had no prenatal care for this pregnancy. The reason care was not received should be indicated (e.g., drugs, denial, access barriers).

Column 2 is used if prenatal care started late, in the 2nd or 3rd trimester, and for mothers who only kept some of the appointments.

Column 3 is used when prenatal care was started late, in the 2nd or 3rd trimester, but
most of the appointments were kept.

**Column 4** is scored for mothers who started prenatal care early, in the 1st trimester, and kept most of the appointments.

**Column 5** is used for those mothers who completed the pregnancy within the last 6 months, had early (Score 4) care, and who also kept the postpartum appointment. The postpartum appointment is considered the completion of maternal perinatal care. (See Scale 19, Family Planning; services often start at the postpartum appointment.)

**18. Parent Sick Care**

This scale targets knowledge and behaviors that lead to appropriate care and treatment, as opposed to the inappropriate use of care such as using emergency rooms for routine care. Use of medical care involves multiple external and personal variables, including access skills and payment resources (see Scale 33, Medical/Health Insurance).

**Column 1** is used for a parent who has an acute and chronic medical condition that was without diagnosis and treatment in the past 6 months.

**Column 2** is used for a parent who, for whatever combination of reasons, seeks medical care late and who has become very ill before seeking care. The home is not a “medical home” and the family may use the emergency room for care of nonemergent conditions.

**Column 3** is scored for a parent who seeks care in a timely way inconsistently and who fails to follow through with the treatment recommended, such as not taking medication as prescribed. The family uses multiple providers or medical home.

**Column 4** describes a parent who seeks care appropriately, follows treatment as prescribed, and has a stable medical home. However, a healthy, preventive lifestyle has not yet been established and chronic conditions may be present.

**Column 5** is used when a parent seeks care appropriately to cure or control medical conditions and makes lifestyle changes to maintain a healthy lifestyle. He or she has a stable medical home.

**19. Family Planning**

This scale focuses on current family planning use during the past 6 months. If the woman is pregnant, check “NA” and score “0.” Written comments such as “method failure,” “HIV risk” or “history of 4 abortions” are useful to target needs for intervention. The words “history of sexually transmitted disease” and “therapeutic abortion” apply only to the previous 6 months. Use of a “morning after” pill would be scored in Column 3. A permanent method of family planning would score in Column 5, signaling completion of birth control as a parent need, although the need for protection against sexually transmitted diseases (STDs) might continue. This scale can be scored if the client is male.

**Column 1** indicates that the parent has not used a family planning method and is not trying to get pregnant. The parent may lack information needed to use an effective method or may lack life skills to prevent unplanned pregnancies. Unplanned pregnancy...
cies within the last 6 months are scored in Column 1.

**Column 2** indicates that use of a family planning method, such as a condom, has only happened on *rare* occasions.

**Column 3** indicates that the parent *inconsistently* and intermittently uses a family planning method.

**Column 4** is used for parents who *regularly* use a family planning method to prevent pregnancy.

**Column 5** indicates that parents *voluntarily plan to space* their children and regularly use a family planning method and STD protection. Parents who are planning a pregnancy and trying to get pregnant are scored here, as are those who have chosen a permanent birth control method at the end of intentional childbearing.

### 20. Child Well Care (Preventive Care)

This scale may need split scores if there are multiple children in the home and the use of well-child health care is different for each child. Lack of well-child care, while less than optimal, is not considered reportable neglect in most locations. Follow agency policy and state reporting laws.

**Column 1** is used for children who have *never* had well-child or preventive health care. This is most frequently seen in new immigrants.

**Column 2** is used for children who have *seldom* had well-child care or for whom well-child care stopped after early infancy visits.

**Column 3** is used for children who still have an *occasional* well-child visit but who do not meet periodicity recommendations.

**Column 4** indicates that children have planned annual well-child visits. Scores of 4 and 5 are both good scores. An annual examination takes less parental effort than the multiple examinations needed by younger infants.

**Column 5** is used for children who have regular planned periodic visits for well-child purposes, such as the recommended CHDP examination schedule, and have not yet reached the age for annual examinations.

### 21. Child Sick Care

“Medical Neglect” should be circled and the scale scored as a “1” if a child abuse report has been filed for neglect in the past 6 months or if there has been a *failure to thrive* diagnosis for nonorganic causes and neglect is the conclusion of the physicians. Low scores will need further clarification and sometimes a psychological diagnosis to determine which factors contribute to a parent’s ability to obtain proper care (e.g., depression, mental illness, or cognitive delays). Scores in Columns 4 and 5 are both good scores. Column 5 is intended to describe the difference between the effort needed and importance of regular care for a significant or chronic illness such as cancer, cerebral palsy, or a heart condition. A score of 5 can indicate the number of children with serious illnesses who are receiving the care they need. Because home visitation services are not responsible for
medical diagnosis and treatment, the LSP does not use the ICD-9 diagnostic codes. Special databases would be needed to link LSP characteristics with the extensive categories and conditions listed in the ICD-9.

**Column 1** is used to identify medical neglect and situations in which a child has received *no diagnosis or treatment* for acute or chronic medical conditions.

**Column 2** identifies a child who *receives diagnosis and treatment only when very ill* or for whom the emergency room is the usual source of care.

**Column 3** reflects a child who receives timely care for illness but who has inconsistent follow-up on treatment or return appointments.

**Column 4** reflects a child who receives both timely treatment for *minor illnesses* and recommended follow-up.

**Column 5** is scored for a child with a significant *acute or chronic medical condition*, for whom either control of the condition is maintained or cure achieved. A child receiving hospice care for impending death is scored here as well, because he or she is receiving the care needed.

### 22. Child Dental Care

Check “NA” and score “0” if the child is an only child and has no teeth. If there are several children with varying dental care needs, split scores will be required. Prevention of early childhood caries (ECC) or “baby bottle mouth” by prenatal maternal dental care and use of water only in bottles for sleep, if at all, would rate a 5. Inadequate funding and availability of dental care is a barrier to good dental health nationally.

**Column 1** is used for toddlers with *serious ECC*, who have poor dental hygiene and no dental or preventive care.

**Column 2** is used for children who have *some ECC*, inadequate dental hygiene, and no dental care.

**Column 3** is scored for late treatment of ECC, but there is an established dental home and some dental hygiene.

**Column 4** includes timely treatment of caries and some preventive care by a dentist and parents. Use Column 4 if an infant’s age is less than the customary start of preventive dental care, about age 2 years, and if the parent brushes the child’s teeth daily.

**Column 5** reflects regular preventive care and daily oral hygiene by parent and timely treatment of early disease.

### 23. Child Immunizations

Split scores may apply for multiple children, because younger children are more likely to have complete immunizations (IZ) than those older than age 2 years. The difference between Column 3 and Column 4 is subtle. Column 3 suggests that immunizations were begun and stopped without active plans to continue. Column 4 implies a short delay, with return appointments planned or scheduled. Delay recommended by a physician due to an illness is an example of the latter. Most health departments issue updated lists
of recommended immunization and schedules annually and offer low- or no-cost immunization clinics.

**Column 1** is for a child who has had *no immunizations*, including a child whose parents refuse them because of alternative health or religious beliefs.

**Column 2** is for families who have lost the records or for children whose immunization history is uncertain, such as immunizations given in another country without adequate documentation of the type of vaccine used.

**Column 3** is for immunizations which were begun but are incomplete for age.

**Column 4** indicates that immunizations are planned or scheduled but are overdue.

**Column 5** reflects immunizations that are complete and current for a child’s age.

**Mental Health and Substance Use/Abuse (Scales 24–29)**

Substance use (drugs and/or alcohol) and depression are both found in the DSM-IV, which categorizes mental illness for clinical purposes; however, because these conditions are so prevalent in low-income populations, and because they each have specific treatment implications, they have been given separate LSP scales. It is recommended that programs serving this population have copies of the DSM-IV available for reference for diagnostic criteria for mental illness and addiction. Studies of maternal depression incidence in low-income populations suggest rates of between 10% and 40%.

**24. Substance Use/Abuse**

This scale applies to the use or abuse of drugs and/or alcohol during the past 6 months. If a client has a history of drug use or abuse, the Depression and Self-Esteem scales may be important to assess carefully because the three are often related, as is a history of rape, molestation, incest, or sexual abuse. Drug use may be a part of PTSD. The DSM-IV defines substance dependence and stages of recovery or “remission” and offers a useful perspective for collaborative support to parents in treatment.

**Column 1** identifies parents who have a chronic and continuing history of drug addiction and/or alcohol abuse. Use the following criteria:

- Behavioral reasons for suspicion of use (e.g., slurred speech, disorientation or aggression, unsteady gait, alcohol breath)
- Client self-report
- Known history of arrest, incarceration, or treatment for drugs or alcohol
- Positive toxicology or tests during pregnancy or birth
- Suspected or diagnosed fetal alcohol syndrome (FAS) or fetal alcohol effects (FAE)
- Infant withdrawal symptoms and self-regulation problems

For clients who have no history and none of the above criteria applies, circle “no use” in Column 5 and do not use “NA” and a score of “0.” This scale allows for repeated
regression and recovery to be documented.

**Column 2** indicates intermittent or episodic heavy use or binging but without apparent addiction. These parents are at great risk of becoming addicted or progressing to more or “harder” drugs.

**Column 3** describes parents with occasional or experimental use of illegal substances, or those who are “clean” and participating in a recovery program (e.g., methadone treatment, Narcotics Anonymous, Alcoholics Anonymous). This may include parents participating in court-ordered treatment or treatment as a condition for the return of a child from foster care. These parents may be motivated to change. A methadone client with “clean” tests scores in Column 3, whereas someone in treatment who tests positive for other drugs would score in Column 1.

**Column 4** indicates a client who describes a recent history (within the past 6 months) of light “social” use of legal substances (e.g., alcohol). This includes women who stopped any use during a current pregnancy.

**Column 5** indicates a parent with no reported or observed use/abuse of drugs or alcohol within the past 6 months.

**25. Tobacco Use**

As with other scales, this scale applies to current use of tobacco products within the past 6 months, and “smoking” includes the use of any tobacco products. Use of marijuana or other drug-laced cigarettes would be scored on Scale 24. Smoking is a major cause of premature births. For multifamily households or work environments, reducing exposure to second-hand smoke can be a difficult educational challenge.

**Column 1** is used for chain-smoking or equivalent nicotine exposure from smokeless tobacco products with use or second-hand exposure, more than two packs per day.

**Column 2** applies to those who smoke less than two packs per day or who have some second-hand tobacco smoke exposure at home or at work.

**Column 3** describes the parent who continues smoking while pregnant but decreases the number of cigarettes or second-hand exposure. It can also refer to parents who, after delivery, protect the child from smoke exposure.

**Column 4** indicates the parent who stops completely while pregnant or for whom there is no close second-hand exposure.

**Column 5** describes the parent who has never smoked or been closely exposed to second-hand smoke.

**26. Depression/Suicide**

The incidence of depression in perinatal clients is estimated at between 10% and 40%, with the higher percentages more common in studies of poverty-level women. Intervention with clients who are depressed should always include assessment for suicide risk and referral for treatment when needed. Screening scales to assess depression (Edinburgh Postnatal Depression Scale, Beck Depression Inventory, and CES-D) are available, and
depression is described in the DSM-IV-TR. The LSP Depression scale includes clients with postpartum depression, chronic depression with or without a history of PTSD, and situational or environmental depression. A diagnosis of bipolar disorder and related mood disorders should be scored under Scale 27, Mental Illness. If the parent has been so severely depressed that he or she was hospitalized within the past 6 months, or if there is a dual mental health diagnosis, the severity of illness would also show in scores on Scale 27. The activities of daily living (ADL), which consist of the ability to manage food, clothes, hygiene, bills, and so forth, are often affected by depression, mental illness, and cognitive ability, as is the ability to parent well and to perceive self and life (reflective function).

**Column 1** indicates a parent who has a *history of reoccurring or chronic depression with suicide attempts*. These parents have severe difficulty carrying out ordinary ADL and parenting, and they lack perception into the extent of their illness or its effects on their child or family life.

**Column 2** applies to people who *report recurrent or chronic depression* but who deny having suicidal thoughts or attempts. They have moderate problems with ADL and parenting, but they have some perspective and awareness of it being a problem for them and their family.

**Column 3** indicates a parent with *recent postpartum depression or current situational depression* (e.g., unhappy about life or relationships). ADL, parenting, and awareness are only somewhat affected. These parents may or may not have had treatment.

**Column 4** accounts for a parent who *manages or controls depression*, including those who use mental health or counseling services and/or medication and have gained good control, so that ADL, parenting, and insight are adequate.

**Column 5** is reserved for a parent who is *not depressed* or who has successfully recovered before the past 6 months. This includes a happy, content, or optimistic parent who has not been depressed.

### 27. Mental Illness

This scale refers to mental illness as listed in the DSM-IV-TR. It excludes depression as defined above but includes those hospitalized for depression and those with more complex conditions that have depression as one component, such as bipolar disorder.

**Column 1** is for a parent with *severe symptoms* of psychosis or other types of mental illness, *with or without diagnosis*, treatment, or medication. These parents have severe difficulty managing ADL and parenting, and insight into the extent or effects of their illness is not evident.

**Column 2** is for clients with *symptoms of mental illness, who have been diagnosed but treatment is inconsistent or ineffective*. They have moderate problems with ability to carry out ADL, to parent, or to demonstrate insight into the extent or effects of their illness.

**Column 3** indicates that *symptoms of mental illness are under control, and diagnosis and treatment are established*. These parents are under enough control that ADL, parenting, and insight are only somewhat affected.
Column 4 indicates mental illness that is due to situational causes. Illness tends to be short-term and treatment is effective. ADL, parenting, and insight are adequate.

Column 5 indicates parents with no history or symptoms of mental illness.

28. Self-Esteem

The scores on Scale 26, Depression/Suicide, and this scale will often be very similar. Self-esteem is learned in a social and family context as children, and it is rooted in perceptions of ourselves and our worth and abilities relative to others.

The low side of the self-esteem scale involves lack of goals that are acted on, generalized inertia or fear of trying something, and depression. Defensive behaviors that are coping mechanisms, but are not helpful to progress in life, are also likely. Recognition and support that is given in such a way that the person perceives his or her strengths, abilities, and goals can be used to revive self-esteem and accounts for much of the progress seen in families served by strengths-based programs.

Column 1 identifies a parent who shows poor self-esteem by being self-critical and expecting criticism from others. He or she has difficulty initiating action, particularly in new situations. This parent usually appears or reports being depressed.

Column 2 is for a parent who is not openly self-critical and who is able to cope but lacks confidence; he or she may have a flat affect or fearfulness and may have limited initiative for trying new skills.

Column 3 identifies a parent who shows poor self-esteem by living shrouded in defensiveness and irritability. The blame is directed outward toward others or as excuses for him or herself in a way that seems on the surface to be protection from self-criticism. The parent may initiate new things but may give up easily.

Column 4 can be used to describe the parent who is gaining in confidence and skills, and who is beginning to actively initiate new skills. This parent tends to be shy when praised but can recognize his or her own competence, and emerging self-confidence is visible.

Column 5 is for the parent who expresses confidence in his or her skills and ability to learn and who expresses pride in achievements and successes.

29. Cognitive Ability

This scale offers a structure in which to identify a parent with developmental delays (DD) or learning disabilities (LD). Cognitive delays, called mental retardation in the DSM-IV, are classified as Mild (IQ = 50–70), Moderate (IQ = 35–50), Severe (IQ = 20–35), and Profound (IQ < 20). Most parents with cognitive disabilities who are enrolled in community visitation programs will be in the Mild range and may not be able to read or tell time. As with mental illness and because of an underlying condition, parents with cognitive disabilities may show limited or slower life skills progress. Program intervention focuses on obtaining adequate support rather than a cure and is usually undertaken in collaboration with social services and programs serving individuals with developmental disabilities. Immigration and language issues add another layer of complexity for home visitors.
For the parent with a delay, noting whether the parent is able to read, tell time, use good judgment, and respond appropriately to a baby's cues will be extremely important for the child's welfare. Nurturing responsiveness should be indicated on Scale 5 (Nurturing).

LDs are also classified in the DSM-IV, although they are managed primarily by educational interventions, and these parents have a much higher life skills potential with adequate educational support. Obtaining educational and psychological testing records, if available, may prove extremely helpful in adapting parenting materials and obtaining support services.

**Column 1** is used when a DD (Mild to Moderate with IQ < 70) is suspected but when there has been no known diagnosis or support services are not in place. The ability to carry out normal ADL, parenting, and judgment are significantly impaired.

**Column 2** indicates a parent who has been diagnosed with a DD but has adequate educational or special services support. The degree to which ADL, parenting, and judgment are impaired is moderate but is mitigated by the support available.

**Column 3** is for parents with more functional levels of DD or LD, who have some problems with ADL, parenting, and judgment but are able to cope with some support from a spouse or family.

**Column 4** indicates that the cognitive ability to carry out ADL, parenting, and judgment is adequate without support. The parent has received special education or learning services. Markers such as ability to work, drive, shop, and pay bills independently are present.

**Column 5** is used for a parent who, because of the abilities observed, such as reading or high school graduation, demonstrates average or above average cognitive abilities. He or she is competent with ADL.

### Basic Essentials (Scales 30–35)

This section deals with the parent’s abilities to provide for the basic needs in life. It contains what are perhaps the most concrete areas of life skills. They are directly influenced by the abilities reflected in LSP Section 2, Education, and Section 3, Mental Health, and by the supportive relationships described in Scales 1 and 2 found in Section 1.

#### 30. Housing

Housing is one of the basic areas that is essential to quality of life and sometimes makes the impact of poverty graphically visible. Frequent moves, chaotic lives, overcrowding, squalor, and homelessness mean that little time or energy is available to be directed to other needs and often to children’s needs. As the economy worsens, home visitors frequently encounter overcrowded, multifamily housing. Poor housing can be a strong motivation for improving life skills.

**Column 1** is used to indicate homeless families. Use this column for home environments that are so substandard that some basic utilities are missing or so poor as to be danger-
ous and require reporting to environmental health services. Homes that are so dirty that the children are endangered are scored here.

**Column 2** indicates the parent with unstable housing who moves frequently (e.g., family moved more than once in the last 6 months).

**Column 3** is used for low-income families that share rental space with strangers or friends, or for a teen in a foster home. If there are also frequent moves, split scores with Column 2 may be needed.

**Column 4** indicates parents who are able to live with families or extended family or in-laws. Overcrowding may be an issue, but this is usually a more stable and supportive environment than that scored in Column 3.

**Column 5** can be used for the family who rents or owns its own apartment or home.

### 31. Food/Nutrition

This scale focuses on the parent’s ability to obtain and provide adequate food and nutrition. Many factors, including culture and immigration issues or information, may influence a parent’s eligibility for services and ability to provide food adequately. This scale does not measure the quality of the nutrition of the individual parent or child and does not address food-related conditions such as diabetes, obesity, or anorexia. Codes for these conditions can be listed in the medical code field found in the heading.

**Column 1** indicates families who run out of food and must rely on charity or food banks for emergency food. Hunger exists as a real threat for these families.

**Column 2** indicates that the family has inadequate food resources but has food; the concern is about the amount or quality.

**Column 3** indicates families that use nutritional resources for low-income families, such as WIC, food stamps, or other similar services.

**Column 4** is scored if the family income allows for adequate amount and quality of food. This is frequently seen in extended families that share housing and resources.

**Column 5** is scored if family income provides for optimal food and nutrition.

### 32. Transportation

This is a key scale that affects the parent’s ability to access other needed services. The ability to use public transportation, have a driver’s license, obtain car insurance, and drive or have access to a car usually needs to be assessed in order to support a parent’s skill development. There is a significant difference in the use and value of public transportation versus private cars in large urban versus rural settings. In some urban environments, use of public transportation (Column 2) may be a good permanent answer to transportation needs.

**Column 1** identifies families who have no transportation resources.

**Column 2** identifies families who use public transportation.

**Column 3** identifies whether a parent has access to a car or can ride with others, including a spouse.
Column 4 indicates that the family has a car and the client (not just the spouse) has a license. Immigration may influence licensure.

Column 5 identifies that the parent has a car and license and drives.

33. Medical/Health Insurance
This scale refers to the health coverage for the parent being scored, not the child or family. Some families, particularly undocumented immigrants, may have different coverage for different members. Most low-income children are eligible for federally or state-funded health care coverage. Medical insurance or publicly funded health care programs vary greatly between states and communities. The names of publicly funded health care programs vary between states and communities.

Column 1 indicates that the parent has no health care coverage and is unable to afford care.

Column 2 is used if the parent has government-funded coverage for pregnancy or emergency only and does not have coverage for routine health care. This is seen most frequently in low-income immigrant families.

Column 3 is used for low-income families who are eligible for and have full scope Medicaid with or without a monthly Share-of-Cost (SOC).

Column 4 indicates a parent who has a state-subsidized insurance program, with or without a partial pay plan or copayment.

Column 5 indicates that a parent has private insurance (privately or job-linked) with or without copayments.

34. Income
This scale refers to the income of the parent being scored, not the family. For clients who are pregnant teens living at home or unemployed, dependent women, the score would be based on the parent’s or the supporting FOB’s income, until they have TANF, child support, or income from employment. “Low income” refers to parents whose income qualifies for the 200% of FPL, a scale that is adjusted annually and is available through social service or CHDP programs. “None” is usually an infrequent temporary crisis but should be used if that has been the case in the last 6 months. Because these conditions change quickly, a split score may be needed. This may be seen with homelessness in Scale 30, Housing. Income from illegal activities such as drug sales or prostitution is not counted.

Column 1 reflects that the parent has no source of income.

Column 2 identifies a parent receiving TANF, SDI, or child support.

Column 3 is used for a low-income, employed parent. It can reflect seasonal employment and includes families who meet 200% for FPL criteria (e.g., family is eligible for the WIC or CHDP program).

Column 4 indicates that parents are employed with a moderate income and are able to meet expenses most of the time.

Column 5 reflects that the parent is receiving an adequate salary for the area’s cost of living.
**35. Child Care**

Check “NA” and score “0” if the woman is pregnant. This scale reflects the reality that for these economic times, most low-income families need both parents working in order to survive and be independent. As a result, finding good child care becomes a life skill. It is not intended to devalue the importance of a mother staying home with her infant. Because of research on infant brain development, the quality of the child care environment is extremely important. Many extended family environments that are secure and nurturing lack adequate stimulation for good brain development, and the quality in other child care resources varies greatly. Providing information on how to select good child care and local resources can help young families make good choices.

**Column 1** is used for parents with no child care or who have not yet used it.

**Column 2** indicates that multiple people or places are used for occasional child care with unsafe or poorly supervised environments that create unstable caretaking relationships for the child.

**Column 3** is scored when parents prefer to use a caring friend or relative where the environment is stable and safe but offers limited developmental support.

**Column 4** is used for care environments, both homes and centers, that are used regularly and provide both the love and stimulation needed by young children.

**Column 5** reflects use of a high-quality child care center that intentionally provides the best in child care. These centers have low staff-to-child ratios, have nurturing and well-trained staff, and provide toys and activities for cognitive, physical, and social development.

**CHILD SCALES**

**Child Development (Scales 36–40)**

The LSP child scales summarize developmental data gathered from visit observations, parental report, and use of standardized screening tools such as the ASQ, ASQ:SE, or Denver II. Scales 36–40 match the order of the ASQ to facilitate translation of developmental domain scored to the LSP, and Scale 41 can be based on information from the ASQ:SE. Because the ASQ is based on parent observation, it is consistent with strengths-based home visitation services and facilitates parents’ interest in and knowledge of their child’s development. Some programs use both the ASQ and ASQ:SE; others choose to use the ASQ:SE only when scores on the Personal-Social questions of the ASQ suggest that more information is needed. Some programs also use The FIRST, for neurologically immature babies and their parents, or the DC:0-3.

**Mandated Early Intervention**

Under federal educational law (Individuals with Disabilities Education Act [IDEA] Amendments of 1997 [PL 105-17], Part C), all states must provide early intervention/education for infants with delays. Specific criteria for eligibility exist in all states (e.g., 25% delay in two areas of development or 50% delay in one area of development).
There is confusion about screening versus assessment in some home visitation programs, and the terms should not be used interchangeably. Screening refers to the identification of children who need further diagnosis or formal assessment of developmental or psychosocial characteristics. Screening tools (e.g., ASQ, Denver II) are different from assessment tools (e.g., BSID-II) and functional development assessments (e.g., The Ounce of Prevention Scale [The Ounce Scale]; Meisels et al., 2003). Formal assessments are the legal responsibility of the educational programs providing early intervention services and generally are done by a multidisciplinary team as part of the individualized education program (IEP).

Because of the growing body of evidence showing that children with special needs and their parents benefit from a more individualized and functionally based approach to developmental screening, assessment and intervention are needed. Over the next few years there may be a shift by early intervention services to the use of functionally based tools and approaches. The Ounce is one such example. Work by Greenspan, Lourie, and Weider has resulted in the Functional Developmental Growth Chart and Questionnaire (Greenspan, DeGangi, & Wieder, 2001; Greenspan & Weider, 2000), which lists developmental behaviors by age in months. It is significantly different from and more comprehensive than previous scales. These essential developmental behaviors include focusing and attention, engaging in relationships, purposeful interaction, problem solving, use of ideas (words and symbols to convey intent or feelings), and logical bridges between ideas.

The LSP child scales are useful for programs that screen children for special developmental needs. The child scales are not designed to provide a formal or functional assessment of children likely to be eligible for special developmental intervention services. However, early intervention services can use the LSP scales to track parental life skills development and to summarize program participation, and in many cases the infants progress into an average range of development for age.

LSP scales are primarily for use with children from ages 6 months to 3 years, although the developmental Scales 36–40 can be used for preschoolers ages 3–5 years depending on the upper limits of the screening tool used. For preschool use, enrollment in early intervention would be translated to mean special education if delays are identified. (Reminder: use one LSP Page 5 per individual child.)

The LSP does not provide information regarding the range of medical, developmental, psychosocial, affective, or regulatory conditions that may be found in infants, premature infants, toddlers, and preschool-age children. The most common are cerebral palsy, global delays due to birth anoxia, developmental delays related to parenting, congenital genetic and neurological conditions, vision and hearing problems, autism spectrum disorders, regulation and attention difficulties, aphasia, and sensory-motor problems.

LSP caseload data can be used to summarize the number and percentage of children with developmental delays meeting early intervention criteria (score of 1–3) or emerging or improving delays (score of 3.5) and with average (score of 4–4.5) or above-average development (score of 5). These data may prove useful to early interventionists and county offices of education for program planning regarding site and staffing needs.
Child Scale Terminology

Early intervention (EI) services are generally delivered through either local school districts or county offices of education. States and communities each have different names for the required IDEA program, and home visitors are generally familiar with the program name used in their community that provides mandated early intervention services.

Adjusted age (AA) or chronological age (CA) is circled to indicate whether prematurity was a factor considered in the screening. AA is used up until age 2 years if an infant was premature. Screening tests give instructions on how to calculate the AA.

Child Development (Scales 36–40)

Use the following interpretation from the screening tools used (e.g., ASQ or Denver II):

Columns 1–3. Circle and score Columns 1–3 to indicate a child who has IDEA-eligible delays, which means the child has scores in the shaded “cut-off” section (25th percentile on the ASQ or passes less than the 25th percentile of items in the relevant domain on the Denver II for CA or AA, and meets Early Start Criteria of one domain at 50% of AA or CA, or two domains at 25% of AA or CA).

Columns 3–4. If a child shows emerging or improving delays that are not severe enough to meet early intervention criteria, use a score of 3.5.

Column 4. This score reflects average or age-appropriate development and indicates that a child scores above the cut-off score on the ASQ or has passed most items on the Denver II for the domain skills touched by the CA or AA age line. A few cautions or fails on the Denver II can be included.

Column 5. This is for a child who is showing advanced or above average development, meaning that the sixth question in the ASQ domain section was checked “Yes” or the child scored at the 60th percentile (1 standard deviation above the mean). On the Denver II, the child scored above 50% on the domain items.

Emotional Development and Regulation (Scales 41 and 42)

41. Social-Emotional

This scale is designed to reflect those infants who, when screened on instruments like the ASQ:SE, are found to be in need of the support and intervention offered by infant mental health (IMH) specialists. The field of infant mental health is emerging and services for infants and toddlers are not always available in many locations. As with the other developmental LSP scales, this scale reflects both the need for infant mental health services and whether the child is receiving needed services.

42. Regulation

This scale reflects emerging self-regulatory characteristics of a child that aid or interfere with development, exploration, and relationships. This can be scored based on parental report, visitor observation, and/or use of an age-appropriate screening tool.

Column 1 is used for the irritable, hard to console, or extremely active infant or toddler who
sends unclear cues, is unresponsive to parenting, and demonstrates characteristics of poor self-regulation and/or self-comforting. Toddlers with emerging attention deficit disorder (ADD) or attention-deficit/hyperactivity disorder (ADHD) are scored here.

**Column 2** is used for infants with flat affect or significant passivity. They show little exploration of their environment, do not seek comfort or share “conversations,” or seem not to enjoy toys or objects around them. Some neurologically immature infants may “shut down” in response to sensory overload.

**Column 3** indicates children who are anxious, withdrawn, or clingy. They show some play and some limited exploration. They are very dependent on parents for regulation.

**Column 4** is used for a child with average regulation abilities, with quiet or changeable moods, who explores and returns to share or seek comfort from a parent.

**Column 5** is for the “easy,” happy, well-regulated infant who is easily consoled or redirected in play to another object. The child shows secure parental connection, explores actively, and shares delight.

In the book *From Neurons to Neighborhoods* (Shonkoff & Phillips, 2000), the authors state, “the growth of self-regulation is a cornerstone for early childhood development that cuts across all domains of behavior,” and one chapter is dedicated to this subject. Children who show behaviors described in Columns 1–3 may need help making the transition from a coregulation relationship with their parent to functional self-regulation.

The ZERO TO THREE’s DC:0-3 (Greenspan et al., 1994) provides valuable reference material for clinicians and health professionals for the screening, referral, and treatment of infants. Infants who are likely to have regulation problems will often have neurologically immature bodies, will have been exposed to substances, or live in marginal or violent home environments. Parents with infants with regulatory issues frequently need special support. Regulatory parent/infant support is described in *Individualized Developmental Care for the Very Low Birth Weight Preterm Infant* (Als et al., 1994) and in the Family Infant Relationship Support Training tool known as FIRST (Browne et al., 1999). There is also a variety of excellent texts regarding sensory integration, and many communities have access to occupational and physical therapists with skills in this area of practice, although funding for treatment may be harder to identify. Hospitals, primary care, and home visitation programs are the pivotal resources available to support parents’ learning about infant states, cues, and how to help babies develop self-regulation skills.

Children are born with some temperament characteristics (Thomas & Chess, 1997). The definition of temperament now most commonly accepted is “biologically rooted individual differences in behavior tendencies that are present in early life and are relatively stable across various kinds of situations and over the course of time” (Bates, 1989). However, a young child’s genetically based temperament characteristics and regulatory behavior can be influenced to various degrees by several factors. These include “brain processes, family environment, culture, nutrition, biomedical conditions, and toxic substances” (Wachs, 2004). Learned behaviors can be changed and neurological synapses grown, and behaviors that have organic causes can be influenced. In some biomedical
situations, such as phenylketonuria (PKU) or cardiac conditions, which can be treated, or in the case of neurological immaturity second to pre-term birth, delays can be mitigated by adapted care and appropriate environmental supports. Supporting a parent’s skill, confidence, and success with the infant is as important to the baby’s self-regulatory outcome as a timely referral for special services is for developmental delays.

Breast Feeding (Scale 43)

43. Breast Feeding

This scale is intended to be applicable to infants from birth to 3 years, to capture the length of time a baby has been breast-fed. Score “0” if the infant’s age is older than 6 months and they were never breast-fed at any time. Use Columns 1–4 for infants whose age is younger than 6 months.

Column 1 is scored if the infant’s age is younger than 6 months and if the infant was never breast-fed or was breast-fed less than 2 weeks.

Column 2 is used for infants older than 6 months who were breast-fed, including expressed, for less than 1 month (2 weeks to 1 month).

Column 3 is used for infants younger than 6 months old who were breast-fed, including expressed, for 1–3 months.

Column 4 includes infants younger than 6 months old who were breast-fed/expressed, with or without supplementation, for 3–6 months.

Column 5 is for infants older than 6 months who were breast-fed with some supplementation for more than 6 months.

Resources to educate parents regarding value of breast feeding, to support the mother’s decision process, and to provide expert consultation if problems arise can be found in most communities in prenatal care and WIC programs, and other breast-feeding groups such as La Leche League.