
Santa Clara County
Child and Adolescent
Needs and Strengths –
Early Childhood
(SCC CANS-EC 3.0)

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GUIDE

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A large number of individuals have collaborated in the development of the Child and Adolescent Needs and Strengths. Along with the CANS versions for developmental disabilities, juvenile justice, and child welfare, this information integration tool is designed to support individual case planning and the planning and evaluation of service systems. The CANS is an open domain tool for use in multiple child-serving systems that address the needs and strengths of children, adolescents, and their families. The copyright is held by the Praed Foundation to ensure that it remains free to use. Training and annual certification are expected for appropriate use.

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INTRODUCTION

THE CANS

The CANS is a multiple purpose information integration tool that is designed to be the output of an assessment process. The purpose of the CANS is to accurately represent the shared vision of the child serving system—children, adolescents, and families. As such, completion of the CANS is accomplished in order to allow for the effective communication of this shared vision for use at all levels of the system. Since its primary purpose is communication, the CANS is designed based on communication theory rather than using psychometric theories that have influenced most measurement development. There are six key principles of a communimetric measure that apply to understanding the CANS.

SIX KEY PRINCIPLES OF THE CANS

- 1. Items were selected because they are each relevant to service/treatment planning.** An item exists because it might lead you down a different pathway in terms of planning actions.
- 2. Each item uses a 4-level rating system designed to translate immediately into action levels.** Different action levels exist for needs and strengths. For a description of these action levels please see below.
- 3. Rating should describe the child, not the child in services.** If an intervention is present that is masking a need but must stay in place, this should be factored into the rating consideration and would result in a rating of an “actionable” need (i.e. ‘2’ or ‘3’).
- 4. Culture and development should be considered prior to establishing the action levels.** Cultural sensitivity involves considering whether cultural factors are influencing the expression of needs and strengths. Ratings should be completed considering the child’s developmental and/or chronological age depending on the item. In other words, anger control is not relevant for a very young child but would be for an older children or adolescents regardless of developmental age. Alternatively, school achievement should be considered within the framework of expectations based on the child’s developmental age.
- 5. It is about the “what” not the “why.”** The ratings are generally “agnostic as to etiology.” In other words this is a descriptive tool. Only two items, Adjustment to Trauma and Intentional Misbehavior, has any cause-effect judgments.
- 6. A 30-day window is used for ratings in order to make sure assessments stay relevant to the child’s present circumstances.** However, the action levels can be used to over-ride the 30-day rating period.

HISTORY AND BACKGROUND OF THE CANS

The Child and Adolescent Needs and Strengths is a multi-purpose tool developed to support care planning and level of care decision-making, to facilitate quality improvement initiatives, and to allow for the monitoring of outcomes of services. The CANS was developed from a communication perspective in order to facilitate the linkage between the assessment process and the design of individualized service plans including the application of evidence-based practices.

The CANS gathers information on the child’s and parents/caregivers’ needs and strengths. Strengths are the child’s assets: areas in life where he or she is doing well or has an interest or ability. Needs are areas where a child requires help or serious intervention. Care providers use an assessment process to get to know the child and families with whom they work and to understand their strengths and needs. The CANS helps care providers decide which of a child’s needs are the most important to address in a treatment or service planning. The CANS also helps identify strengths, which can be the basis of a treatment or service plan. By working with the child and family during the assessment process and talking together about the CANS, care providers can develop a treatment or service plan that addresses a child’s strengths and needs while building strong engagement.

The CANS is made up of domains that focus on various areas in a child’s life, and each domain is made up of a group of specific items. There are domains that address how the child functions in everyday life, on specific emotional or behavioral concerns, on risk behaviors, on strengths and on skills needed to grow and develop. There is also a domain

that asks about the family's beliefs and preferences, and about general family concerns. The provider gives a number rating to each of these items. These ratings help the provider, child and family understand where intensive or immediate action is most needed, and also where a child has assets that could be a major part of the treatment or service plan.

The CANS ratings, however, do not tell the whole story of a child's strengths and needs. Each section in the CANS is merely the output of a comprehensive assessment process and is documented alongside narratives where a care provider can provide more information about the child.

HISTORY

The Child and Adolescent Needs and Strengths grew out of John Lyons' work in modeling decision-making for psychiatric services. To assess appropriate use of psychiatric hospitals and residential treatment services, the Childhood Severity of Psychiatric Illness (CSPI) tool was created. This measure assesses those dimensions crucial to good clinical decision-making for intensive mental health service interventions and was the foundation of the CANS. The CSPI tool demonstrated its utility in informing decision-making for residential treatment (Lyons, Mintzer, Kisiel, & Shallcross, 1998) and for quality improvement in crisis assessment services (Lyons, Kisiel, Dulcan, Chesler & Cohen, 1997; Leon, Uziel-miller, Lyons, Tracy, 1998). The strength of this measurement approach has been that it is face valid and easy to use, yet provides comprehensive information regarding clinical status.

The CANS assessment builds upon the methodological approach of the CSPI, but expands the assessment to include a broader conceptualization of needs and an assessment of strengths – both of the child and the parent/ caregiver, looking primarily at the 30-day period prior to completion of the CANS. It is a tool developed with the primary objective of supporting decision making at all levels of care: children, adolescents, and families, programs and agencies, and child-serving systems. It provides for a structured communication and critical thinking about the child and their context. The CANS is designed for use either as a prospective assessment tool for decision support and recovery planning or as a retrospective quality improvement device demonstrating an individual child's progress. It can also be used as a communication tool that provides a common language for all child-serving entities to discuss the child's needs and strengths. A review of the case record in light of the CANS assessment tool will provide information as to the appropriateness of the recovery plan and whether individual goals and outcomes are achieved.

Annual training and certification is required for providers who administer the CANS and their supervisors. Additional training is available for CANS super users as experts of CANS assessment administration, scoring, and use in the development of service or recovery plans.

MEASUREMENT PROPERTIES

Reliability

Strong evidence from multiple reliability studies indicates that the CANS can be completed reliably by individuals working with children and families. A number of individuals from different backgrounds have been trained and certified to use the CANS assessment reliably including health and mental health providers, child welfare case workers, probation officers, and family advocates. With approved training, anyone with a bachelor's degree can learn to complete the tool reliably, although some applications or more complex versions of the CANS require a higher educational degree or relevant experience. The average reliability of the CANS is 0.78 with vignettes across a sample of more than 80,000 trainees. The reliability is higher (0.84) with case records, and can be above 0.90 with live cases (Lyons, 2009). The CANS is auditable and audit reliabilities demonstrate that the CANS is reliable at the item level (Anderson et al., 2002). Training and certification with a reliability of at least 0.70 on a test case vignette is required for ethical use. In most jurisdictions, re-certification is annual. A full discussion on the reliability of the CANS assessment is found in Lyons (2009) *Communimetrics: a Communication Theory of Measurement in Human Service Settings*.

Validity

Studies have demonstrated the CANS' validity, or its ability to measure children's and their caregiver's needs and strengths. In a sample of more than 1,700 cases in 15 different program types across New York State, the total scores on the relevant dimensions of the CANS-Mental Health retrospectively distinguished level of care (Lyons, 2004). The CANS assessment has also been used to distinguish needs of children in urban and rural settings (Anderson & Estle,

2001). In numerous jurisdictions, the CANS has been used to predict service utilization and costs, and to evaluate outcomes of clinical interventions and programs (Lyons, 2004; Lyons & Weiner, 2009; Lyons, 2009). Five independent research groups in four states have demonstrated the reliability and validity of decision support algorithms using the CANS (Chor, et al, 2012, 2013, 2014; Cordell, et al, 2016; Epstein, et al, 2015; Israel, et al, 2015; Lardner, 2015).

DEVELOPMENT OF THE CANS-EARLY CHILDHOOD

The CANS-EC was adapted from a version of the CANS designed for children from birth to four years old (CANS: 0-4). The CANS-EC was developed to assist in the management and planning of services for children from birth until eight years old to achieve permanency, inclusion, and healthy development. It incorporates commonly used clinical and diagnostic markers from the fields of psychology and pediatrics. Thus, for example, the measure's psychological items are based on the Diagnostic and Statistical Manual-5, as well as on the Diagnostic Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood (DC: 0-5). The items, anchor descriptions and prompt questions used in the CANS-EC were developed by workgroups comprised of a variety of participants including families, family advocates, and representatives of the provider community.

PURPOSE OF THE CANS-EC

The CANS-EC is designed to be used either as a prospective information integration tool for decision support during the process of planning services or as a retrospective decision support tool based on the review of existing information for use in the design of high quality systems of services. This flexibility allows for a variety of innovative applications.

As a **prospective information integration tool**, the CANS-EC provides a structured profile of a child and family along a set of dimensions relevant to service decision-making. The CANS-EC provides information regarding the service needs of the child and their family for use during the development of the individual plan of care. *The primary purpose of the CANS: EC is to help service coordinators work with families to develop a strengths-based service plan.*

As a **retrospective decision support tool**, the CANS-EC provides an assessment of the children currently in care and the functioning of the current system in relation to the needs and strengths of the child and family. It clearly points out "service gaps" in the current services system. This information can then be used to design and develop the community-based, family-focused system of care appropriate for the target population and the community. Retrospective review of prospectively completed CANS-EC allows for a form of measurement audit to facilitate the reliability and accuracy of information (Lyons, Yeh, Leon, Uziel-Miller & Tracy, 1999).

In addition, service coordinators and supervisors can use the CANS-EC as a quality assurance/monitoring device. A review of the case record in light of the CANS-EC tool will provide information as to the appropriateness of the individual plan of care and whether individual goals and outcomes are achieved.

RATING NEEDS & STRENGTHS

The CANS-EC is easy to learn and is well liked by children and families, providers and other partners in the services system because it is easy to understand and does not necessarily require scoring in order to be meaningful to the child and family.

- Basic core items – grouped by domain - are rated for all individuals.
- A rating of '1', '2' or '3' on key core questions triggers extension modules.
- Individual assessment module questions provide additional information in a specific area.

Each CANS-EC rating suggests different pathways for service planning. There are four levels of rating for each item with specific anchored definitions. These item-level descriptions, however, are designed to translate into the following action levels (separate for needs and strengths):

Basic design for rating Needs

Rating	Level of need	Appropriate action
0	No evidence of need	No action needed
1	Significant history or possible need that is not interfering with functioning	Watchful waiting/prevention/additional assessment
2	Need interferes with functioning	Action/intervention required
3	Need is dangerous or disabling	Immediate action/intensive action required

Basic design for rating Strengths

Rating	Level of strength	Appropriate action
0	Centerpiece strength	Central to planning
1	Strength present	Useful in planning
2	Identified strength	Build or develop strength
3	No strength identified	Strength creation or identification may be indicated

The rating of 'N/A' for 'not applicable' is available for a few items under specified circumstances (see reference guide descriptions). For those items where the 'N/A' rating is available, it should be used only in the rare instances where an item does not apply to that particular child. To complete the CANS-EC, a CANS-EC-trained and certified care coordinator, case worker, clinician, or other care provider should read the anchor descriptions for each item and then record the appropriate rating on the CANS-EC form (or electronic record).

Remember that the item anchor descriptions are examples of circumstances which fit each rating ('0', '1', '2', or '3'). The descriptions, however, are not inclusive. The rater must consider the basic meaning of each level to determine the appropriate rating on an item for an individual.

As a quality improvement activity, a number of settings have utilized a fidelity model approach to look at service/treatment/action planning based on the CANS assessment. A rating of '2' or '3' on a CANS-EC need suggests that this area must be addressed in the service or treatment plan. A rating of a '0' or '1' identifies a strength that can be used for strength-based planning and a '2' or '3' a strength that should be the focus of strength-building activities. It is important to remember that when developing service and treatment plans for healthy child trajectories, balancing the plan to address risk behaviors/needs and protective factors/strengths is key. It has been demonstrated in the literature that strategies designed to develop child capabilities are a promising means for development, and play a role in reducing risky behaviors.

Finally, the CANS can be used to monitor outcomes. This can be accomplished in two ways. First, CANS items that are initially rated a '2' or '3' are monitored over time to determine the percentage of individuals who move to a rating of '0' or '1' (resolved need, built strength). Dimension scores can also be generated by summing items within each of the domains (Behavioral/Emotional Needs, Risk Behaviors, Life Functioning, etc.). These scores can be compared over the course of treatment. CANS dimension/domain scores have been shown to be valid outcome measures in residential treatment, intensive community treatment, foster care and treatment foster care, community mental health, and juvenile justice programs.

The CANS is an open domain tool that is free for anyone to use with training and certification. There is a community of people who use the various versions of the CANS and share experiences, additional items, and supplementary tools.

THE USE OF THE CANS-EC IN SANTA CLARA COUNTY

The CANS is used in many ways to transform the lives of children and their families and to improve our programs. Hopefully, this guide will help you to use the CANS-EC as a multi-purpose tool.

In Santa Clara County, the CANS-EC should be administered within 14 days of the family's enrollment into the System of Care Initiative (SOCl) and every six months thereafter while the family is enrolled in the program. It should also be administered upon disenrollment. The primary provider will complete the CANS-EC for clients whose program admit date is prior to their 6th birthday. Please note the following:

- The primary provider will continue to review and update the CANS-EC version until the program discharge date, even if the client turns age 6 prior to the program discharge date.
- In the event the primary provide continues beyond the client's 8th birthday, the CANS 5+ version will be used for subsequent measures.

IT IS AN ASSESSMENT STRATEGY

The CANS-EC is designed to facilitate a conversation with the family. Although there is important information that needs to be gathered and recorded during this conversation, please keep in mind that the CANS-EC is not a "form" to be completed, but the reflection of a story that needs to be heard.

When initially meeting clients and their caregivers, this guide can be helpful in ensuring that all the information required is gathered. Most items include "questions to consider" which may be useful when asking about needs and strengths. These are not questions that must be asked, but are available as suggestions. Many clinicians have found this useful during initial sessions either in person or over the phone (if there are follow up sessions required) to get a full picture of needs before treatment or service planning and beginning therapy or other services.

As an information integration tool, the CANS-EC assumes that the ratings represent multiple sources of information (e.g., child and family, referral source, treatment providers, school, and observation of the rater). At the time of the initial interview with you, families may have just gone through other assessment processes. Be sure to review these assessment materials, if possible, and to integrate the relevant information into the initial CANS-EC.

As a strength-based approach, the CANS-EC supports the belief that children and families have unique talents, skills, and life events, in addition to specific unmet needs. Strength-based approaches to assessment and service or treatment planning focus on collaborating with children and their families to discover individual and family functioning and strengths. Failure to demonstrate a child's skill should first be viewed as an opportunity to learn the skill as opposed to the problem. Focusing on the child's strengths instead of weaknesses with their families may result in enhanced motivation and improved performance. Involving the family and child in the rating process and obtaining information (evidence) from multiple sources is necessary and improves the accuracy of the rating.

IT GUIDES CARE AND TREATMENT/SERVICE PLANNING

When an item on the CANS-EC is rated a '2' or '3' ('action needed' or 'immediate action needed') we are indicating not only that it is a serious need for our client, but one that we are going to attempt to work on during the course of our treatment. As such, when you write your treatment plan, you should do your best to address any needs, impacts on functioning, or risk factors that you rate as a '2' or higher in that document.

IT FACILITATES OUTCOMES MEASUREMENT

The CANS-EC is completed every 6 months to measure change and transformation. We work with children, adolescents, and families, and their needs tend to change over time. Needs may change in response to many factors including quality clinical support provided. One way we determine how our supports are helping to alleviate suffering and restore functioning is by re-assessing needs, adjusting treatment or service plans, and tracking change.

IT IS A COMMUNICATION TOOL

When a client leaves a treatment programs, a closing CANS-EC defines progress, measures ongoing needs and helps us make continuity of care decisions. Doing a closing CANS-EC, much like a discharge summary, integrated with CANS-EC ratings, provides a picture of how much progress has been made, and allows for recommendations for future care

which ties to current needs. And finally, it allows for a shared language to talk about our child and creates opportunities for collaboration. It is our hope that this guide will help you to make the most out of the CANS-EC and guide you in filling it out in an accurate way that helps you make good clinical decisions.

CANS-EC: A BEHAVIOR HEALTH CARE STRATEGY

The CANS-EC is an excellent strategy in addressing a child’s behavioral health care. As it is meant to be an outcome of an assessment, it can be used to organize and integrate the information gathered from clinical interviews, records reviews, and information from screening tools and other measures.

It is a good idea to know the CANS-EC and use the domains and items to help with your assessment process and information gathering sessions/clinical interviews with the child and family. This will not only help the organization of your interviews, but will make the interview more conversational if you are not reading from a form. A conversation is more likely to give you good information, so have a general idea of the items. The CANS domains can be a good way to think about capturing information. You can start your assessment with any of the sections—Life Functioning Domain or Challenges, Risk Behaviors or Child Strengths, or Caregiver Needs & Resources—this is your judgment call. Sometimes, people need to talk about needs before they can acknowledge strengths. Sometimes, after talking about strengths, then they can better explain the needs. Trust your judgment, and when in doubt, always ask, “We can start by talking about what you feel that you and your child need, or we can start by talking about the things that are going well and that you want to build on. Do you have a preference?”

Some people may “take off” on a topic. Being familiar with the CANS-EC items can help in having more natural conversations. So, if the family is talking about situations around the child’s anger control and then shift into something like---“you know, he only gets angry when he is in Mr. S’s classroom,” you can follow that and ask some questions about situational anger, and then explore.

MAKING THE BEST USE OF THE CANS

Children have families involved in their lives, and their family can be a great asset to their treatment. To increase family involvement and understanding, it is important to talk to them about the assessment process and describe the CANS-EC and how it will be used. The description of the CANS-EC should include teaching the child and family about the needs and strengths rating scales, identifying the domains and items, as well as how the actionable items will be used in treatment or service planning. When possible, share with the child and family the CANS-EC domains and items (see the CANS-EC core item list on page 13) and encourage the family to look over the items prior to your meeting with them. The best time to do this is your decision—you will have a sense of the timing as you work with each family. Families often feel respected as partners when they are prepared for a meeting or a process. A copy of the completed CANS-EC ratings should be reviewed with each family. Encourage families to contact you if they wish to change their answers in any area that they feel needs more or less emphasis.

GIVE AN OVERVIEW

Most people like to have a little overview of what will happen in the time you spend together and why you will be working together—in other words, what will come out of your time together. So, a simple statement like this would be a good way to start:

“We’ve been spending some time together talking about (child’s name) and now I’d like us to organize or fit this information together in a way that will help us to come up with a plan that meets the needs of your child and family, and also builds on (child’s name)’s strong points. We’re going to do this together by using something called the Child and Adolescent Needs and Strengths (we sometimes call it the CANS-EC). You may have looked through this already. The CANS-EC will help us gather information about areas where you would like some help, as well as areas that are a source of strength for you and your child. Both the strengths and the needs will be important as we work together to develop a plan for your child. It may take us about 45 minutes. I’ll give you a copy so that you can follow along or we can just look at my copy together.”

Sometimes the CANS-EC will just happen organically. That is, you will have a “CANS moment”—a time when it just makes sense to start it. That’s great, and sometimes the best exchange of information happens when it is unplanned.

However, before you whip out the CANS-EC and sharpen your pencil, be sure to ask the parent, or do a little introduction:

“You know what, this is really great information and I’d like us to start writing it down. I’d like to show you something. This is the CANS-EC...”

LISTENING USING THE CANS-EC

Listening is the most important skill that you bring to working with the CANS-EC. Everyone has an individual style of listening. The better you are at listening, the better the information you will receive. Some things to keep in mind that make you a better listener and that will give you the best information:

- **Use nonverbal and minimal verbal prompts.** Head nodding, smiling and brief “yes,” “and”—things that encourage people to continue.
- **Be nonjudgmental and avoid giving person advice.** You may find yourself thinking “If I were this person, I would do x” or “That’s just like my situation, and I did “x.” But since you are not that person, what you would do is not particularly relevant. Avoid making judgmental statements or telling them what you would do. It’s not really about you.
- **Be empathic.** Empathy is being warm and supportive. It is the understanding of another person from their point of reference and acknowledging feelings. You demonstrate empathetic listening when you smile, nod, maintain eye contact. You also demonstrate empathetic listening when you follow the person’s lead and acknowledge when something may be difficult, or when something is great. You demonstrate empathy when you summarize information correctly. All of this demonstrates to the child that you are with him/her.
- **Be comfortable with silence.** Some people need a little time to get their thoughts together. Sometimes, they struggle with finding the right words. Maybe they are deciding how they want to respond to a question. If you are concerned that the silence means something else, you can always ask “Does that make sense to you?” Or “Do you need me to explain that in another way?”
- **Paraphrase and clarify—avoid interpreting.** Interpretation is when you go beyond the information given and infer something—in a person’s unconscious motivations, personality, etc. The CANS is not a tool to come up with causes. Instead, it identifies things that need to be acted upon. Rather than talk about causation, focus on paraphrasing and clarifying. Paraphrasing is restating a message very clearly in a different form, using different words. A paraphrase helps you to (1) find out if you really have understood an answer; (2) clarify what was said, sometimes making things clearer; and (3) demonstrate empathy. For example, you ask the questions about health, and the person you are talking to gives a long description. You paraphrase by saying “OK, it sounds like . . . is that right? Would you say that is something that you feel needs to be watched, or is help needed?”

REDIRECT THE CONVERSATION TO PARENTS’/CAREGIVERS’ OWN FEELINGS AND OBSERVATIONS

Often, people will make comments about other people’s observations such as “Well, my mother thinks that his behavior is really obnoxious.” It is important to redirect people to talk about their observations: “So your mother feels that when he does x that is obnoxious. What do YOU think?” The CANS is a tool to organize all points of observation, but the parent or caregiver’s perspective can be the most critical. Once you have their perspective, you can then work on organizing and coalescing the other points of view.

ACKNOWLEDGE FEELINGS

People will be talking about difficult things and it is important to acknowledge that. Simple acknowledgement such as “I hear you saying that it can be difficult when ...” demonstrates empathy.

WRAPPING IT UP

At the end of the assessment, we recommend the use of two open-ended questions. These questions ask if there are any past experiences that people want to share that might be of benefit to planning for their young person, and if there is anything that they would like to add. This is a good time to see if there is anything “left over”—feelings or thoughts that they would like to share with you.

Take time to summarize with the individual and family those areas of strengths and of needs. Help them to get a “total picture” of the individual and family, and offer them the opportunity to change any ratings.

Take a few minutes to talk about what the next steps will be. Now you have information organized into a framework that moves into the next stage—planning.

So you might close with a statement such as: “OK, now the next step is a “brainstorm” where we take this information that we’ve organized and start writing a plan—it is now much clearer which needs must be met and what we can build on. So let’s start. . .”

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SCC CANS-EC BASIC STRUCTURE

The Santa Clara County Child and Adolescent Needs and Strengths – Early Childhood basic core items are noted below.

CORE ITEMS

Potentially Traumatic/Adverse

Childhood Experiences

Sexual Abuse
Physical Abuse
Emotional Abuse
Neglect
Medical Trauma
Witness to Family Violence
Witness to Community/Schl Viol.
Natural or Manmade Disaster
War/Terrorism Affected
Victim/Witness to Criminal Act.
Disrupt. in Caregiving/Attch Losses
Parental Criminal Behaviors

Child Strengths

Family Strengths
Extended Family Relationships
Interpersonal
Natural Supports
Relationship Permanence
Curiosity
Playfulness
Creativity/Imagination
Talents and Interests
Resiliency (Persist. & Adaptability)
Family Spiritual/Religious
Self Esteem/Self Confidence

Life Functioning

Motor
Sensory
Developmental/Intellectual
Communication
Medical/Physical
Family Functioning
Social and Emotional Functioning
Self-Care/Daily Living Skills
Parent/Child Interaction
Early Education
Intentional Misbehavior

Challenges

Impulsivity/Hyperactivity
Depression
Anxiety
Oppositional
Attachment Difficulties
Adjustment to Trauma
Regulatory
Atypical Behaviors
Sleep
Aggression
Attention
Current Environmental Stressors

Risk Behaviors & Factors

Self-Harm (12 months and older)
Exploited
Prenatal Care
Exposure
Labor and Delivery
Birth Weight
Failure to Thrive

Care Intensity and Organization

Service Intensity
Funding/Eligibility
Transportation
Service Permanence
Service Coordination
Service Access/Availability
Cultural Appropriateness of Services

Caregiver Resources & Needs Domain

Supervision
Involvement with Care
Knowledge
Organization
Financial Resources
Social Resources
Residential Stability
Cultural Diversity
Employment
Educational Attainment
Medical/Physical
Mental Health
Substance Use
Developmental
Safety
Family Relationship to the System
Legal Involvement

Dyadic Considerations

Caregiver Emotional Responsiveness
Caregiver Adj. to Trauma Experiences

Cultural Factors - Family

Language
Cultural Identity
Traditions and Rituals
Cultural Stress
Cultural Differences

Parent-Child Rel. Competency

Adjustment to Trauma
Safety, Protection, Comfort
Separation

POTENTIALLY TRAUMATIC / ADVERSE CHILDHOOD EXPERIENCES

All of the potentially traumatic/adverse childhood experiences items are static indicators. In other words, these items indicate whether or not a child has experienced a particular trauma. If the child has ever had one of these experiences it would always be rated in this section, even if the experience was not currently causing problems or distress in the child’s life. Thus, these items are not expected to change except in the case that the child has a new trauma experience or a historical trauma is identified that was not previously known.

Question to Consider for this Module: Has the child experienced adverse life events that may impact his/her behavior?

Rate these items within the child’s lifetime.

For the Potentially Traumatic/Adverse Childhood Experiences, the following categories and descriptions are used:

- No No evidence of any trauma of this type.
- Yes Child has had experience, or there is suspicion that the child has experienced this type of trauma—one incident, multiple incidents, or chronic, on-going experiences.

SEXUAL ABUSE

This item describes whether or not the child has experienced sexual abuse.

Questions to Consider

- Has the caregiver or child disclosed sexual abuse?
- Is there suspicion or evidence that the child has been sexually abused?

Ratings and Descriptions

- No There is no evidence that the child has experienced sexual abuse.
- Yes Child has experienced sexual abuse, or there is a suspicion that they have experienced sexual abuse – including single or multiple episodes, or chronic over an extended period of time. The abuse may have involved penetration, multiple perpetrators, and/or associated physical injury. Child with exposure to secondary sexual abuse (e.g., witnessing sexual abuse, having a sibling sexually abused) should be rated here.

PHYSICAL ABUSE

This item describes whether or not the child has experienced physical abuse.

Questions to Consider

- Is physical discipline used in the home? What forms?
- Has the child ever received bruises, marks, or injury from discipline?

Ratings and Descriptions

- No There is no evidence that the child has experienced physical abuse.
- Yes Child has experienced or there is a suspicion that they experienced physical abuse – mild to severe, or repeated physical abuse with sufficient physical harm requiring medical treatment.

EMOTIONAL ABUSE

This item describes whether or not the child has experienced verbal and/or nonverbal emotional abuse, including belittling, shaming, and humiliating a child, calling names, making negative comparisons to others, or telling a child that they are, “no good.” This item includes both “emotional abuse,” which would include psychological maltreatment such as insults or humiliation towards a child and “emotional neglect,” described as the denial of emotional attention and/or support from caregivers.

Questions to Consider

- How does the caregiver talk to/interact with the child?
- Is there name calling or shaming in the home?

Ratings and Descriptions

- No There is no evidence that child has experienced emotional abuse.
-
- Yes Child has experienced emotional abuse, or there is a suspicion that they have experienced emotional abuse (mild to severe, for any length of time) including: insults or occasionally being referred to in a derogatory manner by caregivers, being denied emotional attention or completely ignored, or threatened/terrorized by others.

NEGLECT

This rating describes whether or not the child has experienced neglect. Neglect can refer to a lack of food, shelter or supervision (physical neglect), lack of access to needed medical care (medical neglect), or failure to receive academic instruction (educational neglect).

Questions to Consider

- Is the child receiving adequate supervision?
- Are the child’s basic needs for food and shelter being met?
- Is the child allowed access to necessary medical care? Education?

Ratings and Descriptions

- No There is no evidence that the child has experienced neglect.
-
- Yes Child has experienced neglect, or there is a suspicion that they experienced neglect. This includes occasional neglect (e.g., occasional failure to provide adequate supervision of the child); multiple and/or prolonged absences of adults, with minimal supervision; or failure to provide basic necessities of life (adequate food, shelter, or clothing) on a regular basis.

MEDICAL TRAUMA

This item describes whether or not the child has experienced medically-related trauma, resulting from, for example, inpatient hospitalizations, outpatient procedures, and significant injuries.

Questions to Consider

- Has the child had any broken bones, stitches or other medical procedures?
- Has the child had to go to the emergency room, or stay overnight in the hospital?

Ratings and Descriptions

- No There is no evidence that the child has experienced any medical trauma.
-
- Yes Child has had a medical experience that was perceived as emotionally or mentally overwhelming. This includes events that were acute in nature and did not result in ongoing medical needs; associated distress such as minor surgery, stitches or bone setting; acute injuries and moderately invasive medical procedures such as major surgery that required only short term hospitalization; events that may have been life threatening and may have resulted in chronic health problems that alter the child’s physical functioning. A suspicion that a child has had a medical experience that was perceived as emotionally or mentally overwhelming should be rated here.

Supplemental Information: This item takes into account the impact of the event on the child. It describes experiences in which the child is subjected to medical procedures that are experienced as upsetting and overwhelming. A child born with physical deformities who is subjected to multiple surgeries could be included. A child/ who must experience chemotherapy or radiation could also be included. Children/ who experience an accident and require immediate medical intervention that results in on-going physical limitations or deformities (e.g., burn victims) could be included here. Common medical procedures, which are generally not welcome or pleasant but are also not emotionally or psychologically overwhelming for children (e.g., shots, pills) would generally not be rated here.

WITNESS TO FAMILY VIOLENCE

This item describes exposure to violence within the child's home or family.

	Ratings and Descriptions
Questions to Consider	
<ul style="list-style-type: none">Is there frequent fighting in the child's family?Does the fighting ever become physical?	<p>No There is no evidence the child/ has witnessed family violence.</p> <hr/> <p>Yes Child/ has witnessed, or there is a suspicion that they witnessed family violence – single, repeated, or severe episodes. This includes episodes of family violence but no significant injuries (i.e. requiring emergency medical attention) and episodes in which significant injuries have occurred as a direct result of the violence.</p>

WITNESS TO COMMUNITY/SCHOOL VIOLENCE

This item describes the exposure to incidents of violence the child has witnessed or experienced in his/her community. This includes witnessing violence at the child's school or educational setting.

	Ratings and Descriptions
Questions to Consider	
<ul style="list-style-type: none">Does the child live in a neighborhood with frequent violence?Has the child witnessed or directly experienced violence at his/her school?	<p>No There is no evidence that the child has witnessed violence in their community or school.</p> <hr/> <p>Yes Child has witnessed or experienced violence in their community or school, such as: fighting; friends/family injuries as a result of violence; severe and repeated instances of violence and/or the death of another person in their community/school as a result of violence; is the direct victim of violence/criminal activity in the community/school that was life threatening; or has experienced chronic/ongoing impact as a result of community/school violence (e.g., family member injured and no longer able to work). A suspicion that the child has witnessed or experienced violence in the community would be rated here.</p>

NATURAL OR MANMADE DISASTER

This item describes the child's exposure to either natural or manmade disasters.

	Ratings and Descriptions
Questions to Consider	
<ul style="list-style-type: none">Has the child been present during a natural or manmade disaster?Does the child watch television shows containing these themes or overhear adults talking about these kinds of disasters?	<p>No There is no evidence that the child has experienced, been exposed to or witnessed natural or manmade disasters.</p> <hr/> <p>Yes Child has experienced, been exposed to or witnessed natural or manmade disasters either directly or second-hand (e.g., on television, hearing others discuss disasters). This includes disasters such as a fire or earthquake or manmade disaster; car accident, plane crashes, or bombings; observing a caregiver who has been injured in a car accident or fire or watching a neighbor's house burn down; a disaster that caused significant harm or death to a loved one; or there is an ongoing impact or life disruption due to the disaster (e.g. caregiver loses job). A suspicion that the child has experienced, been exposed to or witnessed natural or manmade disasters either directly or second-hand would be rated here.</p>

WAR/TERRORISM AFFECTED

This item describes the child's exposure to war, political violence, torture or terrorism.

Questions to Consider	Ratings and Descriptions
<ul style="list-style-type: none">• Has the child or their family lived in a war torn region?• How close were they to war or political violence, torture or terrorism?• Was the family displaced?	No No evidence that the child has been exposed to war, political violence, torture or terrorism.
	Yes Child has experienced, or there is suspicion that they experienced or been affected by war, terrorism or political violence. Examples include: Family members directly related to the child may have been exposed to war, political violence, or torture resulting in displacement, injury or disability, or death; parents may have been physically or psychologically disabled from the war and are unable to adequately care for the child; child may have spent an extended amount of time in a refugee camp, or feared for their own life during war or terrorism due to bombings or shelling very near to them; child may have been directly injured, tortured, or kidnapped in a terrorist attack; child may have served as a soldier, guerrilla, or other combatant in their home country. Also included is a child who did not live in war or terrorism-affected region or refugee camp, but whose family was affected by war.

Supplemental Information: Terrorism is defined as “the calculated use of violence or the threat of violence to inculcate fear, intended to coerce or to intimidate governments or societies in the pursuit of goals that are generally political, religious or ideological.” Terrorism includes attacks by individuals acting in isolation (e.g. sniper attacks).

VICTIM/WITNESS TO CRIMINAL ACTIVITY

This item describes the child's exposure to criminal activity. Criminal behavior includes any behavior for which an adult could go to prison including drug dealing, prostitution, assault, or battery.

Questions to Consider	Ratings and Descriptions
<ul style="list-style-type: none">• Has the child or someone in their family ever been the victim of a crime?• Has the child seen criminal activity in the community or home?	No There is no evidence that the child has been victim of or a witness to criminal activity.
	Yes Child has been victimized, or there is suspicion that they have been victimized or has witnessed criminal activity. This includes a single instance, multiple instances, or chronic and severe instances of criminal activity that was life threatening or caused significant physical harm, or child has witnessed the death of a family friend or loved one.

Supplemental Information: Any behavior that could result in incarceration is considered criminal activity. A child who has been sexually abused or witnesses a sibling being sexually abused or physically abused to the extent that assault charges could be filed would be rated here and on the appropriate abuse-specific items. A child who has witnessed drug dealing, prostitution, assault or battery would also be rated on this item.

DISRUPTIONS IN CAREGIVING/ATTACHMENT LOSSES

This item documents the extent to which a child has had one or more major changes in caregivers, potentially resulting in disruptions in attachment.

Questions to Consider	Ratings and Descriptions
<ul style="list-style-type: none">• Has the child ever lived apart from their caregivers?• What happened that resulted in the child living apart from their caregivers?	No There is no evidence that the child has experienced disruptions in caregiving and/or attachment losses.
	Yes Child has been exposed to, or there is suspicion that they were exposed to, at least one disruption in caregiving with familiar alternative caregivers or unknown caregivers (this includes placement in foster or other out-of-home care such as residential care facilities). Child may or may not have had ongoing contact with primary attachment figure(s) during this disruption. Shift in caregiving may have been temporary or permanent.

Supplemental Information: Children who have been exposed to disruptions in caregiving involving separation from primary attachment figure(s) and/or attachment losses would be rated here. Children who have had placement changes, including stays in foster care, residential treatment facilities or juvenile justice settings, can be rated here. Short-term hospital stays or brief juvenile detention stays, during which the child's caregiver remains the same, would not be rated on this item.

PARENTAL CRIMINAL BEHAVIORS

This item describes the criminal behavior of both biological and step parents, and other legal guardians, but not foster parents.

Questions to Consider

- Has the child's parent/guardian or family been involved in criminal activities or ever been in jail?

Ratings and Descriptions

- No There is no evidence that child's parents have ever engaged in criminal behavior.
-
- Yes One or both of the child's parents/guardians have a history of criminal behavior that resulted in a conviction or incarceration. A suspicion that one or both of the child's parents/guardians have a history of criminal behavior that resulted in conviction or incarceration would be rated here.

CHILD STRENGTHS

This domain focuses on the attributes, traits, talents and skills of the child that can be useful in developing a strength-based treatment plan. Within a Systems of Care approach identifying strengths is considered an essential part of the process (Miles, P., Burns, E.J., Osher, T.W., Walker, J.S., 2006). A focus on strengths that both the child and the family have to offer allows for a climate of hope and optimism and has been proven to engage families at a higher level. Strength-based assessment has been defined as, “the measurement of those emotional and behavioral skills, competencies, and characteristics that create a sense of personal accomplishment; contribute to satisfying relationships with family members, peers, and adults; enhance one’s ability to deal with adversity and stress; and promote one’s personal, social, and academic development” (Epstein & Sharma, 1998, p.3). The benefits of a strength-based assessment include involving parents and children in a service planning experience that builds on what a child and family are doing well, facilitates positive expectations for the child, and empowers family members to take responsibility for the decisions that will affect their child (Johnson & Friedman, 1991; Saleebey, 1992).

As you complete this domain, it is important to remember that strengths are NOT the opposite of needs. Increasing a child’s strengths while also addressing his or her behavioral/emotional needs leads to better functioning, and better outcomes, than does focusing just on the child’s needs. Identifying areas where strengths can be built is a significant element of service planning. In these items the ‘best’ assets and resources available to the child are rated based on how accessible and useful those strengths are. These are the only items that use the Strength Rating Scale with action levels.

Question to Consider for this Domain: What child strengths can be used to support a need? Is this an area that the child would like some help to develop?

For the **Strengths Domain**, the following categories and action levels are used:

- 0 Well-developed or centerpiece strength; may be used as a protective factor and a centerpiece in an intervention/action plan.
- 1 Identified and useful strength. Strength will be used, maintained or built upon as part of the plan. May require some effort to develop strength into a centerpiece strength.
- 2 Strengths have been identified but require strength building efforts before they can be effectively utilized as part of a plan. Identified by not useful.
- 3 An area in which no current strength is identified; efforts may be recommended to develop a strength in this area.

FAMILY STRENGTHS

This item refers to the presence of a sense of family identity as well as love and communication among family members. Even families who are struggling often have a firm foundation that consists of a positive sense of family and strong underlying love and commitment to each other. These are the constructs this strength is intended to identify. As with Family Functioning, the definition of family comes from the child’s perspective (i.e., who the child describes as their family). If this information is not known, then we recommend a definition of family that includes biological/adoptive relatives and their significant others with whom the child is still in contact.

Questions to Consider	Ratings & Descriptions
<ul style="list-style-type: none"> • How does the child get along with siblings or other children in the household? parents or other adults in the household? • Is the child particularly close to one or more members of the family? 	<p>0 <i>Well-developed or centerpiece strength; may be used as a protective factor and a centerpiece in an intervention/action plan.</i></p> <p>Family has strong relationships and significant family strengths. This level indicates a family with much love and respect for one another. There is at least one family member who has a strong loving relationship with the child and is able to provide significant emotional or concrete support. Child is fully included in family activities.</p>
	<p>1 <i>Identified and useful strength. Strength will be used, maintained or built upon as part of the plan. May require some effort to develop strength into a centerpiece strength..</i></p> <p>Family has some good relationships and good communication. Family members are able to enjoy each other’s company. There is at least one family member who has a strong, loving relationship with the child and is able to provide limited emotional or concrete support. [continues]</p>

FAMILY STRENGTHS continued

- 2 *Strengths have been identified but require strength building efforts before they can be effectively utilized as part of a plan. Identified by not useful.*
Family needs some assistance in developing relationships and/or communications. Family members are known, but currently none are able to provide emotional or concrete support.
- 3 *An area in which no current strength is identified; efforts may be recommended to develop a strength in this area.*
Family needs significant assistance in developing relationships and communications, or child has no identified family. Child is not included in normal family activities.

Supplemental Information: Family relationships first offer a child the experience of safety and security that facilitates a feeling of trust and optimism about the world and others in it. A child learns how to communicate needs, accept support and cope with disappointments and frustrations all within their first relationships. This becomes the model for how a child will typically approach all other relationships with teachers, caregivers, peers and other authority figures. When a child experiences challenges within relationships outside of the home the family relationships serve to assist the child in coping with these challenges and further developing the ability to persist in these challenges. Parents serve this role for the child as well as siblings. Children learn how to interact with peers often by “practicing” these interactions with their siblings. Sibling interactions require the basic skills of sharing, cooperating, compromising and expressing feelings and needs which are critical in peer interaction. Guralnick (1988) studied the outcomes for children in various patterns of family interaction and concluded that positive outcomes for children across several domains of development were more likely when family interactions were positive. Landesman, Jaccard, and Gunderson (1991) replicated this finding as well illustrating how positive family interactions have impact in physical development, emotional development and well being, social development, cognitive development, moral development and cultural development. In the assessment of the nature of family relationships it is important to carefully listen to families’ descriptions of the relationships, encourage dialogue about the relationships as well as observe the relationships. This item is rating the nature of the child’s experience of relationships within his family. This item would be considered a strong area if the child feels positive about his relationships with family and observations support a warm and nurturing relationship. The items further in the assessment, Parent Child Interaction and Attachment, are closely related but there are differentiations. Parent Child Interaction takes into account all interactions that are critical to a healthy parent child relationship. A child may feel positively about their relationship with family although there may be deficits in the quality or nature of interactions. The attachment item also takes into account all functions of the attachment relationship that also are manifested in a child’s ability to develop, explore the world and make sense of relationships.

As indicated earlier the assessment of items takes place within the activities of questioning parents and children (as appropriate to age), observation of the child, observation of the parent, observation of the child/parent dyad, and analysis of information received from chart review and others providing information. Others may include extended family, teachers, clinicians, referral source or alternate caregivers. Along with the suggested questions listed in the manual the following suggestions may help in making the determination of the appropriate rating when questioning parents:

- Be aware of the consistency of parent responses. Do the answers to these questions conflict with other answers or not fit with the family’s narrative?
- Do the answers come with some explanation that can back up their responses. For example, when a parent responds that the relationship with their child is very positive can they explain why.
- Do your observations seem in sync with the parent’s report? If not, this can be explored in a gentle way or just held as information that can help later when rapport is better established.

EXTENDED FAMILY RELATIONSHIPS

This item describes close relationships that the child has with “extended family” members. These may be relatives or close family friends that live outside of the child’s household.

<p>Questions to Consider:</p> <ul style="list-style-type: none"> • Does the child’s extended family play a part in his/her life? • What types of activities does the child and extended family members do together? • How would you describe the importance of these relationships to you and the child? 	<p>Ratings & Descriptions</p> <ul style="list-style-type: none"> 0 <i>Well-developed or centerpiece strength; may be used as a protective factor and a centerpiece in an intervention/action plan.</i> The child has at least one relationship with an extended family member that consistently supports their caregiver and their own development in a positive manner. 1 <i>Identified and useful strength. Strength will be used, maintained or built upon as part of the plan. May require some effort to develop strength into a centerpiece strength..</i> The child experiences an overall positive relationship with an extended family member but the relationship could benefit from having this person provide more support to the caregiver or child. 2 <i>Strengths have been identified but require strength building efforts before they can be effectively utilized as part of a plan. Identified by not useful.</i> A relationship between the child and an extended family member is present and positive at times but needs development to be the basis of a strength-based plan. 3 <i>An area in which no current strength is identified; efforts may be recommended to develop a strength in this area.</i> There is no relationships with extended family members, or there is a relationship but it may be described as detrimental to either the caregiver or the child. [continues]
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EXTENDED FAMILY RELATIONSHIPS continued

Supplemental Information: Extended family relationships can be of tremendous value to a child because of the support that this gives the primary caregiver as well as the child's own valuable experience of a synchronous and positive relationship with another adult figure. The level of support given to caregivers is critical to consider because this can either support or hinder the caregivers' availability to their child. When considering the support that extended family such as grandparents, aunts and uncles may offer the caregivers it is useful to think of the areas that this support includes. Support may include actual services for the caregivers such as babysitting, shopping, transporting, or financial assistance. Caregivers may benefit from advice or information and therefore receive this type of assistance. Often caregivers will rely first and foremost on their own parents or family for the emotional support especially during the post-natal period or transitions. Lastly, parents may use their extended family to serve as role models for them regarding the parenting role (Cochran & Niego, 2002). When making determinations regarding the quality of these types of supports the following considerations should be made: Is the support requested or are the extended family members intrusive or insistent, does the support build up the parents' sense of competence or undermine the evolving identity and abilities as a parent, does the support sabotage the parents decisions or wishes in any way, does the support serve to complement or build up the parent/child relationship rather than compete with it. See table below.

Extended Family Support	Caregiver Benefits from Support
Providing Services	Support is wanted and/or requested
Advice or Information	Support builds caregiver competence
Emotional Support	Support is in line with caregiver values and decisions
Role Models	Support complements caregiver-child relationship

In addition to the support that caregivers experience from extended family the child's own experience of these relationships needs to be considered. The following aspects can be either observed or described by the caregiver or child in making the determination of the benefit of these relationships to the child.

- The child and extended family member spend time together in activities that are pleasurable to the child The child and extended family member describe routines and traditions specific to their relationship
- The child and extended family member characterize appropriate roles and boundaries within their relationship The child is able to accept direction, structure, support and affection from the extended family member; if challenges are present in this area they are not inconsistent with reactions in other relationships and may reflect mental health or overall relationship challenges
- The child's experiences with extended family member do not contradict rules, values or expectations that caregiver considers important The experiences with the extended family member are consistent and predictable

INTERPERSONAL

This item is used to identify a child's social and relationship skills. Interpersonal skills are rated independently of Social Functioning because a child can have social skills but still struggle in his or her relationships at a particular point in time. This strength indicates an ability to make and maintain long-standing relationships.

Questions to Consider	Ratings & Descriptions
<ul style="list-style-type: none"> • How does your child interact with other children and adults? • How does your child do in social settings? 	<p>0 <i>Well-developed or centerpiece strength; may be used as a protective factor and a centerpiece in an intervention/action plan.</i> Significant interpersonal strengths. Child has well-developed interpersonal skills and healthy friendships.</p>
	<p>1 <i>Identified and useful strength. Strength will be used, maintained or built upon as part of the plan. May require some effort to develop strength into a centerpiece strength.</i> Child has good interpersonal skills and has shown the ability to develop healthy friendships.</p>
	<p>2 <i>Strengths have been identified but require strength building efforts before they can be effectively utilized as part of a plan. Identified by not useful.</i> Child requires strength building to learn to develop good interpersonal skills and/or healthy friendships. Child has some social skills that facilitate positive relationships with peers and adults but may not have any current healthy friendships.</p>
	<p>3 <i>An area in which no current strength is identified; efforts may be recommended to develop a strength in this area.</i> There is no evidence of observable interpersonal skills or healthy friendships at this time and/or child requires significant help to learn to develop interpersonal skills and healthy friendships. [continues]</p>

INTERPERSONAL continued

Supplemental Information: The infant/child’s capacity to relate to others in a positive manner is a capacity that can be of great benefit. Children that are perceived by others as pleasant to associate with usually are blessed with a greater number of social interactions as well as longer periods of time in interaction with others. The importance of a child experiencing positive interactions with others has been researched extensively and is now proven in numerous brain development studies. The National Research Council and Institute of Medicine authored a book, *From Neurons to Neighborhoods: the Science of Early Childhood Development* (2000) and included as one of their core concepts the notion that “human relationships, and the effects of relationships on relationships, are the building blocks of health development.” They further this concept later when referring to the importance of relationships on brain development in stating that “developmental neurobiologists have begun to understand how experience becomes integrated into the developing architecture of the human brain... brain development therefore depends on an intimate integration of nature and nurture throughout the life course (p. 54). Not only do children that are inept at relating to others have greater and more sustained interactions with others but they are more likely to get their needs met. Infants and young children that evoke positive reactions in others are responded to in a more positive manner than those that are less sociable. Even if a young child’s methods for getting their needs met when upset or stressed are less than desirable if that same child has built up positive relationships with caregivers and other adults they will benefit. Caregivers and authority figures also tend to be less reactive and more nurturing to children that are interpersonally strong when the need for correction or discipline occurs. The following chart lists manifestations of interpersonal skills in infant, toddlers and preschoolers/school age children.

Interpersonal Skills – Infants	Interpersonal Skills – Toddlers	Interpersonal Skills – Preschool/School Age
Smiles	Reactions to others are synchronous	Prefers peers
Establishes eye contact	Acknowledges new people with gestures and/or words	Initiates conversation with adults
Imitates others	Establishes appropriate eye contact	Accepts praise
Initiates physical contact	Develops awareness of social boundaries	Shares successes
Laughs	Responds to humor	Develops appropriate interpretations of social cues

NATURAL SUPPORTS

This item refers to unpaid helpers in the child’s natural environment. These include individuals who provide social support to the target child and family. All family members and paid caregivers are excluded.

Questions to Consider	Ratings and Descriptions
<ul style="list-style-type: none"> Who does the child consider to be a support? Does the child have non-family members in their life that are positive influences? 	<p>0 <i>Well-developed or centerpiece strength; may be used as a protective factor and a centerpiece in an intervention/action plan.</i></p> <p>Child has significant natural supports that contribute to helping support the child’s healthy development.</p>
	<p>1 <i>Identified and useful strength. Strength will be used, maintained or built upon as part of the plan. May require some effort to develop strength into a centerpiece strength.</i></p> <p>Child has identified natural supports that provide some assistance in supporting the child’s healthy development.</p>
	<p>2 <i>Strengths have been identified but require strength building efforts before they can be effectively utilized as part of a plan. Identified by not useful.</i></p> <p>Child has some identified natural supports, however, these supports are not actively contributing to the child’s healthy development.</p>
	<p>3 <i>An area in which no current strength is identified; efforts may be recommended to develop a strength in this area.</i></p> <p>Child has no known natural supports (outside of family and paid caregivers).</p>

RELATIONSHIP PERMANENCE

This item describes whether the child has had to spend time away from their parents or other significant people during these first few years of their life.

Questions to Consider:

- Does your child have consistent contact with both of their parents?
- Does your child have relationships with relatives or family friends that have lasted their lifetime?

Ratings & Descriptions

- 0 *Well-developed or centerpiece strength; may be used as a protective factor and a centerpiece in an intervention/action plan.*
The child has experienced very stable relationships with both parents and significant others such as friends and community members.
- 1 *Identified and useful strength. Strength will be used, maintained or built upon as part of the plan. May require some effort to develop strength into a centerpiece strength.*
The child has experienced stable relationships although there may be some concern about disruption in the near future, or child has had a stable relationship with only one parent.
- 2 *Strengths have been identified but require strength building efforts before they can be effectively utilized as part of a plan. Identified by not useful.*
The child has experienced some instability due to such factors as divorce, death, removal or moving.
- 3 *An area in which no current strength is identified; efforts may be recommended to develop a strength in this area.*
The child does not have any stability in relationships, such as a child in congregate care or a child that has experienced numerous moves throughout their lifetime.

Supplemental Information: This item refers to the presence or absence of ongoing relationships with biological parents and significant others such as family, friends and community members. Due to the primary importance that both the maternal and paternal relationship holds for children this item reflects an appreciation of this concept. The paternal relationship is often characterized as less involved in caregiving than the maternal relationship and more playful and physical in nature. These experiences have been studied to promote assertiveness and participation in organized physical activities (Palm, 1997). The maternal relationship is characterized as more nurturing and promotes increased socialization. Due to the importance of both parenting experiences this item conceptualizes the ideal experience for children as experiencing an ongoing relationship with both biological parents. This item does not consider the quality of these relationships.

CURIOSITY

This item describes whether the child is interested in their surroundings and in learning and experiencing new things.

Questions to Consider:

- How would you describe your child's interest in the world around them?
- Does your child seem aware of changes in the settings they are in?
- Is your child eager to explore?
- Does your child show interest in trying a new task or activity?

Ratings & Descriptions

- 0 *Well-developed or centerpiece strength; may be used as a protective factor and a centerpiece in an intervention/action plan.*
The child consistently demonstrates curiosity and takes action to explore their environment.
- 1 *Identified and useful strength. Strength will be used, maintained or built upon as part of the plan. May require some effort to develop strength into a centerpiece strength.*
The child demonstrates curiosity much of the time and will take action to explore their environment some of the time.
- 2 *Strengths have been identified but require strength building efforts before they can be effectively utilized as part of a plan. Identified by not useful.*
The child, with encouragement, will explore and demonstrate interest in novelty or change.
- 3 *An area in which no current strength is identified; efforts may be recommended to develop a strength in this area.*
The child does not demonstrate curiosity or exploration of their environment.

Supplemental Information: Curiosity is a characteristic or component of a child's personality that promotes, supports and enhances development in all areas. This component is often associated with intelligence as it is often reflected by questioning and exploring. Curiosity serves as a strong motivator and therefore results in actions that put a child in a position to learn and develop. [continues]

CURIOSITY continued

Motor Development	Cognitive Development	Language Development	Social & Emotional Development
<ul style="list-style-type: none"> Initiates Attempts to Move and Explore the Environment Developing both Fine and Gross Motor Skills Keeps Infant Motivated to Sustain Activity and Attempts Curiosity Reduces the Frustration Experienced by Attempting New Tasks 	<ul style="list-style-type: none"> Triggers Learning by Exploring Encourages Children to Question Supports Lateral Thinking Develops Understanding of Causal Relationships Allows the Child to Enter Into New Experiences 	<ul style="list-style-type: none"> Encourages Imitation Encourages Interaction both Verbally and Non Verbally Places the Child in the Position to Observe Social Conventions of Language 	<ul style="list-style-type: none"> Encourages Learning Related to Social Cues, Behavior and Practices Encourages Child to Think in the Mind of Another Supporting Reflective Functioning Challenges the Egocentric Nature of the Child Supports Thinking Related to Feeling States in Relationship to Behavior

To determine the level of curiosity present in a child it is important to note again that this characteristic is considered by some temperament researchers as reflective of temperament. This means that the characteristic is considered a stable and persistent component of personality that while it can be mediated by environmental factors is the child's overall tendency. Assessment occurs by discussion with the caregiver(s) and child depending on age as well as observation of behavior. The following list of observations or descriptions of behavior will assist in identifying curiosity as an area of strength.

PLAYFULNESS

This item rates the degree to which an infant/child is given opportunities for and participates in age appropriate play. Play should be understood developmentally. When rating this item, you should consider if the child is interested in play and/or whether the child needs adult support while playing. Problems with either solitary or group (e.g. parallel) play could be rated here.

Questions to Consider:

- Describe what your child does when they plays.
- Does your child lose interest in play quickly?
- Does your child appear to enjoy playing alone at times?
- How does your child react to playing with others?

Ratings & Descriptions

- 0 *Well-developed or centerpiece strength; may be used as a protective factor and a centerpiece in an intervention/action plan.*
The child consistently demonstrates the ability to make use of play to further their development. Their play is consistently developmentally appropriate, spontaneous, self-initiated and enjoyable.
- 1 *Identified and useful strength. Strength will be used, maintained or built upon as part of the plan. May require some effort to develop strength into a centerpiece strength.*
The child demonstrates play that is developmentally appropriate, self-initiated, spontaneous and enjoyable much of the time. Child needs some assistance making full use of play.
- 2 *Strengths have been identified but require strength building efforts before they can be effectively utilized as part of a plan. Identified by not useful.*
The child demonstrates the ability to enjoy play and use it to support their development some of the time or with support of a caregiver. Even with this in place there does not appear to be investment and enjoying in the child.
- 3 *An area in which no current strength is identified; efforts may be recommended to develop a strength in this area.*
The child does not demonstrate the ability to play in a developmentally appropriate or quality manner.

Supplemental Information: Curiosity is a characteristic or component of a child's personality that promotes, supports and enhances development in all areas. This component is often associated with intelligence as it is often reflected by questioning and exploring. Curiosity serves as a strong motivator and therefore results in actions that put a child in a position to learn and develop.

Cognitive Development	Emotional Development	Social Development	Physical Development	Language Development
<ul style="list-style-type: none"> Improves Attention Improves Problem Solving Enhances Imagination Develops Planning and Sequencing Abilities Promotes Awareness of How Items Function Improves Concentration 	<ul style="list-style-type: none"> Facilitates the Expression of Feelings and Experiences in a Safe Manner Alleviates Anxiety by Promoting Mastery Over Stressful Situations Enhances Self Esteem 	<ul style="list-style-type: none"> Encourages Children Taking on a Variety of Social Roles Develops Sharing, Cooperating and Compromising Abilities Further Develops Sense of Self Encourages Learning to Take Others Perspective 	<ul style="list-style-type: none"> Enhances Fine Motor Skills Enhances Gross Motor Skills Facilitates Visual-Spatial Skills Develops Balance and Coordination 	<ul style="list-style-type: none"> Through Interactions Learns Rhythm, Cadence, and Pace of Speech Enhances Vocabulary Acquisition Develops Social Conventions of Language

[continues]

PLAYFULNESS continued

In assessing the characteristic of playfulness it is necessary to be aware of the developmental appropriateness as well as the emotional characteristics of the play. Ideally play should be spontaneous, self-initiated and enjoyable to the child. A child that is not enjoying play will demonstrate a flat or restricted range of affect, will not prolong the play themes and will often have little spontaneous speech associated with the play. In determining the developmental appropriateness of play the following developmental descriptions can offer some assistance.

0-12 months: Sensorimotor Play: This is seen in exploration of objects through such means as mouthing, touching, banging or dropping objects. As the child moves closer to 6 months they may begin to explore the characteristics of objects by poking or pulling the component parts.

12-18 months: Functional Play: Child demonstrates understanding of how objects are used and does such things as placing a phone to their ear, rolling a car back and forth or manipulating toys in their intended fashion.

18 months to 30 months: Early Symbolic Play: Begins to show capacity for pretend play. First will pretend with themselves, and then with objects and other people. The pretend sequences will become gradually more complex and detailed.

30 months and older: Complex Symbolic Play: Dramatic sequences are acted out in play using both props and imagination. As a child becomes older they further the ability to assign roles to others and include them in pretend play. As a child enters school age they further their ability to imitate, take turns and problem solve in play.

Adapted from *The American Academy of Child and Adolescent Psychiatry Practice Parameters for the Psychiatric Assessment of Infants and Toddlers (1997)*.

CREATIVITY/IMAGINATION

This item describes the child's ability to come up with new ideas or solve problems.

Ratings & Descriptions	
NA	Child is not a toddler or school aged child.
0	<i>Well-developed or centerpiece strength; may be used as a protective factor and a centerpiece in an intervention/action plan.</i> The child consistently demonstrates a significant level of creativity. This appears interwoven into the normal routines and chosen activities.
1	<i>Identified and useful strength. Strength will be used, maintained or built upon as part of the plan. May require some effort to develop strength into a centerpiece strength.</i> The child demonstrates a level of creativity that can be useful to the child. The child could benefit from further development in this area before it is considered a significant strength.
2	<i>Strengths have been identified but require strength building efforts before they can be effectively utilized as part of a plan. Identified by not useful.</i> The child shows creativity and/or imagination when caregivers provide support.
3	<i>An area in which no current strength is identified; efforts may be recommended to develop a strength in this area.</i> The child does not demonstrate creativity or imagination.

Questions to Consider:

- Does your child enjoy telling stories or have imaginary friends?
- Does your child find creative ways to solve problems?
- During play, does your child use toys only for their intended use or in other ways (for example, picking up a block and using it as a "telephone")?

Supplemental Information: Toddlers, Preschoolers and School Age Children may exhibit the characteristic of creativity/imagination in varying ways and to different degrees. Creativity reflects the ability to think "out of the box". Children that demonstrate this ability are able to accept explanations, solutions and alternatives to problems. This allows them to accept changes more easily and therefore cope with challenging situations more successfully. This will also result in expanding play sequences as well as developing opportunities to play when other children would be limited in this capacity. When a child is rigid in their thinking this makes them more challenging to discipline, socialize and interact with. Rigid thinking is as frustrating for the individual as the parent/caregiver due to the inability to control changes and life events. Creativity/Imagination is often manifested in artistic, musical and literary abilities as well as skills in the dramatic arts. This again, demonstrates a child's interest to think broadly and express their ideas, feelings and experiences. The emotional benefit is often anxiety reducing and compliments verbal methods of processing feelings. Some children that are challenged in their ability to process their feelings verbally can compensate for this through using creative means.

Manifestations of Creativity in Toddlers/Pre-Schoolers

Toddlers	Pre-Schoolers
<ul style="list-style-type: none"> • Explores Art and Music • Pretends with Objects • Develops Pretend Play without Objects • Develops Pretend Play with Other Inanimate Objects (i.e., Dolls) • Tells Stories • Has Imaginary Friends • Develops Ability to Use Objects in Alternative Ways (block can be a phone) 	<ul style="list-style-type: none"> • Finds Enjoyment in Drawing and Creating • Offers Interpretations of Artwork Reflecting Feelings and Experiences • Can Play Independently for Extended Periods of Time • Enjoys Music and Sings Songs about Life Experiences • Enjoys Dress Up Activities • Tells Detailed Stories • Greater Capacity for the Abstract

TALENTS AND INTERESTS

This item refers to hobbies, skills, artistic interests and talents that are positive ways that young people can spend their time, and also give them pleasure and a positive sense of self.

Questions to Consider

- Does your child show a special interest in certain activities?
- Does your child seem to have a “natural ability” to do certain things well?
- Does your child use special skills or talents in their play or school environments?

Ratings & Descriptions

- 0 *Well-developed or centerpiece strength; may be used as a protective factor and a centerpiece in an intervention/action plan.*
Child has a talent that provides them with pleasure and/or self-esteem. A child with significant creative/artistic/athletic strengths would be rated here.
- 1 *Identified and useful strength. Strength will be used, maintained or built upon as part of the plan. May require some effort to develop strength into a centerpiece strength.*
Child has a talent, interest, or hobby that has the potential to provide them with pleasure and self-esteem. This level indicates a child with a notable talent. For example, a child who is involved in athletics or plays a musical instrument would be rated here.
- 2 *Strengths have been identified but require strength building efforts before they can be effectively utilized as part of a plan. Identified by not useful.*
Child has expressed interest in developing a specific talent, interest or hobby even if they have not developed that talent to date, or whether it would provide them with any benefit.
- 3 *An area in which no current strength is identified; efforts may be recommended to develop a strength in this area.*
There is no evidence of identified talents, interests or hobbies at this time and/or child requires significant assistance to identify and develop talents and interests.

Supplemental Information: The presence of special skills or talents has been a characteristic of resilient children noted in several longitudinal studies (Werner, 1990). A child that demonstrates capacity in this area can focus their time, attention and skills in a manner that is both enjoyable and supportive of their growth and development. A child that spends time demonstrating a special skill is often encouraged by both peers and adults in a way that develops self concept and self esteem. A talent that is truly of benefit to a child is enjoyable and not imposed on them by adults. A child should demonstrate their own initiative to participate in this activity. This is manifested by the child initiating the activity, conversing about the activity and planning for continuation of the activity. This certainly can be supported by the adults in their life but to fully be of use to the child it should be their own investment. As Howard Gardner has described the concept of multiple intelligences this can be used to identify areas in which a child may have special skills or talent.

Linguistic Intelligence “Word Smart”	Skills in speaking, writing, understanding meaning of words, debating, and explaining concepts or their point of view. May be interested in drama, journaling, or writing stories.
Musical Intelligence	Skills in playing instruments, recognizing songs and patterns/rhythms, or singing.
Interpersonal Intelligence	Skills in listening, responding with empathy, awareness of other’s feelings, awareness of social cues, forming relationships with peers and adults.
Intrapersonal Intelligence	Skills in being aware of own feelings, strengths and weaknesses. Develops within a caring, nurturing relationship with caregivers.
Visual Spatial Intelligence	Skills in puzzle building, legos, construction toys, copying designs, sense of direction.
Logical/Mathematical Intelligence	Skills in sorting and classifying, sequencing, understanding number concepts, understanding shapes.
Bodily/Kinesthetic Intelligence	Skills in physical coordination, sports, hands on tasks, crafts, and expressing feelings through the body.

RESILIENCY (PERSISTENCE AND ADAPTABILITY)

This item refers to how the child reacts to new situations or experiences, how they respond to changes in routines, as well as their ability to keep trying a new task/skill, even when it is difficult for them.

Questions to Consider	Ratings and Descriptions
<ul style="list-style-type: none"> Does child show ability to hang in there even when frustrated by a challenging task? Does child routinely require adult support in trying a new skill/activity? Can child easily and willingly transition between activities? What type of support does the child require to adapt to changes in schedules? 	<p>0 <i>Well-developed or centerpiece strength; may be used as a protective factor and a centerpiece in an intervention/action plan.</i></p> <p>The child consistently has a strong ability to adjust to changes and transitions, and continue an activity when challenged or meeting obstacles. This supports further growth and development and can be incorporated into a service plan as a centerpiece strength.</p> <hr/> <p>1 <i>Identified and useful strength. Strength will be used, maintained or built upon as part of the plan. May require some effort to develop strength into a centerpiece strength.</i></p> <p>Child with good curiosity and some ability to continue an activity that is challenging. An ambulatory child who does not walk to interesting objects, but who will actively explore them when presented to them, would be rated here. The child demonstrates a level of adaptability and ability to continue in an activity that is challenging. The child could benefit from further development in this area before it is considered a significant strength.</p> <hr/> <p>2 <i>Strengths have been identified but require strength building efforts before they can be effectively utilized as part of a plan. Identified by not useful.</i></p> <p>The child shows some ability to continue a challenging task although this needs to be more fully developed. Parents and caregivers need to be the primary support in this area.</p> <hr/> <p>3 <i>An area in which no current strength is identified; efforts may be recommended to develop a strength in this area.</i></p> <p>Child’s difficulties coping with challenges places their development at risk. Child may seem frightened of new information, changes or environments.</p>

Supplemental Information:

Adaptability: A child’s ability to adjust to changes in their routine or environment, known as adaptability, is considered one of the original nine temperament characteristics as defined by Chess and Thomas (1959). Temperament characteristics are defined by Chess and Thomas as “the style in which a person does what he or she does” Children that are adaptable are flexible, tolerant of changes and transitions, not bothered intrusions and “go with the flow”. The characteristic of adaptability is protective for children for a number of reasons. Children that are exposed to high-risk environments are often challenged with multiple stressors, caregivers, and changes in their routine. The ability to cope with such affords them a greater amount of energy to focus on growth and development. Children that are less adaptable often evoke negative reactions from caregivers, authority figures as well as peers due to their increased neediness and changes in behavior. Parents that experience their children as flexible and less demanding overall tend to be more responsive and consistent in their reactions. Parents who are experiencing their own stressors, health or mental health problems typically have less patience to offer their children and are easily overwhelmed.

Manifestations of Adaptability

Infants and Toddlers	<ul style="list-style-type: none"> Easily Falls Asleep and Remains Asleep Changes in Routine Minimally Disrupts Sleep Accepts New Foods Easily Eats a Variety of Foods Accepts Diapering, Dressing and Bathing Tasks Without Resistance Accepts Changes in Day Care Providers or Introduction of Additional Children Accepts Separations
Pre-Schoolers/School Age	<ul style="list-style-type: none"> Transitions from Wake to Sleep State Easily Sleep Cycle Remains Unaffected by Changes Eats a Variety of Foods and Will Try New Foods Accepts Control from Caregivers/Teachers Is Not Excessively Needy Follows Instructions Easily Can “Switch Gears” Easily Makes Friends Easily Tries New Activities

[continues]

RESILIENCY (PERSISTENCE AND ADAPTABILITY) continued

Persistence Persistence refers to the ability to continue an activity that is difficult or unappealing. A persistent child is one that is very focused and motivated. Persistence is another one of the original temperament characteristics described by Thomas and Chess. This characteristic supports the acquisition of new developmental abilities. In children that are challenged by health or developmental disabilities this characteristic can prove to be essential to their well-being. Children that manifest this characteristic show the ability to face challenges physically and emotionally in a more competent fashion.

Manifestations of Persistence

Infants and Toddlers	<ul style="list-style-type: none"> • Attempts Tasks Related to Motor Development Over and Over Until Mastery Occurs • Will Persist in Attempting Tasks Independent of Parents • Plays Alone Well • Does not Cry or Whine Easily Good Attention Span • Sleeps Well
Pre-Schoolers/School Age	<ul style="list-style-type: none"> • Attempts Difficult Tasks • Keeps Focused and On Track • Motivated Internally • Appears Stubborn • Slow to Disengage from Activity or Task Does Not Quit Team Sports or Play Identified as a Perfectionist • Accepts Challenges

FAMILY SPIRITUAL/RELIGIOUS

This item refers to the family's experience of receiving comfort and support from religious or spiritual involvement. This item rates the presence of beliefs that could be useful to the family; however, an absence of spiritual and/or religious beliefs does not represent a need for the family.

Ratings and Descriptions

- 0 *Well-developed or centerpiece strength; may be used as a protective factor and a centerpiece in an intervention/action plan.*
This level indicates a family with strong moral and spiritual strengths. Family may be very involved in a religious community or may have strongly held spiritual or religious beliefs that can sustain or comfort them in difficult times.
-
- 1 *Identified and useful strength. Strength will be used, maintained or built upon as part of the plan. May require some effort to develop strength into a centerpiece strength.*
Family is involved in and receives some comfort and/or support from spiritual and/or religious beliefs, practices and/or community.
-
- 2 *Strengths have been identified but require strength building efforts before they can be effectively utilized as part of a plan. Identified by not useful.*
Family has expressed some interest in spiritual or religious belief and practices and may have little contact with religious institutions.
-
- 3 *An area in which no current strength is identified; efforts may be recommended to develop a strength in this area.*
There is no evidence of identified spiritual or religious beliefs, nor does the family show any interest in these pursuits at this time.

Questions to Consider

- Does the family have spiritual beliefs that provide comfort?
- Is the family involved with any religious community?
- Is family interested in exploring spirituality?

Supplemental Information: Spirituality should be considered as something that if it is present it can be a significant help to a family but if not present should not be considered a need. Many families attest to the fact that having a belief in a higher power contributes to resiliency and stress reduction. This is especially true when tragedy takes place or situations that seem difficult to comprehend or make sense of.

SELF ESTEEM/SELF CONFIDENCE

This item refers to how the child feels about themselves and their abilities.

Questions to Consider:

- How would you describe the child's self-confidence and their abilities?
- Does the child show excitement about their accomplishments?
- How does the child respond to praise?

Ratings & Descriptions

NA	Child is not a toddler or a school aged child.
0	<i>Well-developed or centerpiece strength; may be used as a protective factor and a centerpiece in an intervention/action plan.</i> The child consistently demonstrates a significant level of self-esteem/self-confidence. This self-confidence consistently supports the child in their development and functioning.
1	<i>Identified and useful strength. Strength will be used, maintained or built upon as part of the plan. May require some effort to develop strength into a centerpiece strength.</i> The child demonstrates self-esteem/self-confidence that is of benefit to the child. This area could be further developed to consider it a centerpiece strength.
2	<i>Strengths have been identified but require strength building efforts before they can be effectively utilized as part of a plan. Identified by not useful.</i> The child shows self-esteem/self-confidence when supported by caregivers.
3	<i>An area in which no current strength is identified; efforts may be recommended to develop a strength in this area.</i> The child does not demonstrate self-esteem/self-confidence.

Supplemental Information: Self Esteem/Self Confidence refers to the child's belief that they are worthwhile, competent and able to succeed. It is hard to imagine how this would not be considered an essential characteristic for a child to have. A child is constantly exposed to new tasks, changes and challenges that are tolerated by this core belief. A child that does not reflect a strong sense of self is handicapped in numerous ways. Children will not typically attempt or sustain in new activities or tasks nor will they achieve to the same capacity without self-esteem. Self-esteem often is further developed as a child experiences making friends, achieves developmental milestones, and learns new skills, experiences love and support, experiences encouragement for effort, and feels valued. A positive self-esteem is associated with positive mental health, academic achievement, good behavior and frustration tolerance. Poor self-esteem is more often associated with negative behavior, frustration intolerance, poor academic achievement, social withdrawal and poor peer relations.

Manifestations of Strong Self-Esteem:

- Child Accepts Compliments Child Points Out Successes Child Tries Difficult Tasks
- Child Socializes Well with Peers Child Accepts Correction
- Child Gives Others Compliments

LIFE FUNCTIONING

Life domains are the different arenas of social interaction found in the lives of children and their families. This domain rates how they are functioning in the child, family, peer, school, and community realms. This section is rated using the needs scale and therefore will highlight any struggles the child and family are experiencing.

Question to Consider for this Domain: How is the child functioning in child, family, peer, school, and community realms?

For **Life Functioning**, use the following categories and action levels:

- 0 No evidence of any needs; no need for action or intervention.
- 1 Identified need that requires monitoring, watchful waiting, or preventive action based on history, suspicion or disagreement.
- 2 Action or intervention is required to ensure that the identified need is addressed; need is interfering with functioning.
- 3 Need is dangerous or disabling; requires immediate and/or intensive action.

MOTOR

This item describes the child's fine (e.g., hand grasping and manipulation) and gross (e.g., sitting, standing, walking) motor functioning.

Questions to Consider:

- How would you describe your child's ability to move around and explore their surroundings?
- How would you describe your child's ability to grasp and handle small objects?
- Do you have any concerns that your child is lagging behind in their physical development?

Ratings & Descriptions

- 0 *No current need; no need for action or intervention.*
No evidence of fine or gross motor problems.

- 1 *Identified need that requires monitoring, watchful waiting, or preventive action based on history, suspicion or disagreement.*
There is either a history of fine or gross motor problems or slow development in either or both areas.

- 2 *Action or intervention is required to ensure that the identified need is addressed; need is interfering with functioning.*
The child has delays in either or both fine and gross motor development or challenges in the aspects of motor development related to strength, coordination, tone, or motor planning.

- 3 *Need is dangerous or disabling; requires immediate and/or intensive action.*
The child has significant challenges in either fine or gross motor development or the related areas of strength, coordination, tone or motor planning.

Supplemental Information: This aspect of development is critical to assess because it supports the child's ability to move about and explore their world which is a critical need for children. A child that is challenged in this area may be experiencing a medical or neurological problem that needs to be addressed.

Motor development refers to the development of both fine and gross motor skills. The following reference is from Landy, S. (2002). *Pathways to competence: Encouraging healthy social and emotional development in young children (pp. 12-27)*. Baltimore: Paul H. Brookes Publishing Co.

	Gross Motor	Fine Motor
By 3 Months	<ul style="list-style-type: none"> • Gets fist to mouth • Holds head in upright position • Makes thrusting leg movements • Rolls from side to back • Turns head from side to side • Can lift head by using arms when on stomach • Can sit with support on lap 	<ul style="list-style-type: none"> • Will grasp objects placed in palm with entire hand • May pat at object that is close • Holds hand in an open or semi-open position • Has control of eye muscles • Focuses eyes on objects 8-10 inches away • Gets hand to mouth

[Continues]

MOTOR continued

	Gross Motor	Fine Motor
By 7 Months	<ul style="list-style-type: none"> Rolls from back to stomach and stomach to back Sits unsupported Lifts head when lying on back Pulls self to crawling position and may move backward and forward Enjoys being placed in standing position May pull self to standing by pulling up on the furniture Bounces actively if held to stand 	<ul style="list-style-type: none"> Imitates motor play such as clapping hands Brings hands to center of body Reaches and grasps objects on purpose Lets go of objects to watch them fall Puts objects in mouth May bang objects together Can pick up small objects using raking motion Demonstrates palmar grasp (all four fingers hold object against palm of hand) Transfers objects from one hand to another
By 14 Months	<ul style="list-style-type: none"> Pulls self up to standing position Cruises around furniture Shifts sitting position without falling Walks, usually alone but may need adult support Walks up and down stairs with help Throws a ball 	<ul style="list-style-type: none"> Uses pincer grasp or thumb and forefinger to purposely pick up tiny objects Scribbles with pencil or crayon Builds tower with three blocks Can put objects in shape sorter Can handle two objects at a time and pass them from hand to hand Places objects inside each other Drops and throws objects
By 2 Years	<ul style="list-style-type: none"> Runs with greater confidence Climbs up and down stairs unassisted Stands on tiptoes Throws and catches a ball Uses feet to pedal tricycle Climbs on chairs, turns around, and sits down Jumps 8-14 inches forward and up and down Walks backwards Walks on line Squats while playing 	<ul style="list-style-type: none"> Copies circles and lines Stacks six blocks Puts pieces in puzzles Nest objects Puts tiny object in small container Folds paper in half Strings beads Opens doors by turning doorknob Enjoys pouring and filling
By 4 Years	<ul style="list-style-type: none"> Throws ball overhand Skips Walks on tiptoes Stands on one foot Balances on walking board or plank Walks in straight line Enjoys throwing and catching games Jumps over object 5 or 6 inches high Pedals and steers a tricycle or other wheeled object Climbs stairs using alternating feet Climbs on playground equipment 	<ul style="list-style-type: none"> Can screw things on such as lids on jars Builds tower of 10 or more blocks Inserts pieces in puzzle Threads wooden beads on a string Cuts with scissors Paints with large brush Manipulates clay Draws person with three parts Folds paper Copies shapes and letters

In addition to the assessment of the child's ability to meet developmental milestones the child's coordination, muscle tone, strength, and motor planning should be considered. The child's ability to demonstrate fluid and coordinated movements develops with time and practice. As infants, the first area in which control is developed is the head. An infant's movements are often awkward although there should be improvement in this with practice. It is helpful to ask a parent how long a skill has been in place and if the level of coordination related to this skill is improving. As children develop typically coordination continues to improve in both fine and gross motor skills. It is possible to have coordination challenges in only one area as well as both. Muscle tone can be low or high. A child with low tone often appears slumped, or challenged in supporting oneself in various positions. The child may try to compensate by locking joints or leaning on objects or caregivers. A child with high tone appears stiff and rigid. They may keep their hands closed tightly or walk on their toes. When holding a high tone child they do not feel comfortable or mold into the caregiver. A child that struggles with strength does not display the ability to sustain interactions that would be developmentally appropriate. They tire easily and do not persist in play. When this is a significant problem the child may appear distressed by breathing heavily, having skin changes or blue lips and fingernails. Motor planning is the child's ability to initiate action and sequence movements. In infants, the ability to imitate actions would be slow or impaired if there is motor planning challenges. As a child becomes older and attempts more complex tasks the ability to move through space in a coordinated manner may appear compromised. The ability to climb, jump and judge space and intensity of movement may appear impaired. In summary, the ability to meet developmental milestones as well as the presence of coordination, strength, tone, and motor planning should be considered.

SENSORY

This item rates the child’s ability to use the senses of sound, sight, touch, taste and smell as well as how s/he reacts to these sensory experiences.

Questions to Consider:

- Does your child cry or become irritable with certain types of sensory experiences?
- Does your child avoid certain types of sensory experiences?
- Does your child have trouble touching things of different textures?
- Have you or anyone else noticed a problem with your infant’s vision or sight?

Ratings & Descriptions

- 0 *No current need; no need for action or intervention.*
No evidence of sensory problems.

- 1 *Identified need that requires monitoring, watchful waiting, or preventive action based on history, suspicion or disagreement.*
Child has impairment on a single sense (e.g., mild hearing deficits, correctable vision problems).

- 2 *Action or intervention is required to ensure that the identified need is addressed; need is interfering with functioning.*
Child has an impairment that impacts their functioning in at least one life domain, e.g., moderate impairment on a single sense or mild impairment on multiple senses (e.g., difficulties with sensory integration, diagnosed need for occupational therapy).

- 3 *Need is dangerous or disabling; requires immediate and/or intensive action.*
Child has significant impairment in one or more senses (e.g., profound hearing or vision loss) that could be dangerous or debilitating without intervention. [continues]

Supplemental Information: This area refers to a child’s ability to fully utilize the senses of sight, taste, touch, sound and smell as well as their ability to monitor their reactivity to these experiences. According to Stanley Greenspan (1985) one of the child’s major tasks during the first three months of life is to learn to take in sensory information while remaining calm and organized. When this is poorly developed an infant or young child can do little more than attempt to cope with the sensory experience. This results in an interference in other areas of development as well as in their capacity to develop and make use of social relationships. This often causes parents to feel poorly able to meet the needs of their child and in some cases results in a disturbance in the attachment relationship. In the DC 0-3R there are descriptors of how children with sensory processing challenges may react to these types of experiences.

In the assessment of the infant’s ability to react to sound it is helpful to be aware of how this develops. An infant from 0-1 month will begin to evidence an awareness of sounds that is seen in their pausing their breathing, a startle reaction, change in expression, their body tensing, or eyes widening. These are more primitive reactions and further develop as an infant matures. Into the second and third months of life, an infant shows the capacity to respond to a voice and then search with their eyes for sounds. By the end of the first year they should be able to localize sounds that are hidden, come from below them and later from above them. It is helpful to use these benchmarks when asking parents to tell you how they determine if their child is able to hear normally. In addition, asking parents if there has been hearing tests is important and will offer helpful information. In the assessment of the infant’s ability to react to visual experiences the developmental sequence of this activity is again useful in being familiar with. The infant’s abilities in this area are not fully developed for quite sometime after birth. Initially, within the first month, it is considered on track for an infant to respond to a brightly colored object approximately 8-10 inches away from them. Their response may only be brief, lasting 2-3 seconds. As their vision further develops the infant is later able to follow a person moving toward them and then an object moving in the midline or from side to side. By the end of three months, an infant should be able to follow an object downward and then upward. It is helpful to also ask parents if any vision screenings have occurred. The following listings will give some guidance regarding sensory reactivity as described in the *Diagnostic Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood: Revised Edition, Zero to Three* (2005).

Over Reactivity to Sensory Stimulation	<ul style="list-style-type: none"> • Fearfulness • Crying • “Freezing” • Trying to get away from stimulus Increased distractibility Aggression • Excessive Startle reaction • Motoric agitation • Restricted tolerance for variety in food textures, tastes and smells
Under Reactivity to Sensory Stimulation	<ul style="list-style-type: none"> • Lack of response • Ignores social interactions or encouragement Withdrawal from stimuli • Inattentiveness • Fatigability • Apathetic appearance

DEVELOPMENTAL/INTELLECTUAL

This item describes the child’s development as compared to standard developmental milestones, as well as rates the presence of any developmental or intellectual disabilities. It includes Intellectual Developmental Disorder (IDD) and Autism Spectrum Disorders. Rate the item depending on the significance of the disability and the related level of impairment in personal, social, family, or educational functioning.

Questions to Consider

- Does the child’s growth and development seem age appropriate?
- Has the child been screened for any developmental problems?

Ratings and Descriptions

- 0 *No current need; no need for action or intervention.*
No evidence of developmental delay and/or child has no developmental problems or intellectual disability.
-
- 1 *Identified need that requires monitoring, watchful waiting, or preventive action based on history, suspicion or disagreement.*
There are concerns about possible developmental delay. Child may have low IQ, a documented delay, or documented borderline intellectual disability (i.e. FSIQ 70-85). Mild deficits in adaptive functioning are indicated.
-
- 2 *Action or intervention is required to ensure that the identified need is addressed; need is interfering with functioning.*
Child has mild developmental delays (e.g., deficits in social functioning, inflexibility of behavior causing functional problems in one or more settings) and/or mild to moderate Intellectual Disability/Intellectual Disability Disorder. (If available, FSIQ 55-69.) IDD impacts communication, social functioning, daily living skills, judgment, and/or risk of manipulation by others.
-
- 3 *Need is dangerous or disabling; requires immediate and/or intensive action.*
Child has severe to profound intellectual disability (FSIQ, if available, less than 55) and/or Autism Spectrum Disorder with marked to profound deficits in adaptive functioning in one or more areas: communication, social participation and independent living across multiple environments.

Supplemental Information: This area of development is important to assess due to its impact on all other areas of development. A child that is impaired in their cognitive functioning will demonstrate limitations in other areas of development especially their language development and self-help skills. This is an area in which early intervention is critical. The following reference is from Landy, S. (2002). *Pathways to competence: Encouraging healthy social and emotional development in young children (pp. 12-27)*. Baltimore: Paul H. Brookes Publishing Co.

By 3 Months	<ul style="list-style-type: none"> • Watches hands • Can remember for 3-4 seconds • Usually explores environment by looking around Follows objects that are moving up and down with eyes Recognizes familiar faces, voices and smell
By 7 Months	<ul style="list-style-type: none"> • Likes to make things happen (e.g., pulls a string to get something attached to it) Imitates gestures • Follows and searches for objects with eyes • Establishes object and person permanence • Focuses on toy or person for 2 minutes Throws objects over side of crib to watch it fall
By 14 Months	<ul style="list-style-type: none"> • Understands how things happen (i.e., what causes what) Examines toys to see how they work • Begins to engage in pretend play • Can point to pictures of objects in a picture book when prompted Plays on own for 10 minutes or more • Follows simple directions • Copies activities such as banging a drum to make noise
By 2 Years	<ul style="list-style-type: none"> • Increasingly engages in pretend play • Can play in a focused way for 10 minutes • Points to body parts • Can sort by color, classification • Can match by size and color • Can sequence pretend play into scripts • Concentrates on self-selected activities for longer periods
By 4 Years	<ul style="list-style-type: none"> • Engages in more elaborate pretend play • Can classify objects for their purpose • Can identify up to six geometric shapes by pointing to them when asked Understands nearest, longest, tallest, same • Counts five objects and rote counts to 20 or more • Distinguishes between genders • Can name some letters and recognizes a few words • Understands the sequence of daily events

COMMUNICATION

This item rates the child's ability to communicate through any medium, including all spontaneous vocalizations and articulations. This item refers to learning disabilities involving expressive and/or receptive language. **This item does not refer to challenges in expressing one's feelings.**

Questions to Consider:

- How does your child let you know what they want or need?
- Does your child show you that they understand what you are saying to them?
- Do you or anyone else have concerns in this area?

Ratings & Descriptions

- 0 *No current need; no need for action or intervention.*
No evidence of receptive or expressive language problems.
-
- 1 *Identified need that requires monitoring, watchful waiting, or preventive action based on history, suspicion or disagreement.*
There is either a history of receptive or expressive language problems or slow development in either or both areas.
-
- 2 *Action or intervention is required to ensure that the identified need is addressed; need is interfering with functioning.*
The child has delays in either or both receptive or expressive language development.
-
- 3 *Need is dangerous or disabling; requires immediate and/or intensive action.*
The child exhibits has significant challenges in other receptive or expressive language development.

Supplemental Information: A child's ability to process what is said to them and express their ideas is the foundation for interpersonal relationships and relates strongly to the child's experience of having their needs met. This of course, impacts the child's ability to develop a sense of trust in their caregiver and a beginning experience of relationships that becomes the foundation for all other relationship development. A child that is frustrated in their capacity to communicate either receptively or expressively usually demonstrates this frustration in a variety of ways. The child may become aggressive, withdrawn, disconnected, hypervigilant or distrusting of peers and adults. At times, a child may hit themselves or other objects in frustration. Head banging or other self-injurious behaviors sometimes are rooted in poor communication.

By 3 Months	<ul style="list-style-type: none"> • Coos with two or more different sounds Pays attention to human speech Moves in rhythm to language of caregiver Cries if hungry or upset • Makes sucking sounds, gurgles, and squeals when awake Babbles; repeats simple vowel and consonant sounds
By 7 Months	<ul style="list-style-type: none"> • Babbles with inflection, repeating same syllable in a series Vocalizes back when someone is talking Tries to imitate sounds Can say a number of vowels and some consonants Responds to a few familiar words • Responds to own name
By 14 Months	<ul style="list-style-type: none"> • Begins to use words to communicate Uses two to three words Understands a few simple words and sentences Copies simple gestures such as waving and shaking head Jabbers expressively • Shows communicative intent with gestures Likes rhymes and singing games Understands "no" but does not always do as told Follows a few simple requests when accompanied by gestures
By 2 Years	<ul style="list-style-type: none"> • Expressive language increases to 50+ words • Speaks in two to three-word sentences • Listens to a story • Answers questions • Joins in songs • May understand more than can say
By 4 Years	<ul style="list-style-type: none"> • Language expands to include all parts of speech Repeats three numbers • Knows more than 1,200 words • Points to colors when asked to identify them Uses five-word sentences • Language and emotions are matched • Uses gender words: he/she, boy/girl • Uses prepositions such as in, on, and under Uses possessives such as hers, theirs Knows first and last name • Recites and sings simple songs and rhymes

MEDICAL/PHYSICAL

This rating describes both health problems and chronic/acute physical conditions or impediments.

Questions to Consider

- Do you have concerns about your child's health or physical development?
- Does your child have any medical or physical challenges?
- Do you have any concerns about your child's teeth or oral health?
- Does your child need or use any special medical equipment?

Ratings & Descriptions

- 0 *No current need; no need for action or intervention.*
No evidence that the child has any medical or physical problems, and/or the child is healthy.
-
- 1 *Identified need that requires monitoring, watchful waiting, or preventive action based on history, suspicion or disagreement.*
Child has mild, transient or well-managed physical or medical problems. These include well-managed chronic conditions like juvenile diabetes or asthma.
-
- 2 *Action or intervention is required to ensure that the identified need is addressed; need is interfering with child's functioning.*
Child has serious medical or physical problems that require medical treatment or intervention. Or child has a chronic illness or a physical challenge that requires ongoing medical intervention.
-
- 3 *Need is dangerous or disabling; requires immediate and/or intensive action.*
Child has life-threatening illness or medical/physical condition. Immediate and/or intense action should be taken due to imminent danger to child's safety, health, and/or development.

Supplemental Information: If a child is experiencing any medical conditions obtaining information regarding the impact to the child, the impact to the caregiver in monitoring and treating this condition are both needed to make the assessment of how to rate this item. A child may have a medical condition that is considered a chronic condition but this is managed well by the child and family and therefore not causing problems in their functioning. A child's nutritional and physical condition should be considered in this rating as well. A child may not have a medical condition but appears tired, reports feeling badly or misses school frequently.

FAMILY FUNCTIONING

This item rates the child's relationships with those who are in their family. It is recommended that the description of family should come from the child's perspective (i.e. who the child describes as their family). In the absence of this information, consider biological and adoptive relatives and their significant others with whom the child is still in contact. Foster families should only be considered if they have made a significant commitment to the child. For children involved with child welfare, family refers to the person(s) fulfilling the permanency plan. When rating this item, take into account the relationship the child has with their family as well as the relationship of the family as a whole.

Questions to Consider

- How would you describe how the children in the family get along?
- Are the adults in the family supportive of each other?
- How would you describe how the children respond to the adults in the family?
- Is there usually good communication between family members?
- Do family members respond when someone in the family needs help in any way?
- How do you show that you care for each other?

Ratings & Descriptions

- 0 *No current need; no need for action or intervention.*
No evidence of problems in relationships with family members, and/or child is doing well in relationships with family members.
-
- 1 *Identified need that requires monitoring, watchful waiting, or preventive action based on history, suspicion or disagreement.*
History or suspicion of problems. Child might be doing adequately in relationships with family members, although some problems may exist. For example, some family members may have problems in their relationships with child. Arguing may be common but does not result in major problems.
-
- 2 *Action or intervention is required to ensure that the identified need is addressed; need is interfering with child's functioning.*
Child is having problems with parents, siblings and/or other family members that are impacting the child's functioning. Frequent arguing, difficulty maintaining positive relationships may be observed.
-
- 3 *Need is dangerous or disabling; requires immediate and/or intensive action.*
Child is having severe problems with parents, siblings, and/or other family members. This would include problems of domestic violence, absence of any positive relationships, etc.

Supplemental Information: Family Functioning should be rated independently of the problems the child experienced or stimulated by the child currently assessed. [continues]

FAMILY FUNCTIONING continued

The family functioning is critical to the experience of the child due to the potential impact this has on the child. A family environment that is stressful and characterized by poor relationships can produce high levels of the stress hormone, cortisol in a child. The ongoing presence of cortisol in the bloodstream can have lasting effects such as hypervigilance, increased sensitivity to others, and what some refer to as “addiction to chaos”. This “addiction” is manifested in children creating chaos and not feeling comfortable with routine or novelty. The family relationships also become a guide for a child in determining how relationships should work. A child that is exposed to negative relationships begins to believe that these characteristics are normal and may begin to imitate these characteristics. A family that is supportive of one another lays the foundation for a child to experience success in other relationships, support for school success, positive self-esteem and skills in developing empathy and caring. It is helpful to observe and question the types of activities the family is involved in, if there is mutual enjoyment and investment in these activities, the amount of time spent together, how the family identifies strategies for supporting one another, how the family reacts to challenges, how they react to successes of all or individual members, and the family’s assessment of their level of support and love of one another.

SOCIAL AND EMOTIONAL FUNCTIONING

This item rates the child’s social and relationship functioning. This includes age appropriate behavior and the ability to make and maintain relationships during the past 30 days. When rating this item, consider the child’s level of development.

<p>Questions to Consider</p> <ul style="list-style-type: none"> • How does your child get along with others? • Can your child engage with and respond to adults? • Does your child interact with others in an age-appropriate manner? 	<p>Ratings and Descriptions</p> <p>0 <i>No current need; no need for action or intervention.</i> No evidence of problems with social functioning; child has positive social relationships.</p> <hr/> <p>1 <i>Identified need that requires monitoring, watchful waiting, or preventive action based on history, suspicion or disagreement.</i> Child is having some problems in social relationships. Infants may be slow to respond to adults, Toddlers may need support to interact with peers and preschoolers may resist social situations.</p> <hr/> <p>2 <i>Action or intervention is required to ensure that the identified need is addressed; need is interfering with functioning.</i> Child is having problems with their social relationships. Infants may be unresponsive to adults, and unaware of other infants. Toddlers may be aggressive and resist parallel play. Preschoolers may argue excessively with adults and peers and lack ability to play in groups even with adult support.</p> <hr/> <p>3 <i>Need is dangerous or disabling; requires immediate and/or intensive action.</i> Child is experiencing disruptions in their social relationships. Infants show no ability to interact in a meaningful manner. Toddlers are excessively withdrawn and unable to relate to familiar adults. Preschoolers show no joy or sustained interaction with peers or adults, and/or aggression may be putting others at risk.</p>
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Supplemental Information: This item is important to assess due to how significantly it relates to all other areas of development. A child that is struggling in their capacity to relate to their parents, caregivers and peers will also struggle in their ability to find support for the other areas of development. The importance of the parent/child relationship and the child’s capacity to socialize and regulate their emotions gives a child the tools to move forward in all other areas. Motivation for challenge, coping with frustration and the ability to feel good about one’s accomplishments all occur through healthy relationships and supports further growth

The following reference is from Landy, S. (2002). *Pathways to competence: Encouraging healthy social and emotional development in young children*, (pp. 12- 27). Baltimore: Paul H. Brookes Publishing Co.

<p>By 3 Months</p>	<ul style="list-style-type: none"> • Is available and enjoys responsive interaction with caregivers • Quiets if upset when picked up • Recognizes caregiver and responds with pleasure; reaches out to caregiver Enjoys being held and cuddled at times other than feeding and bedtime • Smiles in response to a friendly face or voice • Stops crying when parent or caregiver comes near • Expresses basic emotions • Uses sustained looking or sucking to calm down • Entertains self by playing with hands, feet, and toes
<p>By 7 Months</p>	<ul style="list-style-type: none"> • Laughs out loud • Cries in response to another infant’s cry • Beginning to feel security with and attachment to primary caregiver • Reacts to emotional displays of others [continued]

SOCIAL AND EMOTIONAL FUNCTIONING continued

<p>By 7 Months continued</p>	<ul style="list-style-type: none"> • Gets upset at “still” face of caregiver or if caregiver does not respond • Shows fear of falling off high places • Expresses emotions with recognizable and different sounds and expressions • May make different emotional responses to different experiences such as hearing a vacuum or a dog barking • Shouts for attention • May cry if caregiver leaves • Plays interactive games such as Peekaboo • Knows difference between familiar and unfamiliar people
<p>By 14 Months</p>	<ul style="list-style-type: none"> • Shows more control over display of emotions • Likes caregivers to be in sight • Indicates social referencing or awareness of emotional signals of caregivers Demonstrates fear of strange objects and events and separation • Develops fear of heights • May show fear of strangers an of separation from parents • Often becomes attached to a cuddly toy or a blanket • Likes to hide • Babbles or jabbers to get attention • Can distinguish between self and others • Engages in parallel play with others children with eye contact and occasional sounds • Can join another person in looking at an object • May point out something to another person and follow the gaze of someone else Recognizes peer as social partner; likes to be around other children • Is capable of turn taking • Imitates actions of another person
<p>By 2 Years</p>	<ul style="list-style-type: none"> • Often checks caregiver’s facial expression to see what caregiver is feeling Shows shame if he or she does not succeed at a task • Recognizes him or herself in a mirror • Experiences anxiety if an object is flawed or broken • Complies about 45%of the time • Gets upset if her or she cannot meet standards • Labels of emotions of others • May be defiant; temper tantrums are at their peak • Demonstrates self-conscious emotions of shame and embarrassment • Shows and points • Can look at something together with another person • Plays close to others and joins in play together • Plays games such as Hide and Seek, rolling a ball back and forth Uses personal pronouns • May comfort another child • Is possessive with toys, and finds it hard to share
<p>By 4 Years</p>	<ul style="list-style-type: none"> • Can consistently bring to mind the memory of a caregiver • Displays emotional reactions to distress of others • Understands rules about what to do and what not to do • Argues and justifies actions more often with parents Integrates “good” and “bad” parts of self and of others • Some fear may increase • Is less likely to change emotion rapidly but can switch between being stubborn and cooperative quite quickly • Some sharing behavior and cooperative play, but at times acts selfishly Imitates and follow the leader • Increased awareness of standards and rules • Shows reciprocal and complementary roles during pretend play • May have a close friend • Less likely to express intense emotions, and emotions switch less rapidly so more likely to sustain social interactions • Expresses less aggression and more verbal anger • Seeks approval from others for accomplishments

SELF CARE/DAILY LIVING SKILLS

This item describes the child's skill level in feeding, dressing, grooming and other self-care tasks.

Questions to Consider:

- Is your child demonstrate age appropriate feeding, grooming, toileting and other self-care tasks?

Ratings & Descriptions

- 0 *No current need; no need for action or intervention.*
No evidence of problems with self-care/daily living skills.
-
- 1 *Identified need that requires monitoring, watchful waiting, or preventive action based on history, suspicion or disagreement.*
There is either a history of self-care/daily living skill problems, or slow development in this area.
-
- 2 *Action or intervention is required to ensure that the identified need is addressed; need is interfering with functioning.*
The child does not meet developmental milestones related to self-care/daily living skills and experiences problems in functioning in this area.
-
- 3 *Need is dangerous or disabling; requires immediate and/or intensive action.*
The child has significant challenges in self-care/daily living and is in need of intensive or immediate help in this area.

Supplemental Information: This item is important to assess due to how significantly it relates to all other areas of development. A child that is struggling in their capacity to relate to their parents, caregivers and peers will also struggle in their ability to find support for the other areas of development. The importance of the parent/child relationship and the child's capacity to socialize and regulate their emotions gives a child the tools to move forward in all other areas. Motivation for challenge, coping with frustration and the ability to feel good about one's accomplishments all occur through healthy relationships and supports further growth

The following reference is from Landy, S. (2002). *Pathways to competence: Encouraging healthy social and emotional development in young children*, (pp. 12- 27). Baltimore: Paul H. Brookes Publishing Co.

By 3 Months	<ul style="list-style-type: none"> • Explores environment by looking around • Opens mouth to touch of nipple or bottle • Sucks well • Enjoys being bathed
By 7 Months	<ul style="list-style-type: none"> • Places hands on bottle or breast during feeding • Enjoys making things happen such as squeezing a toy to make a noise • Can pick up objects
By 14 Months	<ul style="list-style-type: none"> • Sips from a cup with assistance • May begin to use a spoon • Can ask for a drink by pointing or gesturing • Can feed self with finger foods • Interested in pulling off clothes • Removes food from spoon with tongue
By 2 Years	<ul style="list-style-type: none"> • Uses cup with minimal spilling • Puts on shoes, socks and shorts • Can use spoon to feed him or herself • May tell parent when "wet" and may begin to indicate need to use potty • Cooperates in dressing • Unbuttons large buttons; unzips large zippers
By 4 Years	<ul style="list-style-type: none"> • Can dress and undress fully • Can do up buttons • Can feed self with little spilling • Can pour from jug into cup • Is toilet trained, may stay dry at night Uses fork effectively

PARENT/CHILD INTERACTION

This item describes how the parent/primary caregiver and their child interact with each other.

Questions to Consider:

- How would you describe your child's style in getting your attention?
- What are the activities you like and dislike to do with your child?
- Does it feel as if you have enough enjoyable moments with your child?
- Do you have any concerns about the way your child relates to you?

Ratings & Descriptions

- 0 *No current need; no need for action or intervention.*
No evidence of problems in the parent/child interaction.
-
- 1 *Identified need that requires monitoring, watchful waiting, or preventive action based on history, suspicion or disagreement.*
There is either a history of problems or suboptimal functioning in parent/child interaction. There may be inconsistent or indications that interaction is not optimal that has not yet resulted in problems.
-
- 2 *Action or intervention is required to ensure that the identified need is addressed; need is interfering with functioning.*
The parent/child dyad interacts in a way that is problematic and has led to interference with the child's growth and development.
-
- 3 *Need is dangerous or disabling; requires immediate and/or intensive action.*
The parent/child dyad is having significant problems that can be characterized as abusive or neglectful.

Supplemental Information: The way in which a parent/child dyad interacts is a critical area to assess and intervene in if necessary. Perhaps, there is nothing that has more impact on a child than the way that their parent interacts with them. The parent/child interaction that is supportive allows for the child to focus fully on growth and development. It is the foundation for the development of all other social relationships and guides and supports all areas of development. This concept is outlined in the book, *Infant Mental Health Services: Supporting Competencies/Reducing Risks* by Deborah Weatherston and Betty Tableman as one of the basic principles of the infant mental health perspective in the statement that "an impaired or dyssynchronous relationship, or disruption through an extended separation can compromise physical and emotional well-being, impair the ability to trust and relate to others, promote withdrawn or impulsive acting out behavior, delay language development, and constrain the capacity to explore and to learn." The following list will highlight important areas to consider in observing parent/child interaction.

Assessment of Parent/Child Interaction:

- What is the predominant emotional tone of the interaction?
- Does the parent/child demonstrate good eye contact and communication?
- What is the balance of positive to negative interactions?
- What are the typical routines and activities of the parent/child?
- Does the dyad seem comfortable and interested in one another?
- Do the interactions seem smooth and synchronous?
- Does the dyad respond to each other's cues?
- Does the parent allow the child to lead play interactions?
- Does the parent and child demonstrate nurturing touch and behaviors toward one another?
- How does the child respond to limit setting?
- Does the dyad demonstrate appropriate boundaries and expectations of one another?
- Does the parent comfort the child when the child is hurt or upset?
- Can the parent accept the child's display of feelings even negative ones Does the parent support the child in exploration?

EARLY EDUCATION

This item rates the child's experiences in educational settings (such as daycare and preschool) and the child's ability to get their needs met in these settings. This item also considers the presence of problems within these environments in terms of attendance, progress, support from the school staff to meet the child's needs, and the child's behavioral response to these environments.

Questions to Consider	Ratings and Descriptions
<ul style="list-style-type: none">What is the child's experience in preschool/daycare?	<p>0 No current need; no need for action or intervention. No evidence of problem with functioning in current educational environment.</p>
<ul style="list-style-type: none">Does the child have difficulties with learning new skills, social relationships or behavior?	<p>1 <i>Identified need that requires monitoring, watchful waiting, or preventive action based on history, suspicion or disagreement.</i> History or evidence of problems with functioning in current daycare or preschool environment. Child may be enrolled in a special program.</p>
	<p>2 <i>Action or intervention is required to ensure that the identified need is addressed; need is interfering with functioning.</i> Child is experiencing difficulties maintaining their behavior, attendance, and/or progress in this setting.</p>
	<p>3 <i>Need is dangerous or disabling; requires immediate and/or intensive action.</i> Child's problems with functioning in the daycare or preschool environment place them at immediate risk of being removed from program due to their behaviors, lack of progress, or unmet needs.</p>

Supplemental Information: Infants, toddlers and preschoolers often spend the majority of their day with alternate caregivers. It is critical that these environments meet the needs of these individuals. There has been a great deal of momentum in the field of infant mental health to promote positive care-giving practices within these environments. Many child advocates such as Stanley Greenspan have devoted a great deal of time promoting these concepts. It is clear that the same parenting practices and care-giving techniques that are taught to parents need to be promoted within early care/education settings. These experiences are often critical in supporting growth and development and allowing the child to feel positive about relationships with others outside of the home. Early care and education settings have the potential to impact a child's development, school success and overall life success. The quality of the day care environment is important to consider as well as the day care's ability to meet the needs of the individual within a larger care-giving context. It is important for infants and children to be supported in ways that appreciates their individual needs and strengths. When assessing this item look for ways that the parent or child can indicate that the child's uniqueness is being accepted and embraced.

Indicators of an Appropriate Early Care/Educational Setting:

- Infant or child seems comfortable with caregivers and environment
- Environment has sufficient space and materials for child it serves
- Environment offers a variety of experiences and opportunities
- Allowances for individual differences, preferences and needs are tolerated
- Caregivers can offer insight into child's experiences and feelings
- Caregivers provide appropriate structure to the child's day
- Scheduled times for eating, play and rest
- Caregivers provide appropriate level of supervision and limit setting
- Child's peer interactions are observed, supported and monitored
- Correction is handled in a calm and supportive manner
- Child is encouraged to learn and explore at their own pace
- A variety of teaching modalities are utilized
- All areas of development are valued and supported simultaneously
- Small group sizes
- Low child-adult ratios
- Safe and clean environment
- Early care/education setting provides frequent and open communication with parents

This item also considers the presence of problems within these environments in terms of attendance, academic performance and support and behavioral response to these environments. If any of these areas are problematic than the item would be rated a '2'.

INTENTIONAL MISBEHAVIOR

This rating describes intentional behaviors that a child engages in to force others to administer consequences. This item should reflect problematic social behaviors (socially unacceptable behavior for the culture and community in which the child lives) that put the child at some risk of consequences. It is not necessary that the child be able to articulate that the purpose of their misbehavior is to provide reactions/consequences to rate this item. There is always, however, a benefit to the child resulting from this unacceptable behavior even if it does not appear this way on the face of it (e.g., child feels more protected, more in control, less anxious because of the sanctions). This item should not be rated for child who engage in such behavior solely due to developmental delays.

Questions to Consider

- Does the child intentionally do or say things to upset others or get in trouble with people in positions of authority or (e.g., parents or teachers)?
- Has the child engaged in behavior that was insulting, rude or obnoxious and which resulted in sanctions?

Ratings and Descriptions

- 0 No evidence of any needs. Child shows no evidence of problematic social behaviors that cause adults to administer consequences.
-
- 1 *Identified need that requires monitoring, watchful waiting, or preventive action based on history, suspicion or disagreement.*
Some problematic social behaviors that force adults to administer consequences to the child. Provocative comments or behavior in social settings aimed at getting a negative response from adults might be included at this level.
-
- 2 *Action or intervention is required to ensure that the identified need is addressed; need is interfering with functioning.*
Child may be intentionally getting in trouble in school or at home and the consequences, or threat of consequences is causing problems in the child's life.
-
- 3 *Need is dangerous or disabling; requires immediate and/or intensive action.*
Frequent seriously inappropriate social behaviors force adults to seriously and/or repeatedly administer consequences to the child. The inappropriate social behaviors may cause harm to others and/or place the child at risk of significant consequences (e.g. expulsion from educational setting).

Supplemental Information: Intentional Misbehavior refers to the child's behavior within a social setting that may or may not need sanctioning on an adult's part. A child that is unable to function appropriately in a social setting often will be kept from participating in these types of activities. This may interfere with the child's opportunity to further develop in this area. Parents often relate concerns for allowing children to be in problematic social situations as harm to others, possible harm to self, lack of willingness or energy to adequately supervise and support the child's challenges, and embarrassment of parents regarding behavior. In assessing whether or not there are challenges in this area the following considerations should be made: what is the parent's understanding of age appropriate behavior, what types of behaviors are present and how long lasting are they, can the child discontinue behaviors considered inappropriate with adult intervention, do the behaviors threaten either the child or others, does the child's behaviors result in parent's avoiding certain situations and does the child enjoy social situations.

Typically Developing Patterns of Intentional Misbehavior

- Infants will demonstrate voluntary efforts to initiate action with others and sustain interaction with them. Infants will change interaction patterns based on facial expressions.
- Toddlers will use the reactions of their primary caregivers to guide their own reactions (social referencing). Toddlers can comply with simple directions and restrictions.
- Preschoolers will generally cooperate with caregivers and need less ongoing support and guidance to maintain control in social setting. They are able to remember rules and have internalized basic standards of behavior.
- Early School age children are able to regulate their actions through discussion. They have internalized standards of behavior and rely less on others to enforce basic standards. They are capable of judging their own behavior and behavior others.

CHALLENGES

The ratings in this section identify the behavioral health needs of the child. While the CANS is not a diagnostic tool, it is designed to be consistent with diagnostic communication. In the DSM, a diagnosis is defined by a set of symptoms that is associated with either dysfunction or distress. This is consistent with the ratings of '2' or '3' as described by the action levels below.

Question to Consider for this Domain: What are the presenting social, emotional, and behavioral challenges of the child?

For **Challenges**, use the following categories and action levels:

- 0 No current need; no need for action or intervention.
- 1 Identified need that requires monitoring, watchful waiting, or preventive action based on history, suspicion or disagreement.
- 2 Action is required to ensure that the identified need is addressed; need is interfering with functioning.
- 3 Need is dangerous or disabling; requires immediate and/or intensive action.

IMPULSIVITY/HYPERACTIVITY

Problems with impulse control and impulsive behaviors, including motoric disruptions, are rated here. This includes behavioral symptoms associated with Attention-Deficit Hyperactivity Disorder (ADHD), Impulse-Control Disorders and mania as indicated in the DSM-5. Children with impulse problems tend to engage in behavior without thinking, regardless of the consequences. This can include compulsions to engage in gambling, violent behavior (e.g., road rage), sexual behavior, fire-starting or stealing. Manic behavior is also rated here.

Questions to Consider:

FOR INFANTS:

- Does your child's activity level concern you?
- Have you needed to find ways to prevent your child from getting hurt due to their activity level?
- What happens as the result of your child being active?
- Does your child need a high level of supervision due to their activity level?

Ratings & Descriptions

- 0 *No current need; no need for action or intervention.*
No evidence of symptoms of loss of control of behavior.

- 1 *Identified need that requires monitoring, watchful waiting, or preventive action based on history, suspicion or disagreement.*
There is a history or evidence of mild levels of impulsivity evident in action or thought that place the child at risk of future functioning difficulties. The child may exhibit limited impulse control, e.g., child may yell out answers to questions or may have difficulty waiting their turn. Some motor difficulties may be present as well, such as pushing or shoving others.

- 2 *Action or intervention is required to ensure that the identified need is addressed; need is interfering with functioning.*
Clear evidence of problems with impulsive, distractible, or hyperactive behavior that interferes with the child's functioning in at least one life domain. This indicates a child with impulsive behavior who may represent a significant management problem for adults (e.g., caregivers, teachers, coaches, etc.). A child who often intrudes on others and often exhibits aggressive impulses would be rated here.

- 3 *Need is dangerous or disabling; requires immediate and/or intensive action.*
Clear evidence of a dangerous level of hyperactivity and/or impulsive behavior that places the child at risk of physical harm. This indicates a child with frequent and significant levels of impulsive behavior that carries considerable safety risk (e.g., running into the street, dangerous driving or bike riding). The child may be impulsive on a nearly continuous basis. He or she endangers self or others without thinking.

Supplemental information: This item is designed to allow for the description of the child's ability to control his/her own behavior, including impulsiveness, hyperactivity and/or distractibility. If a child has been diagnosed with Attention-Deficit/Hyperactivity Disorder (AD/HD) and disorders of impulse control, this may be rated here. Children with impulse problems tend to engage in behavior without thinking, regardless of the consequences. A '3' on this item is reserved for those whose lack of control of behavior has placed them in physical danger during the period of the rating. Consider the child's environment when rating (i.e., bored kids tend to be impulsive kids). [continues]

IMPULSIVITY/HYPERACTIVITY continued

AD/HD is characterized by either frequently displayed symptoms of inattention (e.g., difficulty sustaining attention, not seeming to listen when spoken to directly, losing items, forgetful in daily activities, etc.) or hyperactivity or impulsivity (e.g., fidgety, difficulty playing quietly, talking excessively, difficulty waiting his or her turn, etc.) to a degree that it causes functioning problems.

DSM-5 Criteria for **Attention-Deficit/Hyperactivity Disorder**: A persistent pattern of inattention and/or hyperactivity-impulsivity that interferes with function or development characterized by (1) and/or (2):

1. Inattention: 6 or more of the following symptoms for 6 months:
 - Often fails to give close attention to details or makes careless mistakes
 - Difficulty sustaining attention in tasks or play activities
 - Does not seem to listen when spoken to directly
 - Does not follow through on instructions and fails to finish tasks
 - Difficulty organizing tasks and activities
 - Avoids, dislikes, or is reluctant to engage in tasks that require sustained mental effort
 - Loses things necessary for tasks or activities
 - Easily distracted by extraneous stimuli
 - Forgetful in daily activities
2. Hyperactivity and Impulsivity: 6 or more of the following symptoms for 6 months:
 - Fidgets with or taps hands or feet or squirms in seat; leaves seat in situations when remaining seated is expected
 - Runs about or climbs where it is inappropriate
 - Unable to play or engage in leisure activities quietly
 - Often "on the go" acting as if "driven by a motor"
 - Talks excessively; interrupts or intrudes on others; blurts out an answer before a question has been complete
 - Has difficulty waiting his/her turn

DEPRESSION

This item rates symptoms such as irritable or depressed mood, social withdrawal, sleep disturbances, weight/eating disturbances, and loss of motivation, interest or pleasure in daily activities. This item can be used to rate symptoms of the depressive disorders as specified in DSM-5.

	Ratings & Descriptions
Questions to Consider: <ul style="list-style-type: none">• How would you describe your child's mood most of the time?• Is it difficult to engage your child in play?• Have there been changes in how your child relates to you and others?• If this has been a problem, what have you done to help the situation?	0 <i>No current need; no need for action or intervention.</i> No evidence of problems with depression.
	1 <i>Identified need that requires monitoring, watchful waiting, or preventive action based on history, suspicion or disagreement.</i> History or suspicion of depression or evidence of depression associated with a recent negative life event with minimal impact on life domain functioning. Brief duration of depression, irritability, or impairment of peer, family, or academic functioning that does not lead to pervasive avoidance behavior.
	2 <i>Action or intervention is required to ensure that the identified need is addressed; need is interfering with functioning.</i> Clear evidence of depression associated with either depressed mood or significant irritability. Depression has interfered significantly in child's ability to function in at least one life domain.
	3 <i>Need is dangerous or disabling; requires immediate and/or intensive action.</i> Clear evidence of disabling level of depression that makes it virtually impossible for the child to function in any life domain. This rating is given to a child with a severe level of depression. This would include a child who stays at home or in bed all day due to depression or one whose emotional symptoms prevent any participation in school, friendship groups, or family life. Disabling forms of depressive diagnoses would be rated here.

Supplemental information: An infant or young child that is attempting to cope with feelings of sadness or depression is compromised in their ability to attend to the tasks of development. Many clinicians and caregivers do not believe that an infant can experience depression despite the fact that researchers and clinicians began documenting this condition in the early 1940's when Anna Freud and Dorothy Burlingham recorded the reactions of young children removed from their parents during World War II. The two researchers documented a distinct grief reaction that started with protest, continued to despair and finally the children appeared disconnected, withdrawn, developmentally delayed and almost resolved to their fate. A child that is traumatized in any way may first develop a traumatic response that can develop into depression and meet criteria for a depressive disorder. There are children in which it is difficult to identify a specific trauma although they appear depressed. A child may experience depression that is not reactive in nature. At times it is a challenge for the caregiver to identify or even believe a specific environmental condition may contribute to depression in young children. These factors may include a chaotic home environment, poor or limited interaction from caregivers, or preoccupation of caregiver with their own stressors.

ANXIETY

This item rates symptoms associated with DSM-5 Anxiety Disorders characterized by excessive fear and anxiety and related behavioral disturbances (including avoidance behaviors). Panic attacks can be a prominent type of fear response.

Questions to Consider	Ratings and Descriptions
<ul style="list-style-type: none">Does the child have any problems with anxiety or fearfulness?Is the child avoiding normal activities out of fear?Does the child act frightened or afraid?	<p>0 <i>No current need; no need for action or intervention.</i> No evidence of anxiety symptoms.</p> <hr/>
	<p>1 <i>Identified need that requires monitoring, watchful waiting, or preventive action based on history, suspicion or disagreement.</i> There is a history, suspicion, or evidence of some anxiety associated with a recent negative life event. This level is used to rate either a phobia or anxiety problem that is not yet causing the individual significant distress or markedly impairing functioning in any important context.</p> <hr/>
	<p>2 <i>Action or intervention is required to ensure that the identified need is addressed; need is interfering with functioning.</i> Clear evidence of anxiety associated with either anxious mood or significant fearfulness. Anxiety has interfered in the child's ability to function in at least one life domain.</p> <hr/>
	<p>3 <i>Need is dangerous or disabling; requires immediate and/or intensive action.</i> Clear evidence of debilitating level of anxiety that makes it virtually impossible for the child to function in any life domain. [continues]</p>

Supplemental Information: Specific information to consider regarding anxiety and infants and young children:

- Action Level '1': An infant may appear anxious in certain situations but has the ability to be soothed. Older children may appear in need of extra support to cope with some situations but are able to be calmed.
- Action Level '2': Infants may be irritable, over reactive to stimuli, have uncontrollable crying and significant separation anxiety. Older children may have all of the above with persistent reluctance or refusal to cope with some situations.

OPPOSITIONAL (Non-compliance with Authority)

This item rates the child's relationship with authority figures. Generally oppositional behavior is displayed in response to conditions set by a parent, teacher or other authority figure with responsibility for and control over the child.

Questions to Consider	Ratings and Descriptions
<ul style="list-style-type: none">Does the child follow their caregivers' rules?Have teachers or other adults reported that the child does not follow rules or directions?Does the child argue with adults when they try to get the child to do something?Does the child do things that they have been explicitly told not to do?	<p>0 <i>No current need; no need for action or intervention.</i> No evidence of oppositional behaviors.</p> <hr/>
	<p>1 <i>Identified need that requires monitoring, watchful waiting, or preventive action based on history, suspicion or disagreement.</i> There is a history or evidence of mild level of defiance towards authority figures that has not yet begun to cause functional impairment. Child may occasionally talk back to teacher, parent/caregiver; there may be letters or calls from school.</p> <hr/>
	<p>2 <i>Action or intervention is required to ensure that the identified need is addressed; need is interfering with functioning.</i> Clear evidence of oppositional and/or defiant behavior towards authority figures that is currently interfering with the child's functioning in at least one life domain. Behavior causes emotional harm to others. A child whose behavior meets the criteria for Oppositional Defiant Disorder in DSM-5 would be rated here.</p> <hr/>
	<p>3 <i>Need is dangerous or disabling; requires immediate and/or intensive action.</i> Clear evidence of a dangerous level of oppositional behavior involving the threat of physical harm to others. This rating indicates that the child has severe problems with compliance with rules or adult instruction or authority. [continues]</p>

OPPOSITIONAL (Non-compliance with Authority) continued

Supplemental Information: Oppositional behavior is a significant concern for parents, teachers and caregivers. It is one of the most common reasons for referral for a mental health assessment. Behavioral difficulties may range from significant to mild and may interfere with a child's functioning in varying ways. In determining how to rate this item it is important to remember that etiology is not a factor in the rating. Although a child may be experiencing ineffective parenting to explain oppositional behavior, it is still present. Oppositional behavior refers to reactions towards adults, not peers.

Characteristics of Oppositional Behavior in Preschoolers:

- Presence of "hostile defiance" rather than attempts to negotiate or avoid punishment
- Consistent pattern of refusal to comply to adult requests
- Temper tantrums
- Often loses temper
- Often argues with adults Is often angry or vindictive Blames others for mistakes Annoys or provokes others

ATTACHMENT DIFFICULTIES

This item should be rated within the context of the child's significant parental or caregiver relationships.

	Ratings and Descriptions
<p>Questions to Consider</p> <ul style="list-style-type: none">• Does the child struggle with separating from caregiver?• Does the child approach or attach to strangers in indiscriminate ways?• Does the child have the ability to make healthy attachments to appropriate adults or are their relationships marked by intense fear or avoidance?• Does the child have separation anxiety issues that interfere with ability to engage in childcare or preschool?	<p>0 <i>No current need; no need for action or intervention.</i></p> <p>No evidence of attachment problems. Caregiver-child relationship is characterized by mutual satisfaction of needs and child's development of a sense of security and trust. Caregiver is able to respond to child cues in a consistent, appropriate manner, and child seeks age-appropriate contact with caregiver for both nurturing and safety needs.</p>
	<p>1 <i>Identified need that requires monitoring, watchful waiting, or preventive action based on history, suspicion or disagreement.</i></p> <p>Some history or evidence of insecurity in the caregiver-child relationship. Caregiver may have difficulty accurately reading child's bids for attention and nurturance; may be inconsistent in response; or may be occasionally intrusive. Child may have some problems with separation (e.g., anxious/clingy behaviors in the absence of obvious cues of danger) or may avoid contact with caregiver in age-inappropriate way. Child may have minor difficulties with appropriate physical/emotional boundaries with others.</p>
	<p>2 <i>Action or intervention is required to ensure that the identified need is addressed; need is interfering with functioning.</i></p> <p>Problems with attachment that interfere with child's functioning in at least one life domain and require intervention. Caregiver may consistently misinterpret child cues, act in an overly intrusive way, or ignore/avoid child's bids for attention/nurturance. Child may have ongoing difficulties with separation, may consistently avoid contact with caregivers, and have ongoing difficulties with physical or emotional boundaries with others. [continues]</p>
	<p>3 <i>Need is dangerous or disabling; requires immediate and/or intensive action.</i></p> <p>Child is unable to form attachment relationships with others (e.g., chronic dismissive/avoidant/detached behavior in care giving relationships) OR child presents with diffuse emotional/physical boundaries leading to indiscriminate attachment with others. Child is considered at ongoing risk due to the nature of their attachment behaviors. Child may have experienced significant early separation from or loss of caregiver, or have experienced chronic inadequate care from early caregivers, or child may have individual vulnerabilities (e.g., mental health, developmental disabilities) that interfere with the formation of positive attachment relationships.</p>

Supplemental Information: DSM-5 Reactive Attachment Disorder and Disinhibited Social Engagement Disorder criteria are noted below. Social neglect, or the absence of adequate caregiving during childhood, is a part of both disorders.

Reactive Attachment Disorder: An internalizing disorder with depressive symptoms and withdrawn behavior.

A. A consistent pattern of inhibited, emotionally withdrawn behavior toward adult caregivers, manifested by both of the following:

1. The child rarely or minimally seeks comfort when distressed.
2. The child rarely or minimally responds to comfort when distressed.

B. A persistent social and emotional disturbance characterized by at least two of the following:

1. Minimal social and emotional responsiveness to others.
2. Limited positive affect.
3. Episodes of unexplained irritability, sadness, or fearfulness that are evident even during nonthreatening interactions with adult caregivers.

ATTACHMENT DIFFICULTIES continued

Disinhibited Social Engagement Disorder: An externalizing disorder marked by disinhibited behavior.

A pattern of behavior in which a child actively approaches and interacts with unfamiliar adults and exhibits at least two of the following:

1. Reduced or absent reticence in approaching and interacting with unfamiliar adults.
2. Overly familiar verbal or physical behavior (that is not consistent with culturally sanctioned and with age-appropriate social boundaries).
3. Diminished or absent checking back with adult caregiver after venturing away, even in unfamiliar settings.
4. Willingness to go off with an unfamiliar adult with little or no hesitation.

ADJUSTMENT TO TRAUMA

This item is used to describe the child who is having difficulties adjusting to a traumatic experience, as defined by the child. This is one item where speculation about why a person is displaying a certain behavior is considered. There should be an inferred link between the trauma and the behavior.

Questions to Consider	Ratings and Descriptions
<ul style="list-style-type: none">• Has the child experienced a traumatic event?• Does the child experience frequent nightmares?• Is the child troubled by flashbacks?• What are the child's current coping skills?	<p>0 <i>No current need; no need for action or intervention.</i> No evidence that child has experienced a traumatic life event, OR child has adjusted well to traumatic/adverse experiences.</p>
	<p>1 <i>Identified need that requires monitoring, watchful waiting, or preventive action based on history, suspicion or disagreement.</i> The child has experienced a traumatic event and there are some changes in their behavior that are managed or supported by caregivers. These symptoms are expected to ease with the passage of time and therefore no current intervention is warranted. Child may be in the process of recovering from a more extreme reaction to a traumatic experience, which may require a need to watch these symptoms or engage in preventive action.</p>
	<p>2 <i>Action or intervention is required to ensure that the identified need is addressed; need is interfering with functioning.</i> Clear evidence of adjustment problems associated with traumatic life event(s). Symptoms can vary widely and may include sleeping or eating disturbances, regressive behavior, behavior problems or problems with attachment. Adjustment is interfering with child's functioning in at least one life domain.</p>
	<p>3 <i>Need is dangerous or disabling; requires immediate and/or intensive action.</i> Clear evidence of debilitating level of trauma symptoms that makes it virtually impossible for the child to function in any life domain including symptoms such as flashbacks, nightmares, significant anxiety, intrusive thoughts, and/or re-experiencing trauma (consistent with PTSD).</p>

Supplemental Information: Trauma is an experience that can have serious implications for children of all ages. A child may experience developmental arrest, developmental regression, depression, anxiety, cognitive disturbances and perhaps most significantly impairment in their ability to use the attachment relationship. More specifically research has indicated that a child may develop abnormal patterns in their feeling expression, unusual or deviant patterns of behavior, distractibility, inattention, disturbances in eating and elimination patterns, poor sleep, delays in motor and language acquisition (Scheeringa & Gaensbauer, 2000). A child may develop very distorted views about their safety, the safety of others and view others as threatening and harmful to their own well-being. It is also true that children respond to trauma in a very individualized fashion and the duration of these reactions may range from short term to long lasting. A number of factors that may affect the way a child responds to trauma are listed below.

Factors Affecting Response to Trauma:

- Temperamental Variations
- Age and Developmental Stage
- Parental Response and Ability to Support the Child
- Presence of Environmental Supports
- Intellectual Ability
- Degree of Structure and Predictability Within the Home
- Presence of Age Appropriate Explanations Regarding Trauma
- Ability of the Child to Integrate the Traumatic Experience
- Parental Ability to Predict Child's Need for Support in the Presence of Traumatic Reminders and Ability to Demonstrate Support to Child
- Degree of Perceived Threat or Harm to Child and/or Significant Others

[continues]

ADJUSTMENT TO TRAUMA continued

All of the above factors can impact the child's ability to cope with trauma. In considering temperamental variables it is important to be aware of first what the child's temperament consists of and how these variables are received and supported within the home. A child that is adaptable and comfortable with change will use this to their benefit in the face of trauma. If a child is challenged in this capacity a parent that is aware and able to assist the child in this area can make a significant difference for a child. The child's developmental status is significant as well. If a child is focused on attempting to master major developmental tasks their emotional reservoir may be more easily drained. A child's age is also an important factor. Children that are preverbal may incorporate memories in a manner that is harder to access and process. The ability to use cognitive appraisal and restructuring to mediate anxiety is a particular advantage and may not be available to a younger child. Of all age groups, children under the age of 5 are the least resilient when it comes to trauma. Early childhood trauma can have the greatest impact due to its ability to alter fundamental neuro-chemical processes which in turn affect the growth, structure and functioning in the brain. If the child has a caregiver that can provide a basic feeling for the child of being safe and providing a predictable routine a child will stabilize much faster than if this is not present. A child may need the opportunity to process what occurred with an adult and gain an understanding that will also help with feelings of anxiety. A child's magical thinking or errors in cognition may contribute to less managed anxiety. The type of trauma needs to be understood as well. There are various types of trauma such as medical, disasters such as flooding or tornados, abuse, neglect, separation from caregivers, exposure to domestic violence or violence in the community.

REGULATORY

Item refers to all dimensions of self-regulation, including the quality and predictability of sucking/feeding, sleeping, elimination, activity level/intensity, sensitivity to external stimulation, and ability to be consoled.

Questions to Consider

- Does the child have particular challenges around transitioning from one activity to another resulting at times in the inability to engage in activities?
- Does the child have severe reactions to changes in temperature or clothing such that it interferes with engaging in activities/school or play?
- Does the child require more adult supports to cope with frustration than other children in similar settings? Does the child have more distressing tantrums or yelling fits than other children?

Ratings and Descriptions

0 *No current need; no need for action or intervention.*

Strong evidence the child is developing strong self-' capacities. This is indicated by the capacity to fall asleep, regular patterns of feeding and sleeping. Young infants can regulate breathing and body temperature, are able to move smoothly between states of alertness, sleep, feeding on schedule, able to make use of caregiver/ pacifier to be soothed, and moving toward regulating themselves (e.g., infant can begin to calm to caregiver's voice prior to being picked up). Toddlers are able to make use of caregiver to help regulate emotions, fall asleep with appropriate transitional objects, can attend to play with increased attention and play is becoming more elaborated, or have some ability to calm themselves down.

1 *Identified need that requires monitoring, watchful waiting, or preventive action based on history, suspicion or disagreement.*

At least one area of concern about an area of regulation--breathing, body temperature, sleep, transitions, feeding, crying--but caregiver feels that adjustments on their part are effective in assisting child to improve regulation; monitoring is needed.

2 *Action or intervention is required to ensure that the identified need is addressed; need is interfering with functioning.*

Concern in one or more areas of regulation: sleep, crying, feeding, tantrums, sensitivity to touch, noise, and environment. Referral to address self-regulation is needed.

3 *Need is dangerous or disabling; requires immediate and/or intensive action.*

Concern in two or more areas of regulation, including but not limited to: difficulties in breathing, body movements, crying, sleeping, feeding, attention, ability to self soothe, and/or sensitivity to environmental stressors.

ATYPICAL BEHAVIORS

This item describes ritualized or stereotyped behaviors (whether the child repeats certain actions over and over again), or demonstrates behaviors that are unusual or difficult to understand. Behaviors may include mouthing after 1 year, head banging, smelling objects, spinning, twirling, hand flapping, finger-flicking, rocking, tow walking, staring at lights, or repetitive and bizarre verbalizations.

Questions to Consider

- Does the child exhibit behaviors that are unusual or difficult to understand?
- Does the child engage in certain repetitive actions?
- Are the unusual behaviors or repeated actions interfering with the child's functioning?

Ratings and Descriptions

- 0 *No current need; no need for action or intervention.*
No evidence of atypical behaviors (repetitive or stereotyped behaviors) in the infant/child.
-
- 1 *Identified need that requires monitoring, watchful waiting, or preventive action based on history, suspicion or disagreement.*
Atypical behaviors (repetitive or stereotyped behaviors) reported by caregivers or familiar individuals that may have mild or occasional interference in the child's functioning.
-
- 2 *Action or intervention is required to ensure that the identified need is addressed; need is interfering with functioning.*
Atypical behaviors (repetitive or stereotyped behaviors) generally noticed by unfamiliar people and have notable interference in the child's functioning.
-
- 3 *Need is dangerous or disabling; requires immediate and/or intensive action.*
Atypical behaviors (repetitive or stereotyped behaviors) occur with high frequency, and are disabling or dangerous.

SLEEP

This item rates the child's sleep patterns. This item is used to describe any problems with sleep, regardless of the cause including difficulties falling asleep or staying asleep as well as sleeping too much. Both bedwetting and nightmares should be considered sleep issues. **The child must be 12 months of age to rate this item.**

Questions to Consider

- How much does the infant or child sleep during the day and night?
- Describe the activities that take place to assist the child in going to sleep or returning to sleep.
- Is the sleep routine variable or predictable?
- How does the sleep routine of the child affect the family?
- What are the sleeping arrangements?
- Does the child have nightmares or night terrors?
- Have the sleep problems changed over time?

Ratings and Descriptions

- 0 *No current need; no need for action or intervention.*
Child gets a full night's sleep each night.
-
- 1 *Identified need that requires monitoring, watchful waiting, or preventive action based on history, suspicion or disagreement.*
Child has some problems sleeping. Generally, child gets a full night's sleep but at least once a week problems arise. This may include occasionally awakening or bed wetting or having nightmares.
-
- 2 *Action or intervention is required to ensure that the identified need is addressed; need is interfering with functioning.*
Child is having problems with sleep. Sleep is often disrupted and child seldom obtains a full night of sleep.
-
- 3 *Need is dangerous or disabling; requires immediate and/or intensive action.*
Child is generally sleep deprived. Sleeping is almost always difficult and the child is not able to get a full night's sleep.
-
- NA Child is younger than 12 months old.

Supplemental Information: Sleep is one of the primary reasons families seek intervention. This is often due to the impact that this has on parents, and siblings. The bed-time routine, and actual amount of time spent asleep may be of concern to parents. Infants typically sleep 14-18 hours a day. Sleep does not have a regular circadian rhythm till approximately 6 months of age. In early childhood, children sleep approximately 8-12 hours per day and naps may continue throughout the day until the age of 3-5. Night waking is at times a concern. In infants it is not uncommon for the emergence of night waking to occur at approximately 6 months of age. Typically infants should be able to return to sleep easily or with parent support. Nightmares are also common during toddler, and preschool development to occur intermittently. They are often present when a child is attempting to master developmental tasks.

AGGRESSION

This item rates the child's violent or aggressive behaviors. The intention of the behavior is to cause significant bodily harm to others. A supervising adult is also taken into account in this rating, as a rating of '2' or '3' could signify a supervising adult who is not able to control the child's violent behaviors.

Questions to Consider:

- Have there been situations in which others have been hurt by your child?
- What does your child say about this problem?
- Have there been any changes to your child's activities or routines because of this?
- Has your child been asked not to return to a child care or school settings because of this?

Ratings & Descriptions

NA Child is not a toddler or school aged.

0 *No current need; no need for action or intervention.*

No action needed: No evidence of aggressive behavior.

1 *Need that requires monitoring, watchful waiting, or preventive action. This may have been a need in the past.*

History, suspicion or concerns of aggressive behavior towards people or animals that have not yet interfered with functioning.

2 *Action or intervention is required to ensure that the identified need is addressed; need is interfering with functioning.*

Clear evidence of aggressive behavior toward animals or others. Behavior is persistent, and caregiver's attempts to change behavior have not been successful. Help is needed.

3 *Need is dangerous or disabling; requires immediate and/or intensive action.*

Child exhibits a dangerous level of aggressive behavior involving harm to animals or others. Caregivers are unable to manage this behavior.

Supplemental Information: Aggression is often the reason parents seek assistance for young children and therefore this item was included in the early childhood versions. In research conducted by Carolyn Webster-Stratton (2003) it was determined that the need to intervene early with childhood aggressive problems is critical. She concluded that "by intervening early, the trajectory of early conduct problems leading to adolescent delinquency and adult antisocial behavior may be corrected".

Aggressive behavior in young children is often associated with other risk factors such as parental stress, parental drug abuse, maternal depression, and single parenthood. The more risk factors that are associated with the aggressive behavior, the more likely the behavior will persist and develop into more serious conduct problems (Webster-Stratton, 2003). Important considerations in the assessment of this item include: The severity of the aggression, pervasiveness of behavior, ability to use caregiver support to discontinue behavior, and frequency of the behavior. Although aggression may be present for a variety of reasons including parenting concerns, modeling of inappropriate behavior, poor impulse control, regulatory and sensory concerns or depression the etiology is not of concern in rating the item.

ATTENTION

This item rates whether the child has difficulties focusing on tasks and how this impacts their ability to play or participate in other activities.

Questions to Consider:

- Does your child seem to struggle with attention more than others their age?
- Does your child's attention span cause any problems in their ability to play or participate in other activities?
- Does your child's attention span interfere with their routines in any way?

Ratings & Descriptions

0 *No current need; no need for action or intervention.*

No evidence of attention problems.

1 *Identified need that requires monitoring, watchful waiting, or preventive action based on history, suspicion or disagreement.*

There is either a history of attention problems or suboptimal functioning in this area.

2 *Action or intervention is required to ensure that the identified need is addressed; need is interfering with functioning.*

There is clear evidence that the child demonstrates attention problems that interferes with functioning.

3 *Need is dangerous or disabling; requires immediate and/or intensive action.*

The child has significant challenges in attention that is causing delay or problems in development.

Supplemental Information: Attention is something that develops with age and should be considered problematic only within the framework of the child's developmental capacities. Attention is considered problematic when an infant or child cannot focus long enough to complete a task or activity. Ways in which this may be presented includes distractibility, shifting from activity to activity, not finishing tasks or rapidly shifting attention. An infant may not be able to focus for more than 5-6 seconds on a person, toy or interaction. Young children may appear to not play for periods of time that would seem normal for age, often show confusion about what is occurring, miss parts of conversations or pieces of information, and may not attend to self-care tasks.

CURRENT ENVIRONMENTAL STRESSORS

This item describes whether there are situations within the child’s home, community or school environment that have the potential to negatively impact the child or put them at risk.

Questions to Consider:

- Do you have any concerns that your child is being exposed to illegal substances – either directly or by being around those who abuse substances?
- Do you have any concerns that your child is, has been, or may be exposed to violence in the home or community?
- Do you feel that the places where your child spends time are safe?

Ratings & Descriptions

- | | |
|---|---|
| 0 | <i>No current need; no need for action or intervention.</i>
No evidence of current environmental stressors. |
| 1 | <i>Identified need that requires monitoring, watchful waiting, or preventive action based on history, suspicion or disagreement.</i>
There is either a history of environmental stressors or concern that these situations may emerge. |
| 2 | <i>Action or intervention is required to ensure that the identified need is addressed; need is interfering with functioning.</i>
There is clear evidence that the child is exposed to current environmental stressors. |
| 3 | <i>Need is dangerous or disabling; requires immediate and/or intensive action.</i>
The child is exposed to environmental stressors and is showing negative effects due to such. |

Supplemental Information: This item appreciates the stress and potential risk that a child may be exposed to when community and living situations are not ideal. Such situations include the presence of domestic violence, violence within the community, or unsafe school situations. All of these areas if present can be impacted or families can be assisted in problem solving ways to lessen the risk for children.

RISK BEHAVIORS & FACTORS

This section focuses on behaviors that can get children in trouble or put them in danger of harming themselves or others. Time frames in this section can change (particularly for ratings '1' and '3') away from the standard 30-day rating window.

Question to Consider for this Domain: Does the child's behavior put the child at risk for serious harm?

For the **Risk Behaviors & Factors**, use the following categories and action levels:

- 0 No current need; no need for action or intervention.
- 1 Need or risk behavior that requires monitoring, watchful waiting, or preventive action based on history, suspicion or disagreement.
- 2 Action is required to ensure that the identified need or risk behavior is addressed.
- 3 Intensive and/or immediate action is required to address the need or risk behavior.

SELF-HARM

This item includes reckless and dangerous behaviors that, while not intended to harm self or others, place the child or others at some jeopardy. **The child must be 12 months of age to rate this item.**

	Ratings and Descriptions
<p>Questions to Consider</p> <ul style="list-style-type: none"> • Has the child head banged or done other self-harming behaviors? • If so, does the caregiver's support help stop the behavior? 	<p>0 <i>No current need; no need for action or intervention.</i> There is no evidence of self-harm behaviors.</p>
	<p>1 <i>Need or risk behavior that requires monitoring, watchful waiting, or preventive action based on history, suspicion or disagreement.</i> History, suspicion or some evidence of self-harm behaviors. These behaviors are controllable by caregiver.</p>
	<p>2 <i>Action is required to ensure that the identified need or risk behavior is addressed.</i> Child's self-harm behaviors such as head banging that cannot be impacted by supervising adult and interferes with their functioning.</p>
	<p>3 <i>Intensive and/or immediate action is required to address the need or risk behavior.</i> Child's self-harm behavior that puts their safety and well-being at risk.</p>
	<p>NA Child is younger than 12 months of age.</p>

EXPLOITED

This item describes a history and pattern of being the object of abuse and includes a level of current risk for re-victimization. For children birth to age five, this can include sexual exploitation or being taken advantage of by others.

	Ratings and Descriptions
Questions to Consider <ul style="list-style-type: none">Has the child ever been victimized in any way (e.g. mugged, teased, bullied, abused, victim of a crime, etc.)?Are there concerns that they have been or is currently being taken advantage of by peers or other adults?Is the child currently at risk of being victimized by another person?	0 <i>No current need; no need for action or intervention.</i> No evidence of a history of exploitation OR no evidence of recent exploitation and no significant history of victimization within the past year. Child is not presently at risk for re-victimization.
	1 <i>Need or risk behavior that requires monitoring, watchful waiting, or preventive action based on history, suspicion or disagreement.</i> Suspicion or history of exploitation, but the child has not been exploited during the past year. Child is not presently at risk for re-victimization.
	2 <i>Action is required to ensure that the identified need or risk behavior is addressed.</i> Child has been recently exploited (within the past year) but is not at acute risk of re-exploitation. This might include experiences of physical or sexual abuse, significant psychological abuse by family or friends or violent crime.
	3 <i>Intensive and/or immediate action is required to address the need or risk behavior.</i> Child has recently been exploited and is at acute risk of re-exploitation.

PRENATAL CARE

This refers to the health care and pregnancy-related illness of the mother that impacted the child in utero.

	Ratings and Descriptions
Questions to Consider <ul style="list-style-type: none">What kind of prenatal care did the biological mother receive?Did the mother have any unusual illnesses or risks during pregnancy?	0 <i>No current need; no need for action or intervention.</i> Child's biological mother had adequate prenatal care (e.g. 10 or more planned visits to a physician) that began in the first trimester. Child's mother did not experience any pregnancy-related illnesses.
	1 <i>Need or risk behavior that requires monitoring, watchful waiting, or preventive action based on history, suspicion or disagreement.</i> Child's biological mother had some shortcomings in prenatal care, or had a mild form of a pregnancy-related illness. A child whose mother had 6 or fewer planned visits to a physician would be rated here; her care must have begun in the first or early second trimester. A child whose mother had a mild or well-controlled form of pregnancy-related illness such as gestational diabetes, or who had an uncomplicated high-risk pregnancy, would be rated here.
	2 <i>Action is required to ensure that the identified need or risk behavior is addressed.</i> Child's biological mother received poor prenatal care, initiated only in the last trimester, or had a moderate form of pregnancy-related illness. A child whose mother had 4 or fewer planned visits to a physician would be rated here. A mother who experienced a high-risk pregnancy with some complications would be rated here.
	3 <i>Intensive and/or immediate action is required to address the need or risk behavior.</i> Child's biological mother had no prenatal care, or had a severe form of pregnancy-related illness. A mother who had toxemia/preeclampsia would be rated here.

EXPOSURE

This item describes the child's exposure to environmental toxins and substance use and abuse both before and after birth.

	Ratings and Descriptions
Questions to Consider	<p>0 <i>No current need; no need for action or intervention.</i> Child had no in utero exposure to environmental toxins, alcohol or drugs, and there is currently no exposure in the home.</p>
	<p>1 <i>Need or risk behavior that requires monitoring, watchful waiting, or preventive action based on history, suspicion or disagreement.</i> Child had either some in utero exposure (e.g. mother ingested alcohol or tobacco in small amounts fewer than four times during pregnancy, or exposure to lead at home), or there is current alcohol and/or drug use in the home or environmental toxins in the home or community.</p>
	<p>2 <i>Action is required to ensure that the identified need or risk behavior is addressed.</i> Child was exposed to significant environmental toxins, alcohol or drugs in utero. Any ingestion of illegal drugs during pregnancy (e.g., heroin, cocaine), significant use of alcohol or tobacco, or exposure to environmental toxins would be rated here.</p>
	<p>3 <i>Intensive and/or immediate action is required to address the need or risk behavior.</i> Child was exposed to environmental toxins, alcohol or drugs in utero and continues to be exposed in the home or community. Any child who evidenced symptoms of substance withdrawal at birth (e.g., crankiness, feeding problems, tremors, weak and continual crying) would be rated here. A child who ingested lead paint and exhibited symptoms would be rated here.</p>

LABOR AND DELIVERY

This dimension refers to conditions associated with, and consequences arising from, complications in labor and delivery of the child during childbirth.

	Ratings and Descriptions
Questions to Consider	<p>0 <i>No current need; no need for action or intervention.</i> Child and mother had normal labor and delivery. A child who received an Apgar score of 7-10 at birth would be rated here.</p>
	<p>1 <i>Need or risk behavior that requires monitoring, watchful waiting, or preventive action based on history, suspicion or disagreement.</i> Child or mother had some mild problems during delivery, but there is no history of adverse impact. An emergency C-section or a delivery-related physical injury (e.g. shoulder displacement) to the baby is rated here.</p>
	<p>2 <i>Action is required to ensure that the identified need or risk behavior is addressed.</i> Child or mother had problems during delivery that resulted in temporary functional difficulties for the child or mother. Extended fetal distress, postpartum hemorrhage, or uterine rupture would be rated here. A child who received an Apgar score of 4-7, or needed some resuscitative measures at birth is rated here.</p>
	<p>3 <i>Intensive and/or immediate action is required to address the need or risk behavior.</i> Child had severe problems during delivery that have long-term implications for development (e.g. extensive oxygen deprivation, brain damage). A child who received an Apgar score of 3 or lower, or who needed immediate or extensive resuscitative measures at birth, would be rated here.</p>

BIRTH WEIGHT

This describes the child's birth weight as compared to normal development.

Questions to Consider	Ratings and Descriptions
<ul style="list-style-type: none">How did the child's birth weight compare to typical averages?	<p>0 <i>No current need; no need for action or intervention.</i> Child within normal range for weight at birth. A child with a birth weight of 2500 grams (5.5 pounds) or greater would be rated here.</p>
	<p>1 <i>Need or risk behavior that requires monitoring, watchful waiting, or preventive action based on history, suspicion or disagreement.</i> Child born underweight. A child with a birth weight of between 1500 grams (3.3. pounds) and 2499 grams would be rated here.</p>
	<p>2 <i>Action is required to ensure that the identified need or risk behavior is addressed.</i> Child considerably under-weight at birth to the point of presenting a development risk to them. A child with a birth weight of 1000 grams (2.2 pounds) to 1499 grams would be rated here.</p>
	<p>3 <i>Intensive and/or immediate action is required to address the need or risk behavior.</i> Child extremely under-weight at birth to the point of threatening their life. A child with a birth weight of less than 1000 grams (2.2 pounds) would be rated here.</p>

FAILURE TO THRIVE

This item rates the presence of problems with weight gain or growth.

Questions to Consider	Ratings and Descriptions
<ul style="list-style-type: none">Does the child have any problems with weight gain or growth either now or in the past?Are there any concerns about the child's eating habits?Does the child's doctor have any concerns about the child's growth or weight gain?	<p>0 <i>No current need; no need for action or intervention.</i> No evidence of failure to thrive.</p>
	<p>1 <i>Need or risk behavior that requires monitoring, watchful waiting, or preventive action based on history, suspicion or disagreement.</i> The infant/child may have experienced past problems with growth and ability to gain weight and is currently not experiencing problems. The infant/child may presently be experiencing slow development in this area.</p>
	<p>2 <i>Action is required to ensure that the identified need or risk behavior is addressed.</i> The infant or child is experiencing problems in their ability to maintain weight or growth. The infant or child may be below the 5th percentile for age and sex, may weigh less than 80% of their ideal weight for age, have depressed weight for height, or have a rate of weight gain that causes a decrease in two or more major percentile lines over time (75th to 25th).</p>
	<p>3 <i>Intensive and/or immediate action is required to address the need or risk behavior.</i> The infant/child has one or more of all of the above and is currently at serious medical risk.</p>

Supplemental Information: Failure to thrive is considered a condition in which an infant or child has weight below the 5th percentile on NCHS growth charts or has a decrease across two percentiles in growth or weight (Zeanah, 1993). This is critical to monitor due to the possible problems that may be associated with this condition such as possible developmental disorders such as oral motor problems, sensory processing disorders, relationship problems, self-regulation problems or difficult temperament issues. Failure to thrive has also been associated with later cognitive challenges, school problems, attachment difficulties, self-regulation challenges, inability to delay gratification and various health concerns. Relationship disturbances are also present in failure to thrive infants as they grow older which are seen in their frequent lack of confidence in others, poor self esteem, and inability to trust the attachment relationship. The feeding experience for infants also serves additional functions other than caloric intake. It is through this experience that an infant develops a sense of security and source of emotional comfort. It is also an organizing and integrating event in the infant's day. There have been numerous causes for failure to thrive listed in literature some of which are lack of caloric intake due to lack of information on part of parent, lack of caloric intake due to parental neglect, lack of caloric intake due to food refusal, nutritional absorption problems, inappropriate feeding practices, or relationship based problems that manifest in feeding challenges. Some of the characteristics of the infant/toddler that can be associated with failure to thrive are listed below. Possible Characteristics of infants/toddlers with failure to thrive include:

- Extreme watchfulness
- Bizarre eating patterns (excessive intake, hoarding food, refusing food_ Protruding abdomen
- Noted Improvement in weight gain during hospitalizations
- Poor cuddling or social responsiveness

CARE INTENSITY & ORGANIZATION

This domain focuses on the various types of assistance that the caregiver may need in order to care for their child and family.

Question to consider for this domain: Are there any areas where the caregiver needs help in order to be able to care for the child and family?

For **Care Intensity and Organization**, use the following categories and action levels:

- 0 No current need; no need for action. This may be a resource for the child.
- 1 Identified need that requires monitoring, watchful waiting, or preventive action based on history, suspicion or disagreement. This may be an opportunity for resource building.
- 2 Need is interfering with the provision of care; action is required to ensure that the identified need is addressed.
- 3 Need prevents the provision of care; requires immediate and/or intensive action.

SERVICE INTENSITY

This item describes the level/intensity of services that are needed to address the child's challenges and how frequently those services are needed.

Questions to Consider:

- Describe the types of services that are needed for your child.
- How often does your child receive services, including medication?
- What do you have to do to make sure that your child receive the services needed?

Ratings & Descriptions

- 0 *No current need; no need for action or intervention. This may be a resource for the child.*
The child has no behavioral/physical/medical treatment needs that the parent/primary caregiver must manage.
- 1 *Identified need that requires monitoring, watchful waiting, or preventive action based on history, suspicion or disagreement.*
Child requires weekly behavioral/physical/medical treatment that the parent/primary caregiver must manage.
- 2 *Need is interfering with the provision of care; action is required to ensure that the identified need is addressed.*
Child requires daily behavioral/physical/medical treatment that the parent/primary caregiver must manage. This would include ensuring the child takes daily medication.
- 3 *Need prevents the provision of care; requires immediate and/or intensive action.*
Child requires multiple and complex daily behavioral/physical/medical treatment that the parent/primary caregiver must manage (complicated treatment cases).

Supplemental Information: When families experience children with specialized needs there are definitely varying degrees of support that is necessary in providing for these needs. Some families may need to provide medical care or support to their child along with transportation to a multitude of services. This item appreciates the level of strain and stress this can place on a family. Asking parents the level of treatment support or intervention the parent needs to ensure occurs in order to meet their child's needs will help determine how much support the parent may need. The amount of social support to the parent has been shown to be a critical factor in the experience of the child.

FUNDING/ELIGIBILITY

This item describes whether the caregiver has any concerns regarding eligibility or funding for services.

Questions to Consider:

- Do you have any concerns regarding funding for services?
- Have there been any concerns in the past?
- Has your child been determined not eligible for a service that you think they need or do you have worries that this may happen?

Ratings & Descriptions

- 0 *No current need; no need for action or intervention. This may be a resource for the child.*
There are no concerns about eligibility or funding of needed services nor any concerns in the foreseeable future.
-
- 1 *Identified need that requires monitoring, watchful waiting, or preventive action based on history, suspicion or disagreement.*
There is a mild level of concern regarding eligibility or funding of needed services in the future.
-
- 2 *Need is interfering with the provision of care; action is required to ensure that the identified need is addressed.*
Child is not eligible for some needed services or there is immediate concern regarding the funding of some services.
-
- 3 *Need prevents the provision of care; requires immediate and/or intensive action.*
Child is not eligible for some needed services or there is a significant conflict with program eligibility and/or funding need.

Supplemental Information: It is critical for parents and children to have access to insurance or funding of services in order for services to occur. If this is a need for the family it will need to be addressed as soon as possible. Along with this is the importance of children not being excluded from services due to eligibility criteria.

TRANSPORTATION

This item rates whether the caregiver has any concerns regarding transporting the child to services.

Questions to Consider:

- How do you usually get your child to their services?
- How often is transportation a problem for you?
- Does your child have any specific transportation needs, such as a special vehicle?

Ratings & Descriptions

- 0 *No current need; no need for action or intervention. This may be a resource for the child.*
Child has no transportation needs.
-
- 1 *Identified need that requires monitoring, watchful waiting, or preventive action based on history, suspicion or disagreement.*
Child has occasional transportation needs (e.g., appointments). These needs would be no more than weekly and not require a special vehicle. Child with parent(s) who needs transportation assistance to visit a child would be rated here.
-
- 2 *Need is interfering with the provision of care; action is required to ensure that the identified need is addressed.*
Child has occasional transportation needs that require a special vehicle or frequent transportation needs (e.g., daily) that do not require a special vehicle.
-
- 3 *Need prevents the provision of care; requires immediate and/or intensive action.*
Child requires frequent (e.g., daily) transportation in a special vehicle.

Supplemental Information: Caregivers need transportation for a multitude of reasons. Families need the ability to obtain for instance, needed food, clothing, household necessities and support their children's ability to attend activities. If transportation is problematic, families may also be limited in their ability to access needed services for their child. In assessing this item it is important to not just determine if the family has transportation or can access transportation but if it is reliable, consistently available and if there are financial barriers to using the transportation.

SERVICE PERMANENCE

This item rates the extent to which there has been turnover among the service providers working with the child. This applies to both programs as well as the staff within programs.

Questions to Consider:

- Have you had trouble with service providers staying involved?
- How often have providers changed?
- Why have the service providers changed?
- Do you feel the change has been good for your child or not?

Ratings & Descriptions

- 0 *No current need; no need for action or intervention. This may be a resource for the child.*
Service providers have been consistent for more than the past two years. This level is also used to rate a child/family who is initiating services for the first time or re-initiating services after an absence from services of at least one year.
- 1 *Identified need that requires monitoring, watchful waiting, or preventive action based on history, suspicion or disagreement.*
Service providers have been consistent for at least one year, but changes occurred during the prior year.
- 2 *Need is interfering with the provision of care; action is required to ensure that the identified need is addressed.*
Service providers have been changed recently after a period of consistency.
- 3 *Need prevents the provision of care; requires immediate and/or intensive action.*
Service providers have changed multiple times during the past year.

Supplemental Information: One of the frequent complaints that children and families have regarding services is the lack of service permanence in their experience. This refers to the lack of consistency in service providers or the experience of losing a needed service. It is often a challenge for families to establish trust and a working relationship with service providers. The assessment of service permanence therefore is critical to assess to ensure that services are positive and that unnecessary changes do not occur. Families should be asked to reflect on the continuity, consistency of providers and if change has occurred what the time frames have been.

SERVICE COORDINATION

This item rates whether it is difficult for the caregiver to coordinate services for the child.

Questions to Consider:

- Do the times that services are offered often conflict with your schedule or overlap with one another?
- Do you experience conflicting information from different service providers about what to do to help your child?
- Is it a challenge to manage the services your child needs?

Ratings & Descriptions

- 0 *No current need; no need for action or intervention. This may be a resource for the child.*
Caregiver is able to coordinate the child's services;
- 1 *Identified need that requires monitoring, watchful waiting, or preventive action based on history, suspicion or disagreement.*
Caregiver has had challenges with coordinating the child's services in the past, OR caregiver is currently inconsistent in their ability to coordinate the child's services.
- 2 *Need is interfering with the provision of care; action is required to ensure that the identified need is addressed.*
The caregiver's challenges in coordinating the child's services has impacted the child's functioning in at least one life domain.
- 3 *Need prevents the provision of care; requires immediate and/or intensive action.*
Caregiver is unable to coordinate the child's services which impacts the child's functioning and places them at risk and/or their development in danger.

Supplemental Information: One of the important aspects of systems of care principles is the need to assist the family in coordinating and integrating services to ensure a quality experience. This eliminates or assists in the duplication of services. Often times, families may be experiencing multiple service providers addressing the same or similar issues and perhaps in various ways. Especially when families are told conflicting recommendations and strategies this leaves the child and family confused and less likely to demonstrate progress. There often are fragmented delivery systems that do not provide the child and family with complimentary and synergistic efforts. This item rates the child and family's experience when a variety of needs and services are in place.

SERVICE ACCESS/AVAILABILITY

This item rates any challenges that the caregiver may have experienced in getting services for the child. This does not include the caregiver's reluctance to have their child participate in services.

Ratings & Descriptions	
Questions to Consider: <ul style="list-style-type: none">• Have there been services that your child needs that are not available to you?• What types of problems do you encounter when trying to access services?• Were services previously available to you that now are not?• Are there any restrictions that you are aware of keeping your child from getting needed services?	0 <i>No current need; no need for action or intervention. This may be a resource for the child.</i> Caregiver has access to and has obtained services for the child.
	1 <i>Identified need that requires monitoring, watchful waiting, or preventive action based on history, suspicion or disagreement.</i> Caregiver is currently encountering some challenges to accessing and securing services for the child, OR caregiver has had difficulties in securing services for the child in the past which resulted in the child not receiving the services that they needed.
	2 <i>Need is interfering with the provision of care; action is required to ensure that the identified need is addressed.</i> Caregiver has encountered barriers to accessing and securing services for the child. The child's functioning has been impacted by not being able to receive the services and supports that are needed.
	3 <i>Need prevents the provision of care; requires immediate and/or intensive action.</i> Caregiver is unable to access or secure services for the child, placing the child at risk and/or their development in danger.

Supplemental Information: When services are determined as being needed by either the family or professionals it only becomes a help to the family if the services are accessible and available. Families may experience barriers to entering into services or finding the types of services their child needs. In assessing this item considering the caregiver's experience regarding perceived or real barriers is important as well. Even if a parent perceives that a service is not available to them or that it is not what the child needs there is a problem.

CULTURAL APPROPRIATENESS OF SERVICES

This item describes whether the caregiver feels that the services that are needed or provided for the child are respectful of the family's cultural beliefs and practices.

Ratings & Descriptions	
Questions to Consider: <ul style="list-style-type: none">• Do service providers show you that they understand your beliefs and practices?• Have you been unhappy with services because of lack of cultural sensitivity?• Do recommendations that you are given fit within your beliefs?• Is there anything special that you would like services providers to know about your family's culture, beliefs or practices?	0 <i>No current need; no need for action or intervention. This may be a resource for the child.</i> Caregiver identifies the services and supports that the child is receiving as respectful of the family's cultural beliefs and practices.
	1 <i>Identified need that requires monitoring, watchful waiting, or preventive action based on history, suspicion or disagreement.</i> Caregiver is concerned that the services and supports the child is receiving may not be respectful of the family's beliefs and practices, OR the child has received services in the past that were insensitive to the family's cultural beliefs and practices that made it difficult for the child to engage or benefit from care.
	2 <i>Need is interfering with the provision of care; action is required to ensure that the identified need is addressed.</i> Caregiver views the services and supports the child is receiving as not consistently culturally responsive to the family's beliefs and practices. The child's needs are not adequately addressed in this care setting and their functioning is impacted.
	3 <i>Need prevents the provision of care; requires immediate and/or intensive action.</i> Caregiver views the services and supports the child is receiving as culturally insensitive, unresponsive and disrespectful of the family's cultural beliefs and practices. The child is unable to participate and/or benefit from services and is at risk.

Supplemental Information: Every family experiences culture in unique ways. It is important to think broadly about a family's cultural orientation not just in terms of ethnicity but also the region of the country the family comes from, socio-economic status, and how child rearing practices and beliefs are practiced. It is important for families to be offered services that are culturally sensitive and appreciative of individual differences.

CAREGIVER NEEDS & RESOURCES

This section focuses on the resources and needs of the caregiver. Caregiver ratings should be completed by household. If multiple households are involved in the planning, then this section should be completed once for each household under consideration. If the child is in a foster care or out-of-home placement, please rate the identified parent(s), other relative(s), adoptive parent(s), or caretaker(s) who is planning to assume custody and/or take responsibility for the care of this child.

Question to Consider for this Domain: What are the resources and needs of the child’s caregiver(s)?

For **Caregiver Resources & Needs**, use the following categories and action levels:

- 0 No current need; no need for action or intervention. This may be a resource for the child.
- 1 Identified need that requires monitoring, watchful waiting, or preventive action based on history, suspicion or disagreement.
- 2 Need is interfering with the provision of care; action is required to ensure that the identified need is addressed.
- 3 Need prevents the provision of care; requires immediate and/or intensive action.

SUPERVISION

This item rates the caregiver’s capacity to provide the level of monitoring and discipline needed by the child. Discipline is defined in the broadest sense, and includes all of the things that parents/caregivers can do to promote positive behavior with their child.

Questions to Consider

- How do you feel about your ability to keep an eye on and discipline your child?
- Do you need some help with caring and providing supervision for your child?
- Are there times when this is more challenging than others?

Ratings & Descriptions

- 0 *No current need; no need for action or intervention. This may be a resource for the child.*
No evidence caregiver needs help or assistance in monitoring or disciplining the child, and/or caregiver has good monitoring and discipline skills.

- 1 *Identified need that requires monitoring, watchful waiting, or preventive action based on history, suspicion or disagreement.*
Caregiver generally provides adequate supervision, but is inconsistent. Caregiver may need occasional help or assistance.

- 2 *Need is interfering with the provision of care; action is required to ensure that the identified need is addressed.*
Caregiver supervision and monitoring are very inconsistent and frequently absent. Caregiver needs assistance to improve supervision skills.

- 3 *Need prevents the provision of care; requires immediate and/or intensive action.*
Caregiver is unable to monitor or discipline the child. Caregiver requires immediate and continuing assistance. Child is at risk of harm due to absence of supervision or monitoring.

Supplemental Information: One of the core components of the parenting role is the ability to provide for the safety and security of children. Often, if this is a weakness for the parent, the child may be or has been at risk and at worse removed from their parent’s care. The provision of this role for the child not only ensures the well-being of the child but supports the child in seeing the care-giving relationship as responsive to their needs. A child that is not ensured of a safe environment often develops an overall level of anxiety and insecurity about the world. In considering how well developed this area is for a parent it is helpful to listen to scenarios regarding their care-giving routine, observe the interaction and take into account reports from schools or other service providers. It is important to remember as well that the various developmental stages tax parents in terms of supervision in different ways. Some of the developmental stages require a greater level of supervision in terms of constant watching and being with a child. Other stages require knowing how to balance the child’s need for exploration with their need to be restricted. Some of the important factors to consider in assessing this item are:

- How does a parent perceive their child’s needs in terms of supervision?
- Has there ever been any concern regarding their supervision?
- Does this parent seem to understand their child’s developmental abilities in a way that is reflected in their supervision?
- Does this parent show any ability to predict or recognize potential safety hazards?
- What interferes with a parent’s capacity to provide good supervision? i.e. poor health, depression, lack of knowledge

INVOLVEMENT WITH CARE

This item rates the caregiver's participation in the child's care and ability to advocate for the child.

Questions to Consider	Ratings & Descriptions
<ul style="list-style-type: none">• How do you feel about being involved in services for your child?• Do you feel comfortable speaking up on behalf of your child (being an advocate)?• Has this ever been a difficult area for you?• Would you like any help to become more involved with making decisions about your child's services?	<p>0 <i>No current need; no need for action or intervention. This may be a resource for the child.</i> No evidence of problems with caregiver involvement in services or interventions for the child, and/or caregiver is able to act as an effective advocate for the child.</p> <hr/>
	<p>1 <i>Identified need that requires monitoring, watchful waiting, or preventive action based on history, suspicion or disagreement.</i> Caregiver is consistently involved in the planning and/or implementation of services for the child but is not an active or fully effective advocate on behalf of the child. Caregiver is open to receiving support, education, and information.</p> <hr/>
	<p>2 <i>Need is interfering with the provision of care; action is required to ensure that the identified need is addressed.</i> Caregiver does not actively involve themselves in services and/or interventions intended to assist the child.</p> <hr/>
	<p>3 <i>Need prevents the provision of care; requires immediate and/or intensive action.</i> Caregiver wishes for child to be removed from their care.</p>

Supplemental Information This item refers to the parent's capacity to identify, advocate for and participate in the care of their child. This may be difficult to assess if the parent is new to the examiner and there is not a history to refer to. In this case, discussing the parent's values regarding their role in service provision, their comfort level in sharing viewpoints, their ability to assert themselves and their past experiences in other or similar situations will assist in the rating. This is an important component of care due to the importance of the parent being a full partner in the care of their child. It is the goal of all service provision for the parent to be able to better meet the needs of their child in an ongoing way.

KNOWLEDGE

This item identifies the caregiver's knowledge of the child's strengths and needs, and their ability to understand the rationale for the treatment or management of these problems.

Questions to Consider	Ratings & Descriptions
<ul style="list-style-type: none">• Do you feel comfortable with what you know about your child's needs?• Have professionals told you things about your child that were difficult to understand?• If so, what did you do at that time?• Would you like to get more information on your child's challenges?	<p>0 <i>No current need; no need for action or intervention. This may be a resource for the child.</i> No evidence of caregiver knowledge issues. Caregiver is fully knowledgeable about the child's psychological strengths and weaknesses, talents and limitations.</p> <hr/>
	<p>1 <i>Identified need that requires monitoring, watchful waiting, or preventive action based on history, suspicion or disagreement.</i> Caregiver, while being generally knowledgeable about the child, has some mild deficits in knowledge or understanding of the child's psychological condition or their talents, skills and assets.</p> <hr/>
	<p>2 <i>Need is interfering with the provision of care; action is required to ensure that the identified need is addressed.</i> Caregiver does not know or understand the child well and significant deficits exist in the caregiver's ability to relate to the child's problems and strengths.</p> <hr/>
	<p>3 <i>Need prevents the provision of care; requires immediate and/or intensive action.</i> Caregiver has little or no understanding of the child's current condition. Their knowledge problems about the child's strengths and needs place the child at risk of significant negative outcomes.</p>

Supplemental Information: This area refers to the parent's understanding of the child's needs and abilities. This also includes their understanding of service provision, their role in the services, and how to navigate the system. The question to ask parent's in the assessment of this item is, "Is there any information that you could have regarding your child that could improve your ability to parent?" It is important not to assume that high functioning parents do not have a need for more knowledge.

This item is perhaps the one most sensitive to issues of cultural awareness. It is natural to think that what you know, someone else should know and if they don't then it's a knowledge problem. In order to minimize the cultural issues, it is recommended thinking of this item in terms of whether there is information that can be made available to the caregivers so that they could be more effective in working with their child. Additionally, the caregivers' understanding of the child's diagnosis and how it manifests in the child's behavior should be considered in rating this item.

ORGANIZATION

This item should be based on the ability of the caregiver to participate in and direct the organization of the household, services, and related activities.

Questions to Consider:

- Has managing both your child's needs and your other duties been hard for you?
- Has it been difficult to remember appointments?
- Have you found some things you can do to help you stay organized?

Ratings & Descriptions

- 0 *No current need; no need for action or intervention. This may be a resource for the child.*
Caregiver is well organized and efficient.
-
- 1 *Identified need that requires monitoring, watchful waiting, or preventive action based on history, suspicion or disagreement.*
Caregiver has difficulties with organizing and maintaining household to support needed services. For example, may be forgetful about appointments or occasionally fails to return case manager calls.
-
- 2 *Need is interfering with the provision of care; action is required to ensure that the identified need is addressed.*
Caregiver has moderate difficulty organizing and maintaining household to support needed services.
-
- 3 *Need prevents the provision of care; requires immediate and/or intensive action.*
Caregiver is unable to organize household to support needed services.

Supplemental Information: This item refers to the parent's ability to manage the demands of maintaining and coordinating the household, keeping appointments, managing time and demands, responding to the needs of the children and knowing where needed items are kept. This directly affects the experience of the child especially as they grow into preschool and school age years and have increasing needs that may tax a parent's skills in this area. In assessing this item it is again helpful to ask the parent to relate scenarios related to this skill and reflect on their ability in this area. This also may be evaluated based on one's own experiences with this parent. A parent that demonstrates this capacity contributes to a child's security and sense of trust that needs will be met.

FINANCIAL RESOURCES

This item rates the family's financial situation.

Questions to Consider:

- Have you ever struggled financially?
- Do you ever worry that you won't have enough money to meet your family's needs?
- What financial challenges do you have now?

Ratings & Descriptions

- 0 *No current need; no need for action or intervention. This may be a resource for the child.*
Caregiver has sufficient financial resources to raise the child.
-
- 1 *Identified need that requires monitoring, watchful waiting, or preventive action based on history, suspicion or disagreement.*
Caregiver has some financial resources that actively help with raising the child. History of struggles with sufficient financial resources would be rated here.
-
- 2 *Need is interfering with the provision of care; action is required to ensure that the identified need is addressed.*
Caregiver has limited financial resources that may be able to help with raising the child.
-
- 3 *Need prevents the provision of care; requires immediate and/or intensive action.*
Caregiver has no financial resources to help with raising the child. Caregiver needs financial resources.

Supplemental Information: This item reflects whether or not the parent is able to rely on financial resources to support the needs of their child. This does not suggest that the family that is limited in their income does not have strength in this area as they may demonstrate a strong ability to conserve their spending and stretch their resources. A family that overspends and is left with the inability to meet the financial needs of the child and family would not rate highly in this area. The focus is whether or not the family has the resources to meet the needs of the child and how well this is managed.

SOCIAL RESOURCES

This item rates the social assets (extended family) and resources that the caregiver can bring to bear in addressing the multiple needs of the child and family.

Questions to Consider	Ratings & Descriptions
<ul style="list-style-type: none">• Does family have extended family or friends who provide emotional support?• Can they call on social supports to watch the child occasionally?	0 <i>No current need; no need for action or intervention. This may be a resource for the child.</i> Caregiver has significant social and family networks that actively help with caregiving.
	1 <i>Identified need that requires monitoring, watchful waiting, or preventive action based on history, suspicion or disagreement.</i> Caregiver has some family, friends or social network that actively helps with caregiving.
	2 <i>Need is interfering with the provision of care; action is required to ensure that the identified need is addressed.</i> Work needs to be done to engage family, friends or social network in helping with caregiving.
	3 <i>Need prevents the provision of care; requires immediate and/or intensive action.</i> Caregiver has no family or social network to help with caregiving.

Supplemental Information: This item refers to the caregiver's need for support from a network of friends, community members or family members that are not paid and will be available to them. The family of young children may need this more than any other service that can be made available to them. This item looks at the presence of this being available to the caregiver and does not focus on the child's experience of these supports.

RESIDENTIAL STABILITY

This item rates the housing stability of the caregiver and does not include the likelihood that the child will be removed from the household.

Questions to Consider	Ratings & Descriptions
<ul style="list-style-type: none">• Have you moved around much in the past?• Is your current housing situation stable?• Does your current housing adequately meet your needs?• Do you have any concerns that you might have to move in the near future?	0 <i>No current need; no need for action or intervention. This may be a resource for the child.</i> Caregiver has stable housing with no known risks of instability.
	1 <i>Identified need that requires monitoring, watchful waiting, or preventive action based on history, suspicion or disagreement.</i> Caregiver has relatively stable housing but either has moved in the recent past or there are indications of housing problems that might force housing disruption.
	2 <i>Need is interfering with the provision of care; action is required to ensure that the identified need is addressed.</i> Caregiver has moved multiple times in the past year. Housing is unstable.
	3 <i>Need prevents the provision of care; requires immediate and/or intensive action.</i> Family is homeless, or has experienced homelessness in the recent past.

Supplemental Information: The importance of having stable and appropriate housing is critical in both the parent's and child's experience. There is perhaps no other environment that young children may spend more time in and the need for this to be safe and secure is significant for children. Children that do not experience this develop higher levels of anxiety and less trust in the fact that their needs will be attended to. The child that experiences multiple moves also may have challenges in developing a routine and feeling the benefits of predictability. Families may be asked to discuss their experiences in moving and any possible need for this in the future to assess this item.

CULTURAL DIVERSITY

This item describes whether cultural heritage is a strong part of the family's identity.

Questions to Consider:

- Are cultural values and beliefs an important part of your life?
- Does it bring meaning and comfort to your family to practice these beliefs?
- Do you feel stressed about differences in your culture and other cultures, or do you feel that this is not a problem?

Ratings & Descriptions

- 0 *No current need; no need for action or intervention. This may be a resource for the child.*
No evidence of stress between caregiver's cultural identity and current living situation. Cultural practices may be a source of strength for the caregiver.
-
- 1 *Identified need that requires monitoring, watchful waiting, or preventive action based on history, suspicion or disagreement.*
Cultural identity provides some comfort to the caregiver, though some mild or occasional stress results from friction between the caregiver's cultural identity and their current living situation.
-
- 2 *Need is interfering with the provision of care; action is required to ensure that the identified need is addressed.*
Caregiver is experiencing cultural stress that is causing problems of functioning in at least one life domain. Caregiver needs to learn how to manage culture stress.
-
- 3 *Need prevents the provision of care; requires immediate and/or intensive action.*
Caregiver has experiencing a high level of cultural stress that is making functioning in any life domain difficult under the present circumstances. Caregiver needs immediate plan to reduce culture stress.

Supplemental Information: A family that is able to report routines, practices, beliefs and shared values that are reflective of culture often find comfort in this. This item appreciates how a family identity that is unique and rooted in their cultural orientation often brings a sense of pride and connectedness that is supportive to the system. In assessing this item it is important to ask families if they feel that their family's belief systems and shared values are reflective of a larger cultural orientation and how this is helpful or not helpful to them.

EMPLOYMENT

This item rates the caregiver's current employment status and whether any changes in that employment status are anticipated in the near future.

Questions to Consider:

- Tell me about your current employment status.
- What do you like and dislike about your current job(s)?
- Tell me about your past employment experiences.
- Is there anything about your employment status that you would like to change?

Ratings & Descriptions

- 0 *No current need; no need for action or intervention. This may be a resource for the child.*
Caregiver has stable employment that they enjoy and consider a stable, long-term position.
-
- 1 *Identified need that requires monitoring, watchful waiting, or preventive action based on history, suspicion or disagreement.*
Caregiver is employed but concerns exist about the stability of this employment.
-
- 2 *Need is interfering with the provision of care; action is required to ensure that the identified need is addressed.*
Caregiver is not employed currently but has a history of successful employment.
-
- 3 *Need prevents the provision of care; requires immediate and/or intensive action.*
Caregiver is not employed and has no or only very limited history of employment.

Supplemental Information: The benefits of a parent being employed often exceed what is considered as the obvious one, financial gain. Parents often see employment as a vehicle for obtaining benefits such as insurance and this is often one of the primary needs for the family. Employment may also serve as a stress reliever and social support to the parent. Parents describe feeling a need to "be around adults" and without employment may not have this opportunity on a regular basis. In the consideration of whether or not this a strength of parents several factors should be determined: Is the parent employed? Does the employment satisfy the parent? Is the parent in a position that matches their strengths and abilities? Does the situation seem stable and consistent?

EDUCATIONAL ATTAINMENT

This item describes the caregiver's highest level of education completed, and whether the caregiver would ever be interested in seeking more education.

Questions to Consider:

- How far did you go in school?
- Would you like any help in finding ways to further your education or get a GED?
- Are there any concerns that you have about your education or skills?

Ratings & Descriptions

- 0 *No current need; no need for action or intervention. This may be a resource for the child.*
Caregiver has achieved all educational goals or has none but educational attainment has no impact in lifetime vocational functioning.
-
- 1 *Identified need that requires monitoring, watchful waiting, or preventive action based on history, suspicion or disagreement.*
Caregiver has set educational goals and is currently making progress towards achieving them.
-
- 2 *Need is interfering with the provision of care; action is required to ensure that the identified need is addressed.*
Caregiver has set educational goals but is currently not making progress towards achieving them.
-
- 3 *Need prevents the provision of care; requires immediate and/or intensive action.*
Caregiver has no educational goals and lack of educational attainment is interfering with individual's lifetime vocational functioning. Caregiver needs educational/vocational intervention.

Supplemental Information: Education offers families greater opportunities in the job market and therefore can contribute to the reduction of other risk factors. In addition, to education making financial stability easier to attain it also is associated with job satisfaction. Parents that are less stressed and happy with their employment opportunities are better able to meet the needs of the children. Education is also associated with better developed abilities to obtain resources and understand the needs of their children.

MEDICAL/PHYSICAL

This item refers to medical and/or physical problems that the caregiver may be experiencing that prevent or limit their ability to parent the child. This item does not rate depression or other mental health issues.

Questions to Consider

- How is your health?
- Do you have any health problems that make it hard for you to take care of your family?
- Have you had any health problems in the past?

Ratings & Descriptions

- 0 *No current need; no need for action or intervention. This may be a resource for the child.*
No evidence of medical or physical health problems. Caregiver is generally healthy.
-
- 1 *Identified need that requires monitoring, watchful waiting, or preventive action based on history, suspicion or disagreement.*
There is a history or suspicion of, and/or caregiver is in recovery from medical/physical problems.
-
- 2 *Need is interfering with the provision of care; action is required to ensure that the identified need is addressed.*
Caregiver has medical/physical problems that interfere with the capacity to parent the child.
-
- 3 *Need prevents the provision of care; requires immediate and/or intensive action.*
Caregiver has medical/physical problems that make parenting the child impossible at this time.

Supplemental Information: Parents that experience stable health and are in good physical condition are afforded many benefits that parents that are challenged in this area are not. A parent that struggles with poor health or physical condition is often less able to provide support and care to their child and to attend fully to their emotional needs. The parent with health conditions may be so overwhelmed with their own needs that it is a challenge to address their child's needs. In assessing this item it is important to understand that the presence of a chronic health condition that is well managed does not automatically suggest a low rating in this area. The parent in the same vein may be in poor physical condition without a major health condition and be compromised in their abilities to meet the child's needs. Knowing how the parent functions in this capacity allows the service provider/s to better align the parent with resources or supports.

MENTAL HEALTH

This item refers to any serious mental health issues (not including substance abuse) among caregivers that might limit their capacity for parenting/caregiving to child.

Ratings & Descriptions	
Questions to Consider <ul style="list-style-type: none">• Do you have any challenges with emotional issues, such as depression or anxiety?• If so, do you feel it makes it difficult to interact with your child or others?• Have you had any challenges in the past?	0 <i>No current need; no need for action or intervention. This may be a resource for the child.</i> No evidence of caregiver mental health difficulties.
	1 <i>Identified need that requires monitoring, watchful waiting, or preventive action based on history, suspicion or disagreement.</i> There is a history or suspicion of mental health difficulties, and/or caregiver is in recovery from mental health difficulties.
	2 <i>Need is interfering with the provision of care; action is required to ensure that the identified need is addressed.</i> Caregiver's mental health difficulties interfere with their capacity to parent.
	3 <i>Need prevents the provision of care; requires immediate and/or intensive action.</i> Caregiver has mental health difficulties that make it impossible to parent the child at this time.

Supplemental Information: Infants and young children are primarily in need of parents that are emotionally available, reciprocal in their interactions and capable of providing for their needs. When a parent is challenged with difficult symptoms associated with mental health challenges all of these needs may be poorly or intermittently met. Much research has taken place regarding how depression in parents affects children. Carter, Osofsky & Hahn (1991) substantiate the disturbances in infant patterns of regulating affect when experiencing parental depression. In addition, Murray and Cooper (1997) report that two negative interaction patterns, withdrawn-hostile and hostile-intrusive, have been observed in their research with depressed mothers. These two patterns have been demonstrated to interfere with the cognitive and emotional development of their infants. Anxiety or trauma related challenges in parents also have the potential to cause a number of difficulties for children. Children with parents that are anxious can experience anxiety themselves due to their response to the social cues of their parents or the interference with the care-giving routine.

Serious mental illness would be rated '2' or '3' unless the individual is in recovery.

SUBSTANCE USE

This item rates the impact of any notable substance use by caregivers that might limit their capacity to provide care for the child.

Ratings & Descriptions	
Questions to Consider <ul style="list-style-type: none">• If you use alcohol or illegal drugs, do you feel that this is a problem for you?• Do others feel that it is?• If so, do you feel that it impacts your parenting in any way?• Would you like some help in this area?	0 <i>No current need; no need for action or intervention. This may be a resource for the child.</i> No evidence of caregiver substance use issues.
	1 <i>Identified need that requires monitoring, watchful waiting, or preventive action based on history, suspicion or disagreement.</i> There is a history, suspicion or mild use of substances and/or caregiver is in recovery from substance use difficulties where there is no interference in their ability to parent.
	2 <i>Need is interfering with the provision of care; action is required to ensure that the identified need is addressed.</i> Caregiver has some substance use difficulties that interfere with their capacity to parent.
	3 <i>Need prevents the provision of care; requires immediate and/or intensive action.</i> Caregiver has substance use difficulties that make it impossible to parent the child at this time.

Supplemental Information: It is important to note that what typically puts infants at greater risk related to substance abusing parents is the exposure to the multiple risks that usually are associated with substance abuse. Due to the effects of substance abuse, parents often experience poverty, disorganized and chaotic lifestyles, stress, exposure to violence (Lester and Tronick, 1994). Due to the critical importance of forming a secure attachment relationship within the first few years of life, a young child with substance abusing parents may be at considerable risk. In addition, it has also been determined that when the combination of prenatal drug exposure and ongoing substance use in parents occurs a child is at high risk for learning and behavior problems (Lester & Tronick, 1994; Kaplan-Sanoff, 1996).

Substance-related disorders would be rated '2' or '3' unless the individual is in recovery.

DEVELOPMENTAL

This item describes the presence of limited cognitive capacity or developmental disabilities that challenges the caregiver's ability to provide care for the child.

Questions to Consider	Ratings and Descriptions
<ul style="list-style-type: none">• Does the caregiver have developmental challenges that make parenting/caring for the child difficult?• Does the caregiver have services?	<p>0 <i>No current need; no need for action or intervention. This may be a resource for the child.</i> No evidence of caregiver developmental disabilities or challenges. Caregiver has no developmental needs.</p>
	<p>1 <i>Identified need that requires monitoring, watchful waiting, or preventive action based on history, suspicion or disagreement.</i> Caregiver has developmental challenges. The developmental challenges do not currently interfere with parenting.</p>
	<p>2 <i>Need is interfering with the provision of care; action is required to ensure that the identified need is addressed.</i> Caregiver has developmental challenges that interfere with the capacity to parent the child.</p>
	<p>3 <i>Need prevents the provision of care; requires immediate and/or intensive action.</i> Caregiver has severe developmental challenges that make it impossible to parent the child at this time.</p>

SAFETY

This item describes the caregiver's ability to maintain the child's safety within the household. It does not refer to the safety of other family or household members based on any danger presented by the assessed child.

Questions to Consider	Ratings and Descriptions
<ul style="list-style-type: none">• Is the caregiver able to protect the child from harm in the home?• Are there individuals living in the home or visiting the home that may be abusive to the child?	<p>0 <i>No current need; no need for action or intervention. This may be a resource for the child.</i> No evidence of safety <u>issues</u>. Household is safe and secure. Child is not at risk from others.</p>
	<p>1 <i>Identified need that requires monitoring, watchful waiting, or preventive action based on history, suspicion or disagreement.</i> Household is safe but concerns exist about the safety of the child due to history or others who might be abusive.</p>
	<p>2 <i>Need is interfering with the provision of care; action is required to ensure that the identified need is addressed.</i> Child is in some danger from one or more individuals with access to the home.</p>
	<p>3 <i>Need prevents the provision of care; requires immediate and/or intensive action.</i> Child is in immediate danger from one or more individuals with unsupervised access.</p>

All referrants are legally required to report suspected child abuse or neglect.

FAMILY RELATIONSHIP TO THE SYSTEM

This item describes the degree to which the family's apprehension to engage with the formal health care system creates a barrier to receipt of care. For example, if a family refuses to see a psychiatrist due to their belief that medications are over-prescribed for children, a clinician must consider this belief and understand its impact on the family's choices. These complicated factors may translate into generalized discomfort with the formal health care system and may require the care provider to reconsider their approach.

<p>Questions to Consider</p> <ul style="list-style-type: none"> • Does the caregiver express any hesitancy in engaging in formal services? • How does the caregiver's hesitancy impact their engagement in care for their child? 	<p>Ratings and Descriptions</p> <p>0 <i>No current need; no need for action or intervention. This may be a resource for the child.</i> The caregiver expresses no concerns about engaging with the formal helping system.</p> <hr/> <p>1 <i>Identified need that requires monitoring, watchful waiting, or preventive action based on history, suspicion or disagreement.</i> The caregiver expresses some hesitancy to engage with the formal helping system that is easily rectified with clear communication about intentions or past issues engaging with the formal helping system.</p> <hr/> <p>2 <i>Need is interfering with the provision of care; action is required to ensure that the identified need is addressed.</i> The caregiver expresses hesitancy to engage with the formal helping system that requires significant discussions and possible revisions to the treatment plan.</p> <hr/> <p>3 <i>Need prevents the provision of care; requires immediate and/or intensive action.</i> The caregiver's hesitancy to engage with the formal helping system prohibits the family's engagement with the treatment team at this time. When this occurs, the development of an alternate treatment plan may be required.</p>
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LEGAL INVOLVEMENT

This item rates the caregiver's level of involvement in the criminal justice system which impacts their ability to parent. This includes divorce, civil disputes, custody, eviction, property issues, worker's comp, immigration etc.

<p>Questions to Consider</p> <ul style="list-style-type: none"> • Is one or more of the caregivers incarcerated or on probation? • Is one or more of the caregivers struggling with immigration or legal documentation issues? • Is the caregiver involved in civil disputes, custody, family court? 	<p>Ratings and Descriptions</p> <p>0 <i>No current need; no need for action or intervention. This may be a resource for the child.</i> Caregiver has no known legal difficulties.</p> <hr/> <p>1 <i>Identified need that requires monitoring, watchful waiting, or preventive action based on history, suspicion or disagreement.</i> Caregiver has a history of legal problems but currently is not involved with the legal system.</p> <hr/> <p>2 <i>Need is interfering with the provision of care; action is required to ensure that the identified need is addressed.</i> Caregiver has some legal problems and is currently involved in the legal system.</p> <hr/> <p>3 <i>Need prevents the provision of care; requires immediate and/or intensive action.</i> Caregiver has serious current or pending legal difficulties that place them at risk for incarceration. A caregiver needs an immediate comprehensive and community-based intervention. A caregiver who is incarcerated would be rated here.</p>
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DYADIC CONSIDERATIONS

These items look at specific aspects of the caregiver’s needs and their relationship with the child.

Question to Consider for this Domain: How does the caregiver’s needs and their relationship to the child impact their ability to care for the child?

For the **Dyadic Considerations**, use the following categories and action levels:

- 0 No current need; no need for action or intervention. This may be a resource for the child.
- 1 Identified need that requires monitoring, watchful waiting, or preventive action based on history, suspicion or disagreement.
- 2 Need is interfering with the provision of care; action is required to ensure that the identified need is addressed.
- 3 Need prevents the provision of care; requires immediate and/or intensive action.

CAREGIVER EMOTIONAL RESPONSIVENESS

This item refers to the caregiver’s ability to understand and respond to the joys, sorrows and other feelings of the child with similar or helpful feelings.

	Ratings and Descriptions
<p>Questions to Consider</p> <ul style="list-style-type: none"> • Is the caregiver able to empathize with the child? • Is the caregiver able to respond to the child’s needs in an emotionally appropriate manner? • Is the caregiver’s level of empathy impacting the child’s development? 	<p>0 <i>No current need; no need for action or intervention.</i> Caregiver is emotionally empathic and attends to the child’s emotional needs.</p>
	<p>1 <i>Identified need that requires monitoring, watchful waiting, or preventive action based on history, suspicion or disagreement. This may be an opportunity for resource building.</i> The caregiver can be emotionally empathic and typically attends to the child’s emotional needs. There are times, however, when the caregiver is not able to attend to the child’s emotional needs.</p>
	<p>2 <i>Need is interfering with the provision of care; action is required to ensure that the identified need is addressed.</i> The caregiver is often not empathic and frequently is unable to attend to the child’s emotional needs.</p>
	<p>3 <i>Need prevents the provision of care; requires immediate and/or intensive action.</i> The caregiver has significant difficulties with emotional responsiveness. They are not empathic and rarely attends to the child’s emotional needs.</p>

CAREGIVER ADJUSTMENT TO TRAUMATIC EXPERIENCES

This rating covers the caregiver's reactions to a variety of traumatic experiences that challenges the caregiver's ability to provide care for the child.

	Ratings and Descriptions
<p>Questions to Consider</p> <ul style="list-style-type: none">• Has the caregiver experienced a traumatic event?• Does the caregiver experience frequent nightmares?• Are they troubled by flashbacks?• What are the caregiver's current coping skills?	<p>0 <i>No current need; no need for action or intervention.</i></p> <p>There is no evidence that the caregiver has experienced trauma, OR there is evidence that the caregiver has adjusted well to their traumatic experiences.</p>
	<p>1 <i>Identified need that requires monitoring, watchful waiting, or preventive action based on history, suspicion or disagreement. This may be an opportunity for resource building.</i></p> <p>The caregiver has mild adjustment problems and exhibits some signs of distress, OR caregiver has a history of having difficulty adjusting to traumatic experiences.</p>
	<p>2 <i>Need is interfering with the provision of care; action is required to ensure that the identified need is addressed.</i></p> <p>The caregiver has marked adjustment problems and is symptomatic in response to a traumatic event (e.g., anger, depression, and anxiety).</p>
	<p>3 <i>Need prevents the provision of care; requires immediate and/or intensive action.</i></p> <p>The caregiver has post-traumatic stress difficulties. Symptoms may include intrusive thoughts, hyper-vigilance, constant anxiety, and other common symptoms of Post-Traumatic Stress Disorder (PTSD).</p>

CULTURAL FACTORS – FAMILY

These items identify linguistic or cultural issues for which service providers need to make accommodations (e.g., provide interpreter, find a therapist who speaks family’s primary language, and/or ensure that a child in placement has the opportunity to participate in cultural rituals associated with their cultural identity). Items in the Cultural Factors Domain describe difficulties that children and child may experience or encounter as a result of their membership in any cultural group, and/or because of the relationship between members of that group and members of the dominant society.

It is important to remember when using the CANS that the family should be defined from the individual child’s perspective (i.e., who the child describes as part of her/his family). The cultural issues in this domain should be considered in relation to the impact they are having on the life of the child when rating these items and creating a treatment or service plan.

Question to Consider for this Domain: How does the family’s membership in a particular cultural group impact their stress and wellbeing?

For the **Cultural Factors – Family**, use the following categories and action levels:

- 0 No current need; no need for action or intervention.
- 1 Identified need that requires monitoring, watchful waiting, or preventive action based on history, suspicion or disagreement.
- 2 Action is required to ensure that the identified need is addressed; need is interfering with functioning.
- 3 Need is dangerous or disabling; requires immediate and/or intensive action.

LANGUAGE

This item looks at whether the child and family need help with communication to obtain the necessary resources, supports and accommodations (e.g., translator). This item includes spoken, written, and sign language, as well as issues of literacy.

Ratings & Descriptions

- 0 *No current need; no need for action or intervention.*
No evidence that there is a need or preference for an interpreter and/or the child and family speak and read the primary language where the child or family lives.

- 1 *Identified need that requires monitoring, watchful waiting, or preventive action based on history, suspicion or disagreement.*
Child and/or family speak or read the primary language where the child or family lives, but potential communication problems exist because of limited vocabulary or comprehension of the nuances of the language.

- 2 *Action or intervention is required to ensure that the identified need is addressed; need is interfering with functioning.*
Child and/or significant family members do not speak the primary language where the child or family lives. Translator or family’s native language speaker is needed for successful intervention; a qualified individual(s) can be identified within natural supports.

- 3 *Needs are dangerous or disabling; requires immediate and/or intensive action.*
Child and/or significant family members do not speak the primary language where the child or family lives. Translator or family’s native language speaker is needed for successful intervention; no such individual is available from among natural supports.

Questions to Consider

- What language does the family speak at home?
- Does the child or significant family members have any special needs related to communication (e.g., ESL, ASL, Braille, or assisted technology)?

Supplemental Information: A parent’s ability to communicate with others is necessary and important to assess. Parents that experience challenges in this area are in need of support to understand their child’s needs, support their child and ask pertinent questions. It is important to consider both a parent’s ability to express themselves and understand what is being said and their ability to read.

CULTURAL IDENTITY

This item rates refers to the child's or family's view of themselves as belonging to a specific cultural group. This cultural group may be defined by a number of factors including race, religion, ethnicity, geography, or lifestyle.

	Ratings & Descriptions
<p>Questions to Consider</p> <ul style="list-style-type: none">• Does the child and/or family have a cultural identity?• Is the child and/or family connected to others who share their cultural identity?	<p>0 <i>No current need; no need for action or intervention.</i> Child and/or family has clear and consistent cultural identity and is connected to others who share their cultural identity.</p> <hr/> <p>1 <i>Need that requires monitoring, watchful waiting, or preventive action. This may have been a need in the past.</i> Child and/or family is experiencing some confusion or concern regarding their cultural identity.</p> <hr/> <p>2 <i>Action or intervention is required to ensure that the identified need is addressed; need is interfering with functioning.</i> Child and/or family has significant struggles with their own cultural identity. Child and/or family may have cultural identity, but is not connected with others who share their culture.</p> <hr/> <p>3 <i>Needs are dangerous or disabling; requires immediate and/or intensive action.</i> Child and/or family has no cultural identity or is experiencing significant problems due to conflict regarding their cultural identity.</p>

TRADITIONS AND RITUALS

This item rates the child and family's access to and participation in cultural traditions, rituals and practices, including the celebration of culturally specific holidays such as Kwanza, Dia de los Muertos, Yom Kippur, Quinceanera, etc. This also may include daily activities that are culturally specific (e.g., wearing a hijab, praying toward Mecca at specific times, eating a specific diet, access to media), and traditions and activities to include newer cultural identities.

	Ratings & Descriptions
<p>Questions to Consider</p> <ul style="list-style-type: none">• What holidays does the child celebrate?• What traditions are important to the child?• Does the child fear discrimination for practicing the child's traditions and rituals?	<p>0 <i>No current need; no need for action or intervention.</i> Child and/or family consistently practice their chosen traditions and rituals consistent with their cultural identity.</p> <hr/> <p>1 <i>Need that requires monitoring, watchful waiting, or preventive action. This may have been a need in the past.</i> Child and/or family generally practice their chosen traditions and rituals consistent with their cultural identity; however, they sometimes experience some obstacles to the performance of these practices.</p> <hr/> <p>2 <i>Action or intervention is required to ensure that the identified need is addressed; need is interfering with functioning.</i> Child and/or family experience significant barriers and are sometimes prevented from practicing their chosen traditions and rituals consistent with their cultural identity.</p> <hr/> <p>3 <i>Needs are dangerous or disabling; requires immediate and/or intensive action.</i> Child and/or family are unable to practice their chosen traditions and rituals consistent with their cultural identity.</p>

CULTURAL STRESS

This item identifies circumstances in which the child and family's cultural identity is met with hostility or other problems within their environment due to differences in attitudes, behavior, or beliefs of others (this includes cultural differences that are causing stress between the child and their family). Racism, negativity toward sexual orientation, gender identity and expression (SOGIE) and other forms of discrimination would be rated here.

Questions to Consider

- What does the family believe is their reality of discrimination? How do they describe discrimination or oppression?
- Does this impact their functioning as both individuals and as a family?
- How does the caregiver support the child's identity and experiences if different from the caregiver's own?

Ratings & Descriptions

- 0 *No current need; no need for action or intervention.*
No evidence of stress between the child's cultural identity and current environment or living situation.
- 1 *Need that requires monitoring, watchful waiting, or preventive action. This may have been a need in the past.*
Some mild or occasional stress resulting from friction between the child's cultural identity and current environment or living situation.
- 2 *Action or intervention is required to ensure that the identified need is addressed; need is interfering with functioning.*
Child is experiencing cultural stress that is causing problems of functioning in at least one life domain. Child needs support to learn how to manage culture stress.
- 3 *Needs are dangerous or disabling; requires immediate and/or intensive action.*
Child is experiencing a high level of cultural stress that is making functioning in any life domain difficult under the present circumstances. Child needs immediate plan to reduce culture stress.

CULTURAL DIFFERENCES

This item identifies cultural differences regarding child development and child rearing practices between the family and majority cultural values. Different child developmental beliefs and rearing practices which are not usually accepted, but do not put the child at risk, are rated '1.' When the family's child rearing practices are considered to be problematic for the child, rate the item '2.' If the family's child rearing culture is considered to be neglectful or abusive by the majority culture, rate the item '3.'

Questions to Consider

- Does everyone in the family have the same cultural views regarding child development and child rearing?
- Is there any tension amongst family members regarding child rearing/development because of cultural differences?

Ratings & Descriptions

- 0 *No current need; no need for action or intervention.*
The family does not have cultural differences related to child rearing practices, child development, and early intervention that are considered by the majority culture as problematic for the child.
- 1 *Need that requires monitoring, watchful waiting, or preventive action. This may have been a need in the past.*
The family has some cultural differences related to child rearing practices, child development, and early intervention that are not generally accepted, but not considered to put the child at risk.
- 2 *Action or intervention is required to ensure that the identified need is addressed; need is interfering with functioning.*
The family has cultural differences related to child rearing practices and development that are considered by the majority culture as problematic for the child.
- 3 *Needs are dangerous or disabling; requires immediate and/or intensive action.*
The family has cultural differences related to child rearing practices and child development that are considered abusive or neglectful and may result in intervention.

PARENT-CHILD RELATIONSHIP COMPETENCY

Adapted from and with permission by Maria St. John, Ph.D., MFT UCSF Infant-Parent Program

To be completed by the KidConnections Network of Providers and those who have received training on infant and early childhood mental health.

For the **Parent-Child Relationship Competency**, use the following categories:

- 0 Bi-directional competency is present & functioning well to facilitate child development, relationship satisfaction and family wellbeing. All elements of the competency description must be present and functioning well for this rating to be appropriate.
- 1 Bi-directional competency is present but strained such that support may be needed in this area. Some elements of the competency description may be functioning better than others.
- 2 Bi-directional competency functions unevenly or inconsistently or needs strengthening or refining. It may be that one element of the competency description is present and functioning but another is inconsistent or underdeveloped.
- 3 Bi-directional competency is absent or seriously impaired. This rating is appropriate if one or more elements of the competency description are absent or seriously impaired even if another element is present and functioning.
- N No (or not enough) information

ADJUSTMENT TO TRAUMA

Parent is able to **restore a sense of safety, hope, trust and well-being** for self and child **following a** distressing, disturbing or **traumatic event** AND child is able to be helped to restore a sense of safety, hope, trust, and well-being following a distressing, disturbing or traumatic event. (#17 from PCRC)

- 0 Bi-directional competency is present but strained such that support may be needed in this area. Some elements of the competency description may be functioning better than others.
- 1 Bi-directional competency functions unevenly or inconsistently or needs strengthening or refining. It may be that one element of the competency description is present and functioning but another is inconsistent or underdeveloped.
- 2 Bi-directional competency is absent or seriously impaired. This rating is appropriate if one or more elements of the competency description are absent or seriously impaired even if another element is present and functioning.
- 3 No (or not enough) information
- N Bi-directional competency is present but strained such that support may be needed in this area. Some elements of the competency description may be functioning better than others.

SAFETY, PROTECTION, COMFORT

Parent has the capacity to provide **safety, protection, and comfort** for child AND child seeks out and accepts comfort and protection from parent and has a developmentally expectable ability to discern safety and danger. (#3 from PCRC)

- 0 Bi-directional competency is present but strained such that support may be needed in this area. Some elements of the competency description may be functioning better than others.
- 1 Bi-directional competency functions unevenly or inconsistently or needs strengthening or refining. It may be that one element of the competency description is present and functioning but another is inconsistent or underdeveloped.
- 2 Bi-directional competency is absent or seriously impaired. This rating is appropriate if one or more elements of the competency description are absent or seriously impaired even if another element is present and functioning.
- 3 No (or not enough) information
- N Bi-directional competency is present but strained such that support may be needed in this area. Some elements of the competency description may be functioning better than others.

SEPARATION

Child displays an age-expectable capacity to manage and benefit from **separations** from parent AND parent has the capacity to plan for and support the child around separations in ways that promote development and well-being. (#15 from PCRC)

- 0 Bi-directional competency is present but strained such that support may be needed in this area. Some elements of the competency description may be functioning better than others.
- 1 Bi-directional competency functions unevenly or inconsistently or needs strengthening or refining. It may be that one element of the competency description is present and functioning but another is inconsistent or underdeveloped.
- 2 Bi-directional competency is absent or seriously impaired. This rating is appropriate if one or more elements of the competency description are absent or seriously impaired even if another element is present and functioning.
- 3 No (or not enough) information
- N Bi-directional competency is present but strained such that support may be needed in this area. Some elements of the competency description may be functioning better than others.