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Early Childhood Child and Adolescent Needs and Strengths (CANS), Birth to Five

Indiana

Multi-System Comprehensive Version

GLOSSARY v 2.2

Indiana University School of Social Work

and

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Funded by the Indiana Family and Social Service Administration,
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Glossary for the Birth to 5 CANS-Indiana

Introduction

The early childhood or Birth to Five CANS assessment tool is developmentally appropriate for infants, toddlers and preschoolers. Similar to the Comprehensive Child and Adolescent Needs and Strengths (CANS, Lyons, 2009) 5 to 17 tool, the early childhood version considers basic life dimensions or domains (social/emotional needs, risk factors, risk behaviors, daily life functioning, child strengths, acculturation and caregiver strengths and needs). The Praed Foundation holds the copyright (1999) for the communimetric tool.

Early childhood mental health often is described from the perspective of a healthy child within a child-family system. The World Association for Infant Mental Health describes infant mental health as "the ability to develop physically, cognitively, and socially in a manner which allows them to master the primary emotional tasks of early childhood without serious disruption caused by harmful life events. Because infants grow in a context of nurturing environments, infant mental health involves the psychological balance of the infant-family system" (Osofsky & Fitzgerald, 2000, v 1, p.25). Similarly, the Zero to Three Infant Mental Health Task Force Steering Committee (2001) defines infant mental health as "the young child's capacity to experience, regulate, and express emotions, form close and secure interpersonal relationships, and explore the environment and learn."

When rating the CANS domains, assume the child is healthy with typical emotional development including:

Established sleeping and eating patterns,
Demonstrating arousal and focused attention,
Sustained attention, concentration and persistence,
Inhibition of outburst to developmentally appropriate expectations,
Expression of autonomy in a socially acceptable manner,
Enduring and supportive relationship with primary caregivers
Initiates play, discovery and learning,
Persists when discouraged or distracted,
Recovers from disruption, transition or disappointment, and
Emotionally responses match social-cultural context (CIMH, 2005).

Use evidence of such normal emotional development to rate Child Strengths on the CANS. Use evidence of harmful life events or limitations in a young child's capacity to complete normal developmental functions to rate the early childhood CANS needs.

Differences in rating specific items for an infant, toddler or preschooler are highlighted. Additionally, the CANS Birth to Five Glossary includes information about normal early childhood development, indications of need and questions that can be asked of parents and other caregivers. References are added as additional resources. For young children, it is essential that needs are rated

with the infant or child's family and caregiver, reflecting the child and family's experiences and current functioning.

The decision support and information management tools [CANS 5 to 17, CANS Birth to Five, and Adult Needs and Strength Assessment (ANSA)] support communication in a complex environment. They serve to integrate information from whatever sources are available. To accurately reflect the needs and strengths/resources of a young child and family, consider the six key characteristics of a Communimetric tool and scoring guidelines.

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 ('0-3') level rating system. The levels are designed to translate immediately into action levels. Different action levels exist for needs and strengths.

3. Consider cultural and developmental factors before rating any item and establishing the action level.

4. Rating should describe the child and family, not the child and family in services. If an intervention is present that is masking a need but must stay in place, it is factored into the rating and would result in the rating of an 'actionable' need (i.e. '2' or '3').

5. The ratings are generally "agnostic as to etiology". In other words, this is a descriptive tool. It is about the "what" not the "why". The CANS describes what is happening with the individual, but does not seek to assign a cause for a behavior or situation.

6. Unless otherwise specified, a 30-day window is used for ratings in order to make sure assessments stay "fresh" and relevant to the child or youth's present circumstances. However, if the need remains relevant, the action levels can be used to over-ride the 30-day rating period.

Rating and Action Levels for Need Items

Scoring Needs

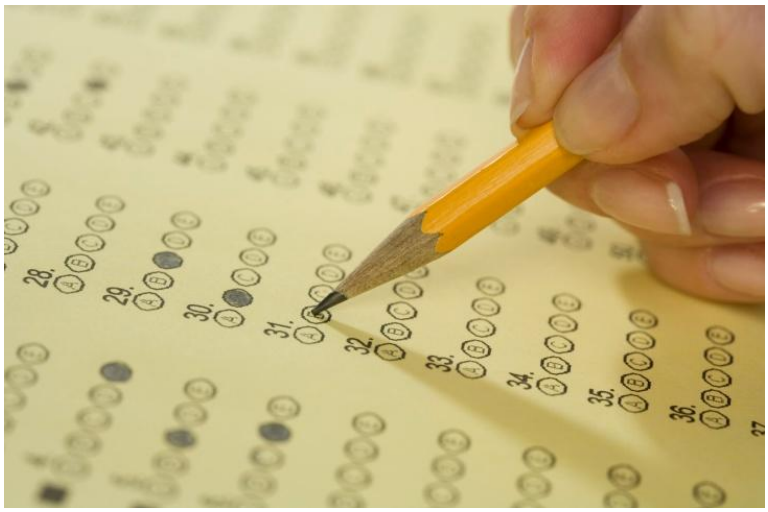
Score	Level of Need	Appropriate Action
0	No evidence of need	No action needed
1	Significant history or possible need which is not interfering with functioning	Watchful waiting/ Prevention/ Additional assessment
2	Need interferes with functioning	Action/Intervention
3	Need is dangerous or disabling	Immediate and/or Intensive action

0 – **no evidence** – This rating indicates that there is no reason to believe that a particular need exists. It does not state that the need categorically does not exist, it merely indicates that based on current assessment information there is no reason to address this need.

1 – **watchful waiting/prevention –** This level of rating indicates that you need to keep an eye on this area, further assess or think about putting in place some preventive actions to make sure things do not get worse.

2 – **action needed –** This level of rating implies that something must be done to address the identified need. The need is sufficiently problematic that it is interfering in the child or family's life in a notable way.

3 – **immediate/intensive action –** This level of rating indicates a need that requires immediate or intensive effort to address. Dangerous or disabling levels of needs are rated with this level. A child who is asked to leave a child care or preschool setting or whose behavior is dangerous to the child or others would be rated with a '3' on the relevant need. Immediate and/or intensive actions are indicated.



Rating and Actions for Child Strengths

The "strengths rating scale" is used only for the Child Strength items.

Scoring Strengths

Score	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

0 – central to planning - This rating indicates that this is a significant and functional strength that could become the centerpiece in service planning.

1 – useful in planning – This level of rating indicates that the strength clearly exists and could become part of the service plan.

2 – build or develop strength – This level of rating indicates that a potential strength has been identified but requires building and development to become useful to the child.

3 – strength creation or identification may be indicated – This level of rating indicates that no strength has been identified at this time. A rating at this level would suggest that in this area the effort would be towards identifying and building strengths that can become useful to the child.

Remember that strengths are NOT the opposite of needs. Increasing strengths, while addressing behavioral and emotional needs, results in better functioning and outcomes than just focusing on the needs. Identifying areas where strengths can be built is an important element of service planning.

Glossary Contents

Indiana's Early Childhood CANS Glossary includes an enhanced description of each item, information about developmental milestones, and questions that could be asked to gather information for each item. Questions from the Family Friendly Interview (Lyons, 2007), developed in cooperation with families and stakeholders in several states, are included as an aide to help engage families, collect relevant information, and reliably rate the CANS items. The Family Friendly Interview questions are indicated with an (*) to highlight how to ask sensitive questions in a manner that is respectful to families and children.

Early Childhood CANS Birth to Five Domains

Life Domain Functioning

Child Strengths

Acculturation

Caregiver Strengths & Needs

Child Behavioral/Emotional Needs

Child Risk Factors

Child Risk Behaviors

Details for specific items in each domain follow.

LIFE FUNCTIONING DOMAIN

Life domains are the different areas in a child and family's life.

Family Functioning

This item rates how the child is functioning within his/her family. "Family" ideally should be defined by the child; however, in the absence of this knowledge consider biological and adoptive relatives and their significant others with whom the child has contact as the definition of family. Foster families should only be considered if they have made a significant commitment to the child. For youth involved with child welfare, family refers to the person(s) fulfilling the permanency plan.

Ratings	FAMILY FUNCTIONING Anchor Definitions (examples of what family functioning looks like for each rating)
0	No evidence of problems in interaction with family members.
1	Child is doing adequately in relationships with family members although some problems may exist. For example, some family members may have some problems in their relationships with child including sibling rivalry or under-responsive to child's needs.
2	Child is having moderate problems with parents, siblings and/or other family members. Frequent arguing, difficulties in maintaining any positive relationship may be observed.
3	Child is having severe problems with parents, siblings, and/or other family members. This would include problems of domestic violence, constant arguing, and aggression with siblings.

This item is rating the way in which the child relates to others within the family. It is helpful to observe and ask about:

- the types of activities the family is involved in and 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.

When stressors occur between family members such as marital/relationship violence, consider how, as a result of emotional trauma, witnessing or being aware of violence often negatively impacts the child's ability to function optimally with family members.

Of all the factors that may impact a child, the ongoing nature of their family relationships has perhaps the greatest potential to positively or negatively affect a child. The child typically spends a great portion of their day with family and relies on the routine and structure of the family to offer them a framework for all other experiences. 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. Family functioning often becomes the model for how a child will 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.

When assessing family relationships (functioning), it is important to carefully listen to families' descriptions of the relationships, encourage dialogue about the relationships as well as observe the relationships. Look for evidence of family relationship needs which negatively impact the child's functioning.

Evidence of Family Functioning Needs
Adapted from Cornett (2011) & Cornett & Podrobinok (2009)

Negative Parent/Child Relationships	Negative Sibling Relationships
• Interactions Appear Strained and Difficult • Low Level of Physical Contact; Little Initiation of Physical Contact • Minimal Eye Contact, Flat or Negative Affect • Skewed Family Boundaries • Little Time Spent in Interactions • Extreme Reactions to Infractions or Disappointments; Difficulty Reestablishing Positive Interaction Following Such • Few Bids for Attention or Expectations to have Needs Met	• Child Rarely Interacts with Siblings • Negative Statements on Frequent Basis Regarding Siblings • Predominantly Negative Behaviors and Interactions with Siblings • Ongoing Issues not Resolved • Inappropriate Roles/Boundaries with Siblings • Fearful Statements or Behavior regarding Sibling Interaction

Assessment activities include questioning parents and children (as appropriate to age), observing the child, observing the parent, observing of the child-parent dyad, and review of information received from chart review and others providing information. Others may include extended family, teachers, clinicians, referral source or alternate caregivers. 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 responses come with some explanation that can back up their response? 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.

The bulleted items in the Evidence of Family Functioning Needs Table can be observed in a number of ways. It is important to attend to your own reactions in observing the relationships, as that often is a good indication of the actual nature of the relationship. If the interaction feels unpleasant and harsh for instance and the parent or child is describing satisfaction with the relationship there probably is more to consider. In addition, take into consideration that what is observed may be different due to parent anxiety about the assessment. A good way to account for this is to attempt to alleviate parent or child anxiety by assessing the positive nature and purpose of assessment and asking parent's if what is being observed seems normal or typical to them.

In summary, this item is rating functional needs associated with the child's relationships within his family. Parent Child Interaction, Family Strengths and Attachment are closely related, but there are differences. 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; such strengths are rated under Family Strengths. 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. More discussion of these items will take place in the relevant sections.

Family Functioning Discussion Points:

- **How does your family get along?***
- **Are there problems between family members?***
- **Has there ever been any violence?***

Additional Questions:

- How would you describe the relationships between the child and others in the family?
- What types of strategies does the child have for coping with siblings when frustrated?
- How would you describe how the siblings feel and behave towards the child?
- How would you describe how the child feels and behaves towards his siblings?
- How does the child typically relate to his parents/caregivers?
- Can you describe special family activities that the child enjoys?
- Are there things about your relationship with your child that you wish were better?
- Are there stressors within the family relationships that may be affecting the child and his/her interactions within the family?

(*from Family Friendly Interview, Lyons, 2007)

Living Situation

This item refers to the functioning of the child within their current living arrangement. When the child is potentially returning to biological parents, this item is rated independent of the Family Functioning item. When the child lives with biological parents this item is rated the same as the Family Functioning item. Hospital and shelters do not count as "living situations". If a child is presently in one of these places, rate the previous living situation.

Ratings	
0	No evidence of problems with functioning in current living environment.
1	Mild problems with functioning in current living situation. Caregivers concerned about child's behavior at home.
2	Moderate to severe problems with functioning in current living situation. Child has difficulties maintaining his/her behavior in this setting creating significant problems for others in the residence.
3	Profound problems with functioning in current living situation. Child is at immediate risk of being removed from living situation due to his/her behaviors.

When considering the rating for this item it is important to explore the caregiver/family's perceptions of the relationship with the child. Often this may identify potential stressors that would warrant a watchful stance with the rating of a "1".

One of the most important interventions that can occur for young children in foster care is minimizing placement disruptions. Often times, concerns may be emerging despite the denial of problems presently impacting the family.

Living Situation Discussion Points:

- **How is the child behaving and getting along with others in their current living situation?***
- Can you describe any situations that have been difficult for family members to adjust to?
- If situations occur how do they usually get resolved?
- Have family members come to caregivers with concerns and if so how were they dealt with?
- How would you describe how the child typically reacts to others within the household?

Preschool/Day Care Functioning

This item rates the child's experiences in preschool or day care settings and the child's ability to get his/her needs met in these settings. This item also considers the presence of problems within these environments in terms of attendance, academic achievement, support from the day care or preschool staff to meet the child's needs, and child's behavioral response to these environments.

Ratings	
0	No evidence problems with functioning in current preschool or day care environment.
1	Mild problems with functioning in current preschool or day care environment.
2	Moderate to severe problems with functioning in current preschool or day care environment. Child has difficulties maintaining his/her behavior in this setting creating significant problems for others
3	Profound problems with functioning in current preschool or day care environment. Child is at immediate risk of being removed from program due to his/her behaviors or unmet needs.

Preschool/Day Care Functioning Discussion Points:

- **How is your child doing in daycare/preschool?***
- **Has he/she had any problems?***
- **Has a teacher or other school personnel called you to talk about your child's behavior?***
- **How is your child progressing (learning) in daycare/preschool?***

Infants:

- Describe the input you receive from teachers/providers at preschool/day care regarding your infant.
- How do you feel about the care your infant receives in this setting?
- How do you feel your infant does within this setting?
- Has the staff indicated concerns regarding attendance or achievement (development)?
- If so, what have their comments been?

Toddlers:

- Describe the feedback or input you receive from staff at day care regarding your toddler's behavior and interactions with staff and other children.
- Does your toddler seem to enjoy this setting?
- What observations have you made of your toddler in this setting?
- Are there areas or things that you wish the staff would do differently?
- What are the strengths of your child's day care or preschool provider?

Preschool Age Children:

- Describe your child's past and current preschool/day care experiences.
- What are your child's attitudes regarding preschool/school?
- Does your child's teacher seem to understand your child's needs?
- How does your child get along with staff and other children in school?
- Are there areas you wish were different?
- Would you change providers if able?

A rating of a "1" or greater on Preschool/Day Care Functioning requires further specification of these needs through the completion of four additional items in the CANS Birth to Five ***School Module.*** *Note: The highest level of need on any one preschool/day care "School Module" item equals the overall Preschool/Day Care School Functioning item under Life Functioning Domain.*

Preschool/Day Care Quality

This item rates the overall quality of the preschool or day care as well as the ability of the program to meet the needs of the child within a larger care giving context.

Ratings	
0	Infant/child's preschool/day care meets the needs of the infant/child.
1	Infant/child's preschool/day care is marginal in its ability to meet the needs of the infant/child. Caregivers may be inconsistent or curriculum may be weak in areas.
2	Infant/child's preschool/day care does not meet the needs of the infant/child in most areas. Care giving may not support the child's growth or promote further learning.
3	The infant/child's preschool/day care is contributing to problems for the infant/child in one or more areas.

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 (Greenspan, 1985, 2003; Geoffroy, Cote, Parent, & Seguin, 2006). 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 youth to be supported in ways that appreciates their individual needs and strengths. When assessing this item look for evidence that the parent or child can indicate that the child's uniqueness is being accepted and embraced.

Indicators of an Appropriate Early Child Care/Education Setting
Adapted from Cornett (2011) & Cornett & Podrobinok (2009)

- Infant or child seems comfortable with caregivers and environment
- Environment has sufficient space and materials for youth 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

Preschool/Day Care Behavior

This item rates the child's behavior in day care or preschool. This is rated independently from attendance. Sometimes children are often absent but when they are in school they behave appropriately. If the child's behavior is disruptive and multiple interventions have been tried, rate this item '2'. If the day care/preschool placement is in jeopardy due to behavior, this would be rated a '3'.

Ratings	
0	Child is behaving well in preschool/day care.
1	Child is behaving adequately in preschool/day care although some mild behavior problems may exist. Child may have a history of behavioral problems.
2	Child is having moderate behavioral problems at school. He/she is disruptive and many types of interventions have been implemented.
3	Child is having severe problems with behavior in preschool/day care. He/she is frequently or severely disruptive. The threat of expulsion is present.

A reciprocal relationship has been suggested between social behavior and academic success (Welsh, Parke, Widaman & O'Neil, 2001). Recent early childhood learning standards include expectations for social as well as academic learning (Scott-Little, et al., 2006). Behavioral learning standards could include expectations to cooperate with others in play and group activities, to demonstrate understands concept of taking turns and to display effective communication skills (Holmes-Longergan, Thomas, Leong & Bodrova, 2006). Logue (2007) argues for school based social workers to become liaisons between prekindergarten programs and children by using the common language of early learning standards to support high-quality programs.

Preschool/Day Care Achievement

This item rates the child's level of developmentally appropriate achievement.

Ratings	
0	Child is doing well acquiring new skills.
1	Child is doing adequately acquiring new skills with some challenges. Child may be able to compensate with extra adult support.
2	Child is having moderate problems with acquiring new skills. Child may not be able to retain concepts or meet expectations even with adult support in some areas.
3	Child is having severe achievement problems. Child may be completely unable to understand or participate in skill development in most or all areas.

The importance of early childhood development for future success is reflected in the emphasis on a child's readiness for Kindergarten and school. All facets of child development -- physical well being, motor, social, emotional, communication and cognitive skills—are included. Preschool education and early childhood research have focused on factors that predict school readiness. Grissmer, Grimm, Aiver, Murrah & Steele (2010, p. 1008) found that "together, attention, fine motor skills, and general knowledge are much stronger overall predictors of later math, reading, and science scores than early math and reading scores alone." Increased emphasis for accountability in education is impacting preschool with academic pressures on early childhood educators, toddlers and preschoolers. Young children's dispositions toward learning, social skills, as well as physical

and emotional wellbeing directly impact their academic learning. Stipek (2006) argues that learning basic skills can be fun and effective.

Preschool/Day Care Attendance

This item assesses the degree to which the child attends preschool or day care.

Ratings	
0	Child attends preschool/day care regularly.
1	Child has some problems attending preschool/day care but generally is present. May miss up to one day per week on average OR may have had moderate to severe problem in the past six months but has been attending regularly in the past month.
2	Child is having problems with school attendance. He/she is missing at least two days each week on average.
3	Child is absent most of the time and this causes a significant challenge in achievement, socialization and following routine.

Regular attendance in an effective preschool program has been linked to readiness for and achievement in school (Logan, et al., 2011, Kmak, 2011).

Social Functioning

This item rates the child's current 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. For example, can an infant engage with and respond to adults? Does a toddler interact positively with peers and caregivers?

Ratings	
0	No evidence of problems in social functioning.
1	Child is having some minor 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.
2	Child is having some moderate problems with his/her 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.
3	Child is experiencing severe disruptions in his/her 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.

Social Functioning significantly relates to all other areas of development for young children. A child that is struggling to relate to their parents, caregivers and peers will also struggle in their ability to find support for the other areas of development. The parent-child relationship, the child's capacity to socialize, and to 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.

Social Functioning Milestones
Infants, Toddlers & Preschoolers
Adapted from Landy (2002, p. 12–27)

Evidence of Normal Social Functioning	
By 3 Months	• 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
By 7 Months	• 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 • 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 Peek-a-boo • Knows difference between familiar and unfamiliar people
By 14 Months	• 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

By 2 Years	• 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 he or she cannot meet standards • Labels 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
By 4 Years	• 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

Social Functioning Discussion Points:

- **How well does your child get along with others?***
- **Preschooler: Does s/he make new friend easily?***
- **How does s/he get along with adults?***
- How does your infant relate to you and other family members?
- How does your infant behave differently with you, family members and others outside the family?
- Does your infant seem interested in surroundings and people around them?
- How does your child interact with peers and others outside the family?
- How would you describe your preschooler's ability to engage others, deal with conflict and play with peers?
- Can you describe any situations in which others have described concerns about your child's social functioning?
- Are there things that others point out that are positive about your child's interpersonal interactions?

Recreation/Play

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.

Ratings	
0	No evidence that infant or child has problems with recreation or play.
1	Child is doing adequately with recreational or play activities although some problems may exist. Infants may not be easily engaged in play. Toddlers and preschoolers may seem uninterested and poorly able to sustain plan. There may also be a history of these behaviors.
2	Child is having moderate problems with recreational activities. Infants resist play or do not have enough opportunities to play. Toddlers and preschoolers show little enjoyment or interest in activities within or outside the home and can only be engaged in play/recreational activities with ongoing adult interaction and support.
3	Child has no access to or interest in play or toys recreational activities. Infant spends most of time not interacting with toys or people. Toddlers and preschoolers, even with adult encouragement, cannot demonstrate enjoyment in "pretend" play.

The experience of play is critical to the child in a number of ways. Play serves as a vehicle to further a child's social, emotional, physical, language and cognitive development.

Developmental Benefits Facilitated By Play
Adapted from Cornett & Podrobinok (2009)

Cognitive	Emotional	Social	Physical	Language
• Improves Attention • Improves Problem Solving • Enhances Imagination • Develops Planning and Sequencing Abilities • Promotes Awareness of How Items Function • Improves Concentration	• Facilitates the Expression of Feelings and Experiences in a Safe Manner • Alleviates Anxiety by Promoting Mastery Over Stressful Situations • Enhances Self Esteem	• Encourages Children Taking on a Variety of Social Roles • Develops Sharing, Cooperating and Compromising Abilities • Further Develops Sense of Self • Encourages Learning to Take the Perspective of Others	• Enhances Fine Motor Skills • Enhances Gross Motor Skills • Facilitates Visual Spatial Skills • Develops Balance and Coordination	• Through Interactions Learns Rhythm, Cadence, and Pace of Speech • Enhances Vocabulary Acquisition • Develops Social Conventions of Language

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.

Recreation/Play Discussion Points:

- What activities does your child enjoy?
- Describe your child's typical routine; how often is play a part of the routine?
- How would you describe your child's interest and enjoyment in play?
- What types of toys or activities are available to your child?
- Are there certain times or settings in which your child is most likely to play?
- Have there been settings in which your child does not take advantage of play opportunities?

Developmental Functioning

This item rates the presence of any developmental or Intellectual Disability. 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 school, or occupational functioning.

Ratings	
0	There is no evidence of a developmental delay and/or child has no developmental problem or intellectual disability.
1	Child may have low IQ. Child has some problems with physical immaturity or there are concerns about possible developmental delay. Child may have low IQ, a documented delay, learning disability, or documented borderline intellectual disability. Mild deficits in adaptive functioning are indicated.
2	Child has mild developmental delays (deficits in social functioning, inflexibility of behavior causing functional problems in one or more settings) and/or mild to moderate Intellectual Disability. IDD impacts communication, social functioning, daily living skills, judgment, and/or risk of manipulation by others.
3	Child has severe to profound intellectual disability 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.

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. Early intervention is critical when a young child has developmental needs.

Normal Developmental Milestones

Adapted from Landy's *Pathways to Competence: Encouraging Healthy Social & Emotional Development in Young Children* (2002, pp. 12 – 27)

By 3 Months	• 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	• 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	• 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	• 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	• 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

Developmental Functioning Discussion Points:

- **Has your child developed like other children his/her age?***
- **Does your child's growth and development seem healthy?***
- **Has s/he reached appropriate developmental milestones (such as walking, talking)?***
- **Has anyone ever told you that your child may have developmental problems?***

A rating of a "1" or greater on Developmental Functioning requires further specification of these needs through the completion of the ***Developmental Needs Module.*** The Developmental Module specifies the type of developmental problem and associated self care and assistive needs.

Cognitive Development

Ratings	
0	There is no evidence of cognitive development problems.
1	Infant/child has some indicators that cognitive skills are not appropriate for age or are at the upper end of age expectations. Infants may not consistently demonstrate familiarity with routines and anticipatory behavior. Infants may seem unaware of surroundings at times. Older children may have challenges in remembering routines, and completing tasks such as sorting, or recognizing colors some of the time.
2	Infant/child has clear indicators that cognitive development is not at expected level and interferes with functioning much of the time. Infants may not have the ability to indicate wants/needs. Infants may not demonstrate anticipatory behavior all or most of the time. Older children may be unable to demonstrate understanding of simple routines or the ability to complete simple tasks.
3	Infant/child has significant delays in cognitive functioning that are seriously interfering with their functioning. Infant/child is completely reliant on caregiver to function.

Self-Care/Daily Living Skills

Ratings	
0	Child's self-care and daily living skills appear developmentally appropriate. There is no reason to believe that the child has any problems performing daily living skills.
1	Child requires some assistance on self-care tasks or daily living skills at a greater level than would be expected for age. Development in this area may be slow. Infants may require greater than expected level of assistance in eating and may demonstrate a lack of progression in skills.
2	Infant/child requires consistent assistance (physical prompting) on developmentally appropriate self-care tasks and/or does not appear to be developing the needed skills in this area.
3	Child is not able to function independently at all in this area.

Motor Functioning

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

Ratings	
0	No evidence of fine or gross motor development problems.
1	Child has some indicators that motor skills are challenging and there may be some concern that there is a delay.
2	Child has either fine or gross motor skill delays.
3	Child has significant delays in fine or gross motor development or both. Delay causes impairment in functioning.

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.

Motor Developmental Milestones
Adapted from Landy (2002)

	Gross Motor Milestones	Fine Motor Milestones
By 3 Months	• 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	• 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
By 7 Months	• 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	• 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	• 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	• 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	• 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	• Copies circles and lines • Stacks six blocks • Puts pieces in puzzles • Nests objects • Puts tiny object in small container

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 coordination usually 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.

Motor Developmental Discussion Points:

- Does your child appear to be using their large and small muscles in a way that you see as typical?
- Can you describe any motor skill concerns your or others may have noticed?
- Do you see any ways in which your child's fine or gross motor development is different than your other children's or other children you have seen?
- How would you describe your child's physical abilities and coordination?

Communication

This rating describes 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 expressing feelings.

Ratings	
0	No evidence of communication problems.
1	Child has a history of communication problems but currently is not experiencing problems. An infant may rarely vocalize. A toddler may have very few words and become frustrated with expressing needs. A preschooler may be difficult for others to understand.
2	Child has either receptive or expressive language problems that interfere with functioning. Infants may have trouble interpreting facial gestures or initiate gestures to communicate needs. Toddlers may not follow simple 1-step commands. Preschoolers may be unable to understand simple conversation or carry out 2-3 step commands.
3	Child has serious communication difficulties and is unable to communicate in any way including pointing and grunting.

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.

Communication Developmental Milestones
Adapted from Landy (2002)

Expected Receptive and Expressive Communication Behaviors	
By 3 Months	• 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	• 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	• 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	• 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	• 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

Communication Discussion Points:

- **Has your child ever been diagnosed with having a problem with understanding words or using words to express him/herself?***
- **Have you ever worried about your child's ability to understand or use words?***
- **Has anyone told you that your child has or could have a learning problem related to understanding others or expressing him/herself?***

Medical

This item rates the child's current health status. Most transient, treatable conditions would be rate as a '1'. Most chronic conditions (e.g., diabetes, severe asthma, HIV) would be rated as a '2'. The rating of '3' is reserved for life threatening medical conditions.

Ratings	
0	Child is healthy.
1	Child has some medical problems that require medical treatment.
2	Child has chronic illness that requires ongoing medical intervention.
3	Child has life threatening illness or medical condition.

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 is not causing problems in the child's functioning.

Medical Discussion Points:

- **Is your child generally healthy?***
- **Does s/he have any medical or physical problems?***
- **Does your child have to see a doctor regularly to treat any problems (such as asthma, diabetes, etc.)?***
- Are there any activities in which your child cannot participate because of a medical condition?
- If your child has a medical condition, what care is routinely required?

Physical Functioning

This item is used to identify any physical limitations and could include chronic physical conditions such as limitations in vision or hearing or difficulties with fine or gross motor functioning.

Ratings	
0	Child has no physical limitations.
1	Child has some physical condition that places mild limitations on activities. Conditions such as impaired hearing or vision would be rated here.
2	Child has physical condition that notably impacts activities. Sensory disorders such as blindness, deafness, or significant motor difficulties would be rated here.
3	Child has severe physical limitations due to multiple physical conditions.

A child may have physical limitations that are not identified as a medical condition. A child may have physical limitations related to poor nutrition. A child may not have a medical condition but appears tired, reports feeling badly or misses school frequently.

Physical Functioning Discussion Points:

- **Does your child have any physical limitations (such as may be caused by asthma, e.g. child cannot go to gym or need an inhaler)?***
- **Are there any activities your child cannot do because of a physical or medical condition?***
- **How much does this interfere with his/her life?***

Sleep

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. Bedwetting and nightmares should be considered a sleep issue. The child must be 12 months of age or older to rate this item.

Ratings	
0	No evidence of problems with sleep.
1	Child has some problems sleeping. Toddlers resist sleep and consistently need a great deal of adult support to sleep. Preschoolers may have either a history of poor sleep or continued problems 1-2 nights per week.
2	Child is having problems with sleep. Toddlers and preschoolers may experience difficulty falling asleep, night waking, night terrors or nightmares on a regular basis
3	Child is experiencing significant sleep problems that result in sleep deprivation. Parents have exhausted numerous strategies for assisting child.

Sleep is one of the primary reasons families seek intervention. Concerns may include initiating, maintaining or excessive sleep (CIMH, 2005). 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 and may occur intermittently. They are often present when a child is attempting to master developmental tasks. In assessing sleep concerns the following areas of questioning will help with the rating of this item:

- 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?

Additional Sleep Discussion Points:

- **How many hours does your child sleep each night on average?***
- **Is this the proper amount for him/her?***
- **How well does your child sleep?***
- **Does s/he have trouble falling asleep or staying asleep?***
- **Does the child have nightmares or bedwetting?***

Relationship Permanence

This rating refers to the stability of significant relationships in the child's life. Significant relationships likely include family members, but may also include other individuals. This item identifies whether parents or other relatives have been a consistent part of the child's life *regardless of the quality* of that relationship.

Ratings	
0	This level indicates a child who has very stable relationships. Family members, friends, and community have been stable for most of his/her life and are likely to remain so in the foreseeable future. Child is involved with both parents.
1	This level indicates a child who has had stable relationships but there is some concern about instability in the near future (one year) due to transitions, illness or age. A stable relationship with only one parent may be rated here.
2	This level indicates a child who has had at least one stable relationship over his/her lifetime but has experienced other instability through factors such as divorce, moving, removal from home, and death.
3	This level indicates a child who does not have any stability in relationships. Adoption must be considered.

Relationship Permanence Discussion Points:

- **Does your child have relationships with adults that have lasted a lifetime?***
- **Is s/he in contact with both parents?***
- **Are there relatives in your child's life with whom s/he has long-lasting relationships?***

CHILD STRENGTHS DOMAIN

Rate
CHILD STRENGTHS
items with the
Child Strength Rating Scale on
page 6.
Hint: No evidence of strength is rated "3".

Family Strengths

This item refers to the presence of a 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 his/her family). If you do not know this information, then we recommend a definition of family that includes biological relatives and their significant others with whom the child is still in contact. If the child is in the child welfare system and parental rights continue, rate the biological family.

Ratings	
0	Significant family strengths. This level indicates a family with much love and respect for one another. Family members are central in each other's lives. Child is fully included in family activities.
1	Moderate level of family strengths. This level indicates a loving family with generally good communication and ability to enjoy each other's company. There may be some problems between family members.
2	Mild level of family strengths. Family is able to communicate and participate in each other's lives; however, family members may not be able to provide significant emotional or concrete support for each other.
3	This level indicates a family with no known family strengths. Child is not included in normal family activities.

The family has the potential for significant impact on a child's life. Of all the factors that may impact a child, the ongoing nature of their family relationships has perhaps the greatest potential to positively or negatively affect a child. The child typically spends a great portion of their day with family and relies on the routine and structure of the family to offer them a framework for all other experiences. 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.

Observable Evidence of Positive Parent and Sibling Relationships

(Cornett, 2011)

Positive Parent/Child Relationships	Positive Sibling Relationships
• Mutual Enjoyment • Initiation of Physical Contact on part of both Child and Parent • Good Eye Contact, Positive Affect Demonstrated  • Appropriate roles and boundaries • Positive Verbalizations; Age Appropriate Communication • Appropriate Amount of Time Spent Together • Ability to Tolerate Frustrations; Balanced Perspective Regarding Child or Parent's Strengths and Limitations • Child Demonstrates Belief that Needs Will Be Met	• Interactions with Siblings Occur on Regular Basis • Positive Statements Made Between Siblings and/or About Siblings • Balance of Negative and Positive Interactions • Negative Interactions Resolved • Child Perceives Siblings as Safe and Caring • Appropriate Boundaries 

The items in the table above can be observed in numerous ways. It is important to attend to your own reactions in observing the relationships, as that often is a good indication of the actual nature of the relationship. If the interaction feels unpleasant and harsh for instance, and the parent or child is describing satisfaction with the relationship, there probably is more to consider. However, take into consideration that what is observed may be different due to parent anxiety about the assessment. A good way to account for this is to attempt to alleviate parent or child anxiety by assessing the positive nature and purpose of assessment and asking parent's if what is being observed seems normal or typical to them.

When determining if the relationship is characterized by **mutual enjoyment** several indications may be present. Do the parent and child both appear to be happy, smiling and continuing the interaction, if the interaction is predominantly parent led does the child show interest by looking, responding and non verbal interchanges? Does the play or interaction result in positive comments or laughter on part of parent? All of these areas are also interpreted within the general atmosphere of the home. Does this home feel comfortable emotionally to its' members? Do the children appear comfortable asking questions, getting needs met and interacting with each other?

When observing **eye contact** it is important to keep in mind developmental considerations. As an infant grows older they move from fleeting eye contact and frequent distractions to a more responsive and coordinated level of eye contact. Very young infants may be over-stimulated by both the verbal and auditory sensory pathways being activated simultaneously and demonstrate active gaze aversion until neurological development furthers. If there are positive reactions to talking and holding when an infant is not showing eye contact such as molding, and excited movement of arms and legs, that is significant to note.

When assessing the **role of the child and appropriate boundaries** it is noteworthy to attend to what tasks the child may be asked to do, the interpretations of the child's actions and attention to the cues given for physical space or emotional needs. Does the parent describe exploitation of the child in such ways as having to high of expectations, doing chores or child caring activities that are beyond developmental expectations/abilities? Does the parent intrude into the child's space not giving them time emotionally to calm down or to be alone at times? Does the parent or child report neglect, physical or sexual abuse?

Family Strengths Discussion Points:

- **How do you care about one another in your family?***
- **Is there usually good communication?***
- **Is this an area that you could use some help to develop?***

Extended Family Relationships

This item rates the close relationships that the child has with extended family members.

Ratings	
0	Infant/child has well established relationships with extended family that serve to support his/her growth and development. Family members are a significant support to parents and involved most of the time with infant/child.
1	Child has extended family relationships that are supportive most of the time. Extended family participates in the life of the child and his/her family much of the time.
2	Infant/child has infrequent contact with extended family members. The support the infant/child receives is not harmful but inconsistent.
3	Infant/child has no contact with extended family members or the contact with extended family is detrimental to the infant/child.

Extended family relationships can be of tremendous value to a child because of the support that this gives their primary caregiver and the child's own valuable experience of a positive relationship with another adult figure.

The level of support given to caregivers by extended family is critical to consider because it 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). The type(s) and benefit of extended family supports can be rated based on the indicators in the following chart.

TYPES OF EXTENDED FAMILY SUPPORT	***INDICATORS OF SUPPORT BEING OF BENEFIT TO CAREGIVER***
Provision of Services	Support is Wanted and/or Requested
Advice or Information	Support Builds Parents' Competence
Emotional Support	Support is in Line with Parents' Values and Decisions
Role Models	Support Complements Parent/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 as evidence of the benefit of these extended family 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.

Extended Family Discussion Points:

- Do members of your child's extended family play an integral part in his/her life?
- What types of activities do your child and extended family members do together?
- How would you describe the importance of these relationships to you and your child?
- Do any extended family members take an active role in child-rearing?

Interpersonal Relationships

This item is rated independently of Social Functioning because a child can have skills but be struggling in their relationships at a particular point in time. This strength indicates long standing relationship making and maintaining skills.

Ratings	
0	Significant interpersonal strengths. Child has a prosocial or "easy" temperament and, if old enough, is interested and effective at initiating relationships with other children or adults. If still an infant, child exhibits anticipatory behavior when fed or held.
1	Moderate level of interpersonal strengths. Child has formed a positive interpersonal relationship with at least one non-caregiver. Child responds positively to social initiations by adults, but may not initiate such interactions by him-or herself.
2	Mild level of interpersonal strengths. Child may be shy or uninterested in forming relationships with others, or –if still an infant-child may have a temperament that makes attachment to others a challenge.
3	This level indicates a child with no known interpersonal strengths. Child does not exhibit any age-appropriate social gestures (e.g. Social smile, cooperative play, responsiveness to social initiations by non-caregivers). An infant that consistently exhibits gaze aversion would be rated here.

The infant or child's capacity to relate to others in a positive manner is a strength that can be of great benefit. Children that are perceived by others as pleasant to associate with usually experience 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. In 2000, the National Research Council and Institute of Child Development argued 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.

"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" (Shonkoff & Phillips. 2000, p. 54).

Not only do youth that are adept 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.

Evidence of Interpersonal Skills in Children
(Cornett, 2011)

Interpersonal Skills in Infants	Interpersonal Skills in Toddlers	Interpersonal Skills in Preschoolers/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

Interpersonal Skill Strength Discussion Points:

- **Do you feel that your child is pleasant and likeable?***
- **Is s/he ever charming?***
- **Do adults or other children like him/her?***
- **Do you feel that your child can act correctly in some social settings?***

Adaptability

This item rates how the child reacts to new situations or experiences, as well as how s/he responds to changes in routines.

Ratings	
0	Child has a strong ability to adjust to changes and transitions.
1	Child has the ability to adjust to changes and transitions, when challenged the infant/child is successful with caregiver support.
2	Child has difficulties much of the time adjusting to changes and transitions even with caregiver support.
3	Child has difficulties most of the time coping with changes and transitions. Adults are minimally able to impact child's difficulties in this area.

Adaptability Discussion Points:

For Infants:

- How would you describe your infant's bedtime routine?
- How does your infant respond to interruptions in his/her day, such as getting a diaper changed or getting into a car seat?
- How does your infant respond when a stranger visits?
- How does your infant respond when s/he goes to a familiar child care setting or has a familiar babysitter take care of him/her?

For Toddlers/Preschoolers:

- Does your child resist changes in his/her routine? If so, how?
- If your child becomes ill or stressed, do you notice changes or setbacks in his/her abilities?
- How does your child react if a routine is suddenly changed?
- How does your child respond when s/he goes to a familiar child care or preschool setting OR when s/he has to leave that setting to come home?

Persistence

This item rates the child's ability to keep trying a new task/skill, even when it is difficult for him/her.

Ratings	
0	Infant/child has a strong ability to continue an activity when challenged or meeting obstacles.
1	Infant/child has some ability to continue an activity that is challenging. Adults can assist a child to continue attempting the task or activity.
2	Child has limited ability to continue an activity that is challenging and adults are only sometimes able to assist the infant/child in this area.
3	Child has difficulties most of the time coping with challenging tasks. Support from adults minimally impacts the child's ability to demonstrate persistence.

Persistence Discussion Points:

For Infants:

- Will your infant keep trying a difficult skill, such as rolling over or walking, or does s/he give up easily?
- Does your infant usually want you nearby when trying a difficult task?
- When does your infant show frustration?
- Does your infant cry when frustrated?

For Toddlers/Preschoolers:

- Will your child keep trying a difficult skill, such as tying shoelaces, or does s/he give up easily?
- Does your child avoid activities that cause him/her frustration?
- Does your child have temper tantrums easily when frustrated?
- Does your child require or ask for much adult help when trying a new task?
- Has learning new skills been a challenge for your child?

Curiosity

This rating describes the child's self-initiated efforts to discover his/her world. This item rates whether the child is interested in his/her surroundings and in learning and experiencing new things.

Ratings	
0	This level indicates a child with exceptional curiosity. Infant displays mouthing and banging of objects within grasp; older children crawl or walk to objects of interest.
1	This level indicates a child with good curiosity. An ambulatory child who does not walk to interesting objects, but who will actively explore them when presented to him/her, would be rated here.
2	This level indicates a child with limited curiosity. Child may be hesitant to seek out new information or environments, or reluctant to explore even presented objects.
3	This level indicates a child with very limited or no observable curiosity.

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.

Developmental Benefits of Curiosity in Children
(Cornett & Podrobinok, 2009)

Motor Development	Cognitive Development	Language Development	Social and Emotional Development
• Initiates Attempts to Move and Explore the Environment Developing both Fine and Gross Motor Skills • Keeps Infant/Youth Motivated to Sustain Activity and Attempts • Curiosity Reduces the Frustration Experienced by Attempting New Tasks	• Triggers Learning by Exploring • Encourages Children to Question • Supports Lateral Thinking • Develops Understanding of Causal Relationships • Allows the Child to Enter Into New Experiences	• Encourages Imitation • Encourages Interaction both Verbally and Non Verbally • Places the Child in the Position to Observe Social Conventions of Language	• 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

Curiosity is considered a strength for young children. It is one of the primary signs of school readiness and central to success in school and later in life (Oser & Cohen, 2003). Curiosity has also

shown to protect against interpersonal aggression due to greater context sensitivity (Kashdan, Afram, Brown, Birnbeck & Drvoshanov, 2010; Kashdan et al. 2012).

Assessment of curiosity occurs through a discussion with the caregiver(s) and child depending on age, as well as, observing behavior. The following list of descriptions of behavior will assist in identifying curiosity as an area of strength.

Evidence of Curiosity in Infants, Toddlers and Preschoolers/School Age Children
Adapted from Cornett (2011)

Infants	Toddlers	Preschoolers & School Age Children
• Turns Head to Listen to Sounds • Follows Activity with Eyes or Stops Movement to Watch Activity • Slows Breathing and Movement When Observing New Person or Occurrence • Explores with Mouth and Hands • Reacts to Novelty or Change • Can be Enticed to Take Action • Spontaneously Imitates Intonation and Words	• Communicates a Questioning Stance Through Gestures Resulting in Parent's Explanations of Actions or Occurrences • Actively Explores New Environments • Frequently Imitates Others Actions • Is Persistent in Learning How Items Work • Asks questions	• Requests Adults to Offer Detailed Explanations and Reasons for Behavior • Searches for Relationships between Concepts • Demonstrates Ability to Categorize • Demonstrates a Tendency to Notice Details or Changes in the Environment

Curiosity Discussion Points:

- How would you describe your child's interest in the worlds around him/her?
- Does your child seem aware of changes in the settings s/he is in?
- Is your child eager to explore?
- Does your child show interest in trying a new task or activity?
-

ACCULTURATION DOMAIN

Acculturation items identify cultural related needs that may require accommodation by providers.

Language

This item looks at whether the child and family need help in communication with you or others in their world. It includes both spoken and sign language**.** In immigrant families, the child(ren) often becomes the translator. While in some instances, this might work well, it may become a burden on the child, or the child, say in a juvenile justice situation might not translate accurately, and so assessing this item depends on the particular circumstances.

Ratings	
0	Child and family speak English well.
1	Child and family speak some English but potential communication problems exist due to limits on vocabulary or understanding of the nuances of the language.
2	Child and/or significant family members do not speak English. Translator or native language speaker is needed for successful intervention but qualified individual can be identified within natural supports.
3	Child and/or significant family members do not speak English. Translator or native language speaker is needed for successful intervention and no such individual is available from among natural supports.

Discussion Points:

- **Does the child or significant family members have any difficulty communicating (either because English is not their first language or the need to use/learn sign language)?***
- How well do you speak English? (5 years old or older)**
  (____Very well, ____Well, ____Not well, ____Not at all)
- Do you speak a language other than English at home? (5 years old or older)**
  (____Yes, ___No)

For persons speaking a language other than English (answering yes to the question above):

- What is this language? (5 years old or older)**
  (____Spanish, ____Other Language (Identify) _____)

** Primary Language Data Standards (US Department of Health and Human Services, 2011)

Identity

This item refers to whether the child is experiencing any difficulties or barriers to their connection to their cultural identity. Cultural Identity may be defined by a number of factors including race, religion, ethnicity, geography or lifestyle**.** Can the child be with others who share a common culture? A newly immigrated Indian child living in a predominantly Caucasian neighborhood and attending a predominantly Caucasian school may be rated a "1" or a "2."

Ratings	
0	Child has clear and consistent cultural identity and is connected to others who share his/her cultural identity.
1	Child is experiencing some confusion or concern regarding cultural identity.
2	Child has significant struggles with his/her own cultural identity. Child may have cultural identity but is not connected with others who share this culture.
3	Child has no cultural identity or is experiencing significant problems due to conflict regarding his/her cultural identity.

Discussion Points:

- **Do your child and family have a sense of belonging to a specific cultural group?***
- **Does your child have role models, friends, and community who share his/her sense of culture?***

Ritual

This item looks to identify whether barriers exist for a youth to engage in rituals relevant to his/her culture. Cultural rituals are activities and traditions that are culturally (or family) specific (e.g. the celebration of holidays such as kwanza, cinco de mayo, etc. Rituals also may include daily activities that are culturally specific (e.g. Muslim youth praying toward Mecca at specific times, Buddhist child have a place to chant, eating a specific diet, access to media).

Ratings	
0	Child and family are consistently able to practice rituals consistent with their cultural identity.
1	Child and family are generally able to practice rituals consistent with their cultural identity; however, they sometimes experience some obstacles to the performance of these rituals.
2	Child and family experience significant barriers and are sometimes prevented from practicing rituals consistent with their cultural identity.
3	Child and family are unable to practice rituals consistent with their cultural identity.

Discussion Point:

- **Are your child and family able to celebrate with others (friends, family, community) who share your traditions and customs?***

Cultural Stress

This item identifies circumstances in which the youth's cultural identify is met with hostility or other problems within his/her environment due to differences in the attitudes, behaviors, or beliefs of others. Racism is a form of cultural stress as are all forms of discrimination.

Ratings	
0	No evidence of stress between caregiver's cultural identify and current living situation.
1	Some mild or occasional stress resulting from friction between the caregiver's cultural identify and his/her current living situation.
2	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	Caregiver is 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.

Discussion Points:

- **Has your child experienced problems with the reaction of others to his/her cultural identity?***
- **Has your child experienced discrimination?***

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 not putting 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'.

Ratings	
0	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	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	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	The family has cultural differences related to child rearing practices and child development that is considered abusive or neglectful and may result in intervention.

CAREGIVER STRENGTHS & NEEDS DOMAIN

In general, we recommend that you rate the unpaid caregiver or caregivers with whom the child is currently living. If the child has been placed, then focus on the permanency plan caregiver to whom the child will be returned. If the child is in a long term foster care or pre-adoptive placement, then rate that caregiver(s).

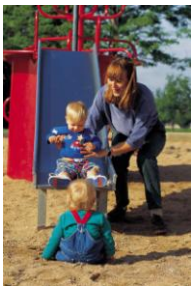
If the child is currently in a congregate care setting, such as a hospital, shelter, group home, or residential treatment center, rate the community caregivers where the child will be placed upon discharge from congregate care. If there is NO community (permanency plan) caregiver, this section would be rated 'Not Applicable' with a note in the case or clinical record that no caregiver is identified.

In situations where there are multiple caregivers, we recommend making the ratings based on the needs of the set of caregivers as they affect the child. For example, the supervision capacity of a father who is uninvolved in monitoring and discipline may not be relevant to the ratings. Alternatively, if the father is responsible for the children because he works the first shift and the mother works the second shift then his skills should be factored into the ratings of Supervision.

Supervision

This item refers to the parent/caregiver's ability to provide monitoring and discipline to the rated child. Discipline is defined in the broadest sense as all of the things that parents/caregivers can do to promote positive behavior with their children. Guidance and loving supervision are among factors which promote optimal child development (CIMH, 2005).

Ratings	
0	Caregiver has good monitoring and discipline skills.
1	Caregiver provides generally adequate supervision. May need occasional help or technical assistance.
2	Caregiver reports difficulties monitoring and/or disciplining child. Caregiver needs assistance to improve supervision skills.
3	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.



Discussion Points:

- **How do you feel about your ability to keep an eye on, set expectations, and discipline your child/children?***
- **Do you think you might need some help with these issues?***

Involvement in Treatment and Services

This rating should be based on the level of involvement and follow-through the caregiver(s) has in the planning and provision of treatment, health, preschool/day care, child welfare, and related services. A '0' on this item is reserved for caregivers who are able to advocate for their child. This requires both knowledge of their child, their rights, options, and opportunities. A '1' is used to indicate caregivers who are willing participants with service provision, but may not yet be able to serve as advocates for their child. When caregivers are not willing to participate in treatment, rate Involvement '2'. If a caregiver has given up, perhaps requesting out-of-home placement for their child, rate Involvement '3'.

Ratings	
0	Caregiver is able to act as an effective advocate for child.
1	Caregiver has history of seeking help for their children. Caregiver is open to receiving support, education, and information.
2	Caregiver does not wish to participate in services and/or interventions intended to assist their child.
3	Caregiver wishes for child to be removed from their care.

Discussion Points:

- **How do you feel about being involved in services for your child?***
- **Do you feel comfortable being an advocate?***
- **Would you like any help to become more involved?***

Knowledge

This rating should be based on caregiver's knowledge of the specific strengths of the child and any needs experienced by the child and their ability to understand the rationale for the treatment or management of these problems.

Ratings	
0	Caregiver is knowledgeable about the child's needs and strengths.
1	Caregiver is generally knowledgeable about the child but may require additional information to improve their capacity of parent.
2	Caregiver has clear need for information to improve how knowledgeable they are about the child. Current lack of information is interfering with their ability to parent.
3	Caregiver has knowledge problems that place the child at risk of significant negative outcomes.

The Knowledge item is perhaps the one most sensitive to issues of cultural competence. 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, we recommend thinking of this item in terms of whether there is information that if you made available to the caregivers they could be more effective in working with their child.

Discussion Points:

- **Do you feel comfortable with what you know about your child's needs?***
- **Have professionals told you things about your child that you didn't know what they were trying to say?***
- **Are there areas that you feel you would like to know more?***

Empathy for Child

This item refers to the parent/caregiver's ability to understand and respond to the joys, sorrows, anxieties and other feelings of children with helpful, supportive emotional responses.

Ratings	
0	Caregiver is strong in his/her capacity to understand how the child is feeling and consistently demonstrates this in interactions with the child.
1	Caregiver has the ability to understand how the child is feeling in most situations and is able to demonstrate support for the child in this area most of the time.
2	Caregiver is only able to be empathetic toward the child in some situations and at times the lack of empathy interferes with the child's growth and development.
3	Caregiver shows no empathy for the child in most situations especially when the child is distressed. Caregiver's lack of empathy is impeding the child's development.

Organization

This rating should be based on the ability of the parent/caregiver to participate in or direct the organization of the household, services, and related activities. Parents who need help organizing themselves and/or their family would be rated a '2' or '3'.

Ratings	
0	Caregiver is well organized and efficient.
1	Caregiver has minimal 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	Caregiver has moderate difficulty organizing and maintaining household to support needed services.
3	Caregiver is unable to organize household to support needed services.

Organization Discussion Points:

- **Do you think you need or want help with managing your home?***
- **Do you have difficulty getting to appointments or managing a schedule?***

Social Resources

This item refers to the financial and social assets (e.g. extended family) and resources that the caregiver(s) can bring to bear in addressing the multiple needs of the child and family. If a family has money, it can buy help. In the absence of money, families often rely on social supports to help out in times of need. This item is used to rate the availability of these supports. This item is the caregiver equivalent to the Natural Supports items for children and youth.

Ratings	
0	Caregiver has significant family and friend social network that actively helps with raising the child (e.g., child rearing).
1	Caregiver has some family or friend social network that actively helps with raising the child (e.g. child rearing).
2	Caregiver has some family or friend social network that may be able to help with raising the child (e.g., child rearing).
3	Caregiver is unable to organize household to support needed services.

Discussion Points:

- **Do you have enough of what you need to take care of your family's needs?***
- **Do you have family members or friends who can help you when you need it?***

Residential Stability

This item rates the parent/caregiver's current and likely future housing circumstances. Stable housing is the foundation of intensive community-based services. A '3' indicates problems of recent homelessness. A '1' indicates concerns about instability in the immediate future. A family having difficulty paying utilities, rent or a mortgage might be rated as a '1'. This item refers *exclusively* to the housing stability of the caregiver and should **not** reflect whether the child might be placed outside of the home.

Ratings	
0	Caregiver has stable housing for the foreseeable future.
1	Caregiver has relatively stable housing but either has moved in the past three months or there are indications of housing problems that might force them to move in the next three months.
2	Caregiver has moved multiple times in the past year. Housing is unstable.
3	Caregiver has experienced periods of homelessness in the past six months.

Discussion Points:

- **Is your current housing situation stable?***
- **Do you have any concerns that you might have to move in the near future?***
- **Have you lost your housing?***

Physical

Physical health includes medical and physical challenges faced by the parent/caregiver(s). For example a single parent who has recently had a stroke and has mobility or communication limitations might be rated a '2' or even a '3'. If the parent has recently recovered from a serious illness or injury or if there are some concerns of problems in the immediate future they might be rated a '1'.

Ratings	
0	Caregiver is generally healthy.
1	Caregiver is in recovery from medical/physical problems.
2	Caregiver has medical/physical problems that interfere with their capacity to parent.
3	Caregiver has medical/physical problems that make it impossible for them to parent at this time.

Discussion Points:

- **How is your health?***
- **Do you have any health problems that make it hard for you to take care of your family?***
- **Does anyone else in the family have serious physical needs?***
- **Do you help care for them?***

Mental Health

This item refers to the parent/caregiver's mental health status. Serious mental illness would be rated as a '2' or '3' unless the individual is in recovery or successfully managing illness. However, a caregiver who is in recovery from mental health difficulties might be rated a '1'. This item should be rated independently from substance use.

Ratings	
0	Caregiver has no mental health needs.
1	Caregiver is in recovery from mental health difficulties.
2	Caregiver has some mental health difficulties that interfere with their capacity to parent.
3	Caregiver has mental health use difficulties that make it impossible for them to parent at this time.

Discussion Points:

- **Do you have any mental health needs that make parenting more difficult?***
- **Does anyone else in the family have serious mental health needs?***
- **Do you help care for them?***

Substance Use

This item rates the caregiver's pattern of alcohol and/or drug use. Substance-related disorders would be rated as a '2' or '3' unless the individual is in recovery. If substance use interferes with parenting a rating of '2' is indicated. If it prevents care giving, a '3' would be used. A '1' indicates a caregiver currently in recovery or a situation where problems of substance use are suspected but not confirmed.

Ratings	
0	Caregiver has no substance use needs.
1	Caregiver is in recovery from substance use difficulties.
2	Caregiver has some substance use difficulties that interfere with their capacity to parent.
3	Caregiver has substance use difficulties that make it impossible for them to parent at this time.

Substance Use Discussion Points:

- **Do you have any substance use needs that make parenting more difficult?***
- **Does anyone else in the family have serious substance use needs?***
- **Do you help care for them?***

Developmental

This item describes the parent/caregiver's developmental status in terms of low IQ, intellectual disability or other developmental disabilities and the impact of these conditions on his/her ability to care for the child. A parent with limited cognitive capacity that challenges their ability to provide parenting would be rated here. Like the Developmental item for children and youth, rating on this item should be restricted to the identification of developmental disabilities (i.e. intellectual disabilities and other related conditions) and does not refer to a broad spectrum of developmental issues (e.g. aging is **not** rated here).

Ratings	
0	Caregiver has no developmental needs.
1	Caregiver has developmental challenges but they do not currently interfere with parenting.
2	Caregiver has developmental challenges that interfere with their capacity to parent.
3	Caregiver has severe developmental challenges that make it impossible for them to parent at this time.

Discussion Point:

- **Has anyone ever told you that you may have developmental problems that makes parenting/caring for your child more difficult?***

Access to Child Care

This item refers to the caregiver's access to appropriate child care for young children.

Ratings	
0	Caregiver has access to sufficient child care services.
1	Caregiver has limited access to child care services. Needs are met minimally by existing, available services.
2	Caregiver has limited access or access to limited child care services. Current services do not meet the caregiver's needs.
3	Caregiver has no access to child care services.

Discussion Points:

- **Do you have access to daycare or child care services you need to parent your child or children?***
- **What services do you need that you feel you currently cannot obtain?***

Military Transitions

This item identifies the impact of military transitions on family's care giving role.

Ratings	
0	Caregiver not experiencing any transitions related to military service. Caregivers not involved in military services would be rated here.
1	Caregiver anticipating a transition related to military service in the near future or a caregiver experienced a transition in the past which was challenging.
2	Caregiver experiencing a transition related to military service.
3	Caregiver experiencing a transition related to military service that has a major impact on their care giving roles.

Family Stress

This item rates the impact of the managing the child's needs on the caregiver(s). A very high need child or one that engages in specific behavior that is very disruptive to a family can create a substantial amount of Family Stress. Historically, this item was referred to as a burden in that raising a child with many needs can weigh on a family.

Ratings	
0	Caregiver able to manage the stress of child/children's needs.
1	Caregiver has some problems managing the stress of child/children's needs.
2	Caregiver has notable problems managing the stress of child/children's needs. This stress interferes with their capacity to give care.
3	Caregiver is unable to manage the stress associated with child/children's needs. This stress prevents caregiver from parenting.

Discussion Points:

- **Do you find it stress at times to manage the challenges you experience when it comes to dealing with your child's needs?***
- **Do you find it hard to manage at times?***
- **Does your stress ever interfere with your ability to care for your child?***
- **If so, does it ever reach the level that you feel like you can't manage it?***

Safety

This rating refers to the safety of the assessed child. It does not refer to the safety of other family or household members based on any danger presented by the assessed child. If a child is involved with child welfare, the minimal rating would be a '1', perhaps if the child was being transitioned back home. A '2' or '3' on this item requires child protective services involvement.

Ratings	
0	Household is safe and secure. Child is at no risk from others. This level indicates that the present placement environment is as safe or safer for the child (in his or her present condition) as could be reasonably expected.
1	Household is safe but concerns exist about the safety of the child due to history or others in the neighborhood who might be abusive. This level indicates that the present placement environment presents some mild risk of neglect, exposure to undesirable environments (e.g. drug use or gangs in the neighborhood, etc.) but that no immediate risk is present.
2	Child is in some danger from one or more individuals with access to the household. This level indicates that the present placement environment presents a moderate level of risk to the child, including such things as the risk of neglect or abuse or exposure to individual who could harm the child.
3	Child is in immediate danger from one or more individuals with unsupervised access. This level indicates that the present placement environment presents a significant risk to the well being of the child. Risk or neglect or abuse is imminent and immediate. An individual in the environment offers the potential of significantly harming the child.

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

Discussion Points:

- **Has the state ever been involved with your family?***
- **What happened that they became involved?***
- **Are they currently involved?***
- **If so, what lead to their involvement?***
- **Is there any current concern about the child's safety from a child protection perspective?***

Marital/Partner Violence in the Home

This rating describes the degree of difficulty or conflict in the parent/caregiver's relationship and the impact on parenting and childcare. The violence could be verbal and/or physical and stem from power and control issues.

Ratings	
0	Parent/caregiver(s) appear to be functioning adequately. There is no evidence of notable conflict in the parenting relationship. Disagreements are handled in an atmosphere of mutual respect and equal power.
1	Mild to moderate level of family problems including marital difficulties and partner arguments. Parent/caregivers are generally able to keep arguments to a minimum when child is present. Occasional difficulties in conflict resolution or use of power and control by one partner over another.
2	Significant level of caregiver difficulties including frequent arguments that often escalate to verbal aggression, the use of verbal aggression by one partner to control the other or significant destruction of property. Child often witnesses these arguments between caregivers, the use of verbal aggression by one partner to control the other or significant destruction of property.
3	Profound level of caregiver or marital violence that often escalates to the use of physical aggression by one partner to control the other. These episodes may exacerbate child's difficulties or put the child at greater risk.

Marital/Partner Violence Discussion Points:

- **Are there problems between adults in the home?**
- **Has there ever been any violence?**

Abuse or Neglect

This item refers to physical, emotional, or sexual abuse occurring, or at risk of occurring in the child's living situation, AND/OR the failure to provide adequate supervision and expectations and access to the basic necessities of life, including food, shelter, and clothing.

Ratings	
0	No evidence of emotional, physical, sexual abuse or neglect.
1	Mild level of emotional abuse or occasional spanking without physical harm, or intention to commit harm. No sexual abuse. OR Mild level of neglect of caretaker responsibilities, such as failure to provide adequate expectations or supervision to child.
2	Moderate level of emotional abuse and/or frequent spanking or other forms of physical punishment. OR Moderate level of neglect, including some supervision and occasional unintentional failure to provide adequate food, shelter, or clothing, with rapid corrective action.
3	Severe level of emotional or physical abuse with intent to do harm and/or actual physical harm, or any form of sexual abuse. This would include regular beatings with physical harm and frequent and ongoing emotional assaults. OR Severe level of neglect, including prolonged absences by adults, without minimal supervision, and failure to provide basic necessities of life on a regular basis.

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

Family/Caregiver Module

When **Caregiver Safety or Abuse/Neglect** is rated '1' or higher, the Family Extension Module identifies the daily life functional needs of families who have care giving responsibilities or to whom a child will be returning.

Self Care/Daily Living Skills

This rating describes the caregiver's ability to provide for the basic needs (e.g., shelter, food, safety, and clothing) of their youth.

Ratings	
0	The caregiver has the daily living skills needed to care for their youth.
1	The caregiver needs verbal prompting to complete the daily living skills required to care for their youth.
2	The caregiver needs assistance (physical prompting) to complete the daily living skills required to care for their youth.
3	The caregiver is unable to complete the daily living skills required to care for their youth. Caregiver needs immediate intervention.

Cultural Stress

Culture stress refers to experiences and feelings of discomfort and/or distress arising from friction (real or perceived) between an individual's own cultural identity and the predominant culture in which he/she lives.

Ratings	
0	There is no evidence of stress between caregiver's cultural identify and current living situation.
1	Some mild or occasional stress resulting from friction between the caregiver's cultural identify and his/her current living situation.
2	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	Caregiver is 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.

Employment/Educational Functioning

This item rates the performance of the caregiver in school or work settings. This performance can include issues of behavior, attendance or achievement/productivity.

Ratings	
0	Caregiver is gainfully employed and/or in school.
1	A mild degree of problems with school or work functioning. Caregiver may have some problems in work environment. Caregiver needs to be monitored and assessed further.
2	A moderate degree of school or work problems and/or difficulties with learning. Caregiver may have history of frequent job loss or may be recently unemployed. Caregiver needs an intervention to address employment and/or learning difficulties.
3	A severe degree of school or work problems. Caregiver is chronically unemployed and not attending any education program. Caregiver needs immediate intervention.

Educational Attainment

This rates the degree to which the individual has completed his/her planned education.

Ratings	
0	Caregiver has achieved all educational goals or has none but educational attainment has no impact on lifetime vocational functioning.
1	Caregiver has set educational goals and is currently making progress towards achieving them.
2	Caregiver has set educational goals but is currently not making progress towards achieving them.
3	Caregiver has no educational goals and lack of educational attainment is interfering with individual's lifetime vocational functioning. Caregiver needs educational/vocational intervention.

Legal

This item rates the family's involvement in the criminal justice system.

Ratings	
0	Caregiver has no known legal difficulties.
1	Caregiver has a history of legal problems but currently is not involved with the legal system.
2	Caregiver has some legal problems and is currently involved in the legal system.
3	Caregiver has serious current or pending legal difficulties that place him/her at risk for incarceration. Caregiver needs an immediate comprehensive and community-based intervention.

Motivation for Care

This rating captures the desire of the caregiver to support their youth in care. The person need not have an understanding of their illness; however they participate in recommended or prescribed care (e.g., taking prescribed medications and cooperating with care providers).

Ratings	
0	The caregiver is engaged in his/her youth's care and supports his/her youth in participating in care.
1	The caregiver is willing for his/her youth to participate in care; however the caregiver may need prompts at times. Caregiver needs to be monitored and assessed further.
2	The caregiver is often unwilling to support his/her youth's care and is often uncooperative with service providers. Caregiver/youth needs to be engaged in care.
3	The caregiver refuses to allow his/her youth to participate in care including taking prescribed medications or cooperating with recommended care. Service coordinator needs to meet with referral source and team to revisit goals.

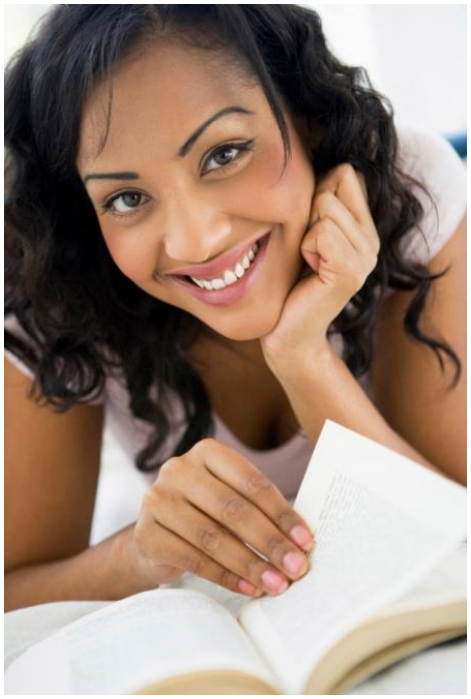
Financial Resources

Ratings	
0	Caregiver has sufficient financial resources to raise the youth (e.g., youth rearing).
1	Caregiver has some financial resources that actively help with raising the youth (e.g. youth rearing).
2	Caregiver has limited financial resources that may be able to help with raising the youth (e.g., youth rearing).
3	Caregiver has no financial resources to help with raising the youth (e.g. youth rearing). Caregiver needs financial resources

Transportation

This rating reflects the caregiver's ability to provide appropriate transportation for his/her child.

Ratings	
0	Youth and his/her caregiver have no transportation needs. Caregiver is able to get his/her youth to appointments, school, activities, etc. consistently.
1	Youth and his/her caregiver have occasional transportation needs (e.g. appointments). Caregiver has difficulty getting his/her youth to appointments, school, activities, etc. no more than weekly.
2	Youth and his/her caregiver have frequent transportation needs. Caregiver has difficulty getting his/her youth to appointments, school, activities, etc. regularly (e.g., once a week). Caregiver needs assistance transporting youth and access to transportation resources.
3	Youth and his/her caregiver have no access to appropriate transportation and is unable to get his/her youth to appointments, school, activities, etc. Caregiver needs immediate intervention and development of transportation resources.



CHILD BEHAVIORAL/EMOTIONAL NEEDS DOMAIN

Attachment

This item rates the relationship between the parent/primary caregiver and the child.

Ratings	
0	No evidence of problems with attachment.
1	Mild problems with attachment are present. Infants appear uncomfortable with caregivers, may resist touch, or appear anxious and clingy some of the time. Caregivers feel disconnected from infant. Older children may be overly reactive to separation or seem preoccupied with parent. Boundaries may seem inappropriate with others.
2	Moderate problems with attachment are present. Infants may fail to demonstrate stranger anxiety or have extreme reactions to separation resulting in interference with development. Older children may have ongoing problems with separation, may consistently avoid caregivers and have inappropriate boundaries with others putting them at risk.
3	Severe problems with attachment are present. Infant is unable to use caregivers to meet needs for safety and security. Older children present with either indiscriminate attachment patterns or withdrawn, inhibited attachment patterns. A child that meets the criteria for Reactive Attachment Disorder would be rated here.

Attachment refers to the special relationship between a child and their caregiver that is established within the first year of life. As the infant experiences getting their needs met throughout the first months of life they begin to associate gratification and security within the care-giving relationship. This ultimately leads to feelings of affection and by 8 months of age an infant will typically exhibit preference for the primary caregiver. An infant that does not experience their needs being met or responded to in a consistent and predictable pattern will typically develop an insecure pattern of attachment.

The benefits of a secure attachment have been researched significantly and are far reaching. Secure attachment between a child and their caregiver promotes positive development in self-esteem, independence and autonomy, impulse control, conscience development, long-term friendships, prosocial coping skills, relationships with caregivers and adults, trust, intimacy and affection, empathy, compassion, behavioral and academic performance and the ability to form secure attachments with their own children when they become adults (Levy, 1998).

Evidence of Attachment Disturbance in Young Children
Adapted from Cornett (2011)

- Lack of preference for primary caregiver
- Indiscriminate affection with unfamiliar adults
- Lack of expectation for getting needs met
- Lack of comfort seeking when hurt or upset
- Comfort seeking in an odd manner
- Excessive clinginess
- Poor ability to tolerate separation
- Strange or mixed reactions to reunion with caregiver
- Low level of compliance with caregivers
- Controlling behavior
- Lack of exploratory behavior
- Low level of affection or physical contact within dyad

Attachment Discussion Points:

Infants*:*

- Are you able to comfort and soothe your infant when he/she is upset?
- Is it difficult to understand what your infant wants from you?
- Do you feel that you and your baby have a special relationship?
- How does your baby react to strangers and separation from you?

Toddlers:

- Do you feel that you and your child have a special relationship?
- How does your child react to you after a separation?
- Do you feel your child is too clingy?
- Does your toddler seek help from you when he/she is hurt or needs something?
- Does your toddler choose to be with you when other adults are around?

Preschoolers:

- How would you describe your relationship with your child?
- How does your child deal with separations from you?
- Do you feel special to your child?
- What does your child do to get your attention?
- Does your child seek help from you when he/she is hurt or needs something?

Regulatory: Body Control/Emotional Control

This item refers to the child's ability to control bodily functions such as eating, sleeping and elimination as well as activity level/intensity and sensitivity to external stimulation. The child's ability to control and modulate intense emotions is also rated here.

Ratings	
0	No evidence of regulatory problems.
1	Some problems with regulation are present. Infants may have unpredictable patterns and be difficult to console. Older children may require a great deal of structure and need more support than other children in coping with frustration and difficult emotions.
2	Moderate problems with regulation are present. Infants may demonstrate significant difficulties with transitions, and irritability such that consistent adult intervention is necessary and disruptive to the family. Older children may demonstrate severe reactions to sensory stimuli and emotions that interfere with their functioning and ability to progress developmentally. Older children may demonstrate such unpredictable patterns in their eating and sleeping routines that the family is disrupted and distressed.
3	Profound problems with regulation are present that place the child's safety, well being and/or development at risk.

Disorders of regulation are present when an infant or child displays difficulties with sleep disturbance, hypersensitivities to sensory stimulation, poor self-calming, irritability, mood deregulation and state deregulation. Sleep disturbance is determined when there is a persistent problem in the regulation of sleep-wake cycles despite parental efforts to manage the sleep routine. This would be considered when it takes over 20 minutes to fall asleep despite calming activities and bedtime routines. Frequent waking of more than two times in the night that are not related to night feedings would also qualify a sleep disturbance.

Difficulty in self-calming includes the inability to self-calm by such techniques as sucking on hands or listening to familiar voices. When a caregiver spends two to four hours a day consoling infants, self-calming is not developing as one would expect. Feeding difficulties are present when an infant does not have a regular schedule, demonstrates distress around feeding, and refuses to eat a variety of textures.

Distress with changes in routine would include the infant becoming overwhelmed by transitions, and when crying regarding such changes persists for periods of over five minutes for at least three times per day. Evidence of distress that occurs in response to sensory stimulation include resisting cuddling, distress at hair or face washed, hates car seat, resists certain positions, avoids certain textures, fear of movement and being startled by loud sounds (DeGangi, 1991).

Other children may be under-reactive, withdrawn and difficult to engage, self-absorbed (CIMH, 2005).

Regulatory Discussion Points:

Infants*:*

- How would you describe your infant's daily routine?
- How would you describe your infant's sleep routine?
- Do you have any concerns about your infant's eating patterns? If so, describe.
- How does your infant respond to frustration and what does it take to console her?

Toddlers:

- How would you describe your toddler's routine?
- Are there areas of concern you can describe regarding your toddler's eating and sleeping?
- How would you describe your toddler's ability to regulate their level of frustration and overall expression of emotion?

Preschoolers:

- How would you describe your child's routine?
- How does your child control his activity level?
- Does your child surprise you with the level of intensity and responses to emotions?
- How does your child respond to excessive stimulation such as noise, light, touch, crowds?
- Do others have concerns about your child's ability to control their emotions or behavior?

When Regulatory (Body Control/Emotional Control) is rated 1, 2, or 3, complete the following Regulatory Extension Module.

Regulatory Functioning Extension Module
(Eating, Elimination, Sensory & Emotional Control)

Eating
This category refers to all items of eating.

Ratings	
1	Mild problems with eating that have been present in the past or are currently present some of the time causing mild impairment in functioning.
2	Infant/child has moderate problems with eating are present and impair the child's functioning. Infants may be finicky eaters, spit food or overeats. Infants may have problems with oral motor control. Older children may overeat, have few food preferences and not have a clear pattern of when they eat.
3	Infant/child has severe problems with eating are present putting the infant/child at risk developmentally. The child and family are very distressed and unable to overcome problems in this area.
1	Mild problems with eating that have been present in the past or are currently present some of the time causing mild impairment in functioning.

Elimination
This category refers to all items of elimination**.**

Ratings	
0	There is no evidence of elimination problems.
1	Infant/child may have a history of elimination difficulties but is presently not experiencing this other than on rare occasion.
2	Infant/child demonstrates problems with elimination on a consistent basis. This is interfering with child's functioning. Infants may completely lack a routine in elimination and develop constipation as a result. Older children may experience the same issues as infants along with encopresis and enuresis.
3	Infant/child demonstrates significant difficulty with elimination to the extent that child/parent are in significant distress or interventions have failed.

Sensory Reactivity
This rating describes the child's ability to use all senses including vision, hearing, smell, touch, taste, and kinesthetics.

Ratings	
0	There is no evidence of sensory reactivity that is hyper or hypo reactive.
1	Infant/child may have a history of sensory issues or have mild issues currently that are controlled by caregiver support.
2	Infant/child demonstrates hyper/hypo reactivity to sensory input in one or more sensory modality such that impairment in functioning is present.
3	Infant/child demonstrates significant reactivity to sensory input such that caregiver cannot mediate the effects of such.

Emotional Control

This rating describes the child's general mood state and ability to be soothed.

Ratings	
0	Infant/child has no problems with emotional control.
1	Infant/child has mild problems with emotional control that can be overcome with caregiver support.
2	Infant/child has a moderate level of problems with emotional control that interferes most of the time with functioning. Infants may be difficult to console most of the time and do not respond well to caregiver support. Older children may quickly become frustrated and hit or bite others.
3	Infant/child has a significant level of emotional control problems that are interfering with development. Caregivers are not able to mediate the effects of this.

Failure to Thrive

This item rates the presence of problems with weight gain or growth. Symptoms of failure to thrive focus on normal physical development such as growth and weight gain.

Ratings	
0	No evidence
1	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.
2	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, have a rate of weight gain that causes a decrease in two or more major percentile lines over time, (75th to 25th)
3	The infant/child has one or more of all of the above and is currently at serious medical risk.

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, 2000). 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

Adapted from Trout (1987)

- 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

Depression

This item refers to any symptoms of depression which may include sadness, irritable mood most of the day nearly every day, changes in eating and sleeping, and diminished interest in playing or activities that were once of interest. A rating of '2' could be a two year old who is often irritable, does not enjoy playing with toys as s/he used to, is clingy to his/her caregiver, and is having sleep issues.

Ratings	
0	No evidence of problems with depression.
1	History or suspicion of depression or mild to moderate depression associated with a recent negative life event with minimal impact on life domain functioning. There are some indicators that the child may be depressed or has experienced situations that may lead to depression. Infants may appear to be withdrawn and slow to engage at times during the day. Older children are irritable or do not demonstrate a range of affect.
2	Moderate problems with depression are present. Infants demonstrate a change from previous behavior and appear to have a flat affect with little responsiveness to interaction most of the time. Older children may have negative verbalizations, dark themes in play and demonstrate little enjoyment in play and interactions. The child meets criteria for a DSM diagnosis.
3	Clear evidence of disabling level of depression, including significant irritability, which 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.

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 (Freud & Burlingham, 1944).

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 (Luby, Stalets & Belden, 2007).

The assessment of depression in young children should meet the criteria outlined in the *Diagnostic Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood: Revised Edition (DC: 0-3R, Zero to Three, 2005).* Both the *DC 0-3R* and the *DSM* consider the symptoms of depression to include depressed/irritable mood, diminished interest or pleasure, weight loss/gain, insomnia/hypersomnia, psychomotor agitation/retardation, fatigue or energy loss, feelings of worthlessness, diminished ability to think/concentrate, or recurrent thoughts of death or suicidal ideation. Clinical observations and manifestations of these symptoms are listed in the chart below. In addition the *DC 0-3 R* states that all of the following general characteristics must be present to diagnosis a child with Major Depression:

- The disturbed affect and pattern of behavior should represent a change from the child's usual mood and behavior.
- The depressed mood or anhedonia (lack of pleasure) must be persistent and, at least some of the time, uncoupled from sad or upsetting experiences. Persistent is defined as present most of the day, more days than not, over a period of at least 2 weeks.
- Symptoms should be pervasive, occurring in more than one activity or setting and in more than one relationship.
- Symptoms should be causing the child clear distress, impairing functioning or impeding development.
- Disturbances are not due to a general medical condition or the direct effect of a medication or substance.

Evidence of Depressive Symptoms in Young Children:

- Depressed or Irritable mood may be displayed by little variation in emotional expression, few smiles, infrequent laughter, and child cries easily and frequently. The infant or toddler may display poor coping skills and difficulty recovering from frustration.
- Diminished pleasure or interest in activities may be displayed by little interest in play and poor response to adult's encouragement to play. The child may appear unhappy or withdrawn during play.
- When assessing the presence of appetite or sleep disturbance there should be a change from a previously established pattern that is now the consistent experience for the child. Due to the dynamic nature of the child's development this may be difficult to assess so weight changes or fatigue may help guide the rating to this.
- Diminished ability to think or concentrate may be illustrated in giving up easily on completing tasks in play, poor ability to sustain attention despite strong motive to do so, and poor persistence in general.

Depression Discussion Points:

- **Do think your child is depressed or irritable?***
- **Has he/she withdrawn from normal activities?***
- **Does your child seem lonely or not interested in others?***

Infants

- How would you describe your infant's mood throughout the day?
- Have there been changes in this?
- Does your infant appear happy at times?
- Is it difficult to get your infant to respond to you or others?
- Have there been situations that have been stressful for your infant?
- Does your infant's development seem to be on track to you?
- Has there been a change in your infant's skills or abilities?

Toddlers

- How is your toddler's mood throughout the day?
- Does your toddler recover from upsetting situations or seem hard to console?
- Is your toddler easy to interact with?
- Does it take a lot to get your toddler to respond to you or others?
- Does your toddler seem to enjoy playtime?
- Has there been a change in your toddler's skills or abilities?

Preschoolers

- 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?
- Has anything helped?

Anxiety

This item describes the child's level of fearfulness, worrying or other characteristics of anxiety.

Ratings	
0	No evidence
1	History or suspicion of anxiety problems or mild to moderate anxiety associated with a recent negative life event. 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.
2	Clear evidence of anxiety associated with either anxious mood or significant fearfulness. Anxiety has interfered significantly in child's ability to function in at least one life domain. 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.
3	Clear evidence of debilitating level of anxiety that makes it virtually impossible for the child to function in any life domain.

A child that is preoccupied with worries or fears may experience significant challenges in their ability to relate to others, accept support and nurturing from others and focus on growth and development. Beyond this, a caregiver that is attempting to assist a child that is anxious is also challenged in their task of being responsive and supportive to their child. This experience may interfere with the attachment relationship making the parent feel inadequate in meeting their child's needs. In the worst case scenario, a parent may reject or withdraw from their child to protect themselves from the negative feelings of perceived rejection.

Anxiety in adults is often described as debilitating and "the worst possible feeling". It is no different in infants and young children and can stalemate development and result in regression. The challenge in assessing anxiety in young children first becomes the determination of the presence of clinically significant anxiety versus temperament characteristics or otherwise normative anxiety. Important considerations in this determination become how persistent is the problem, and to what degree does it interfere with functioning.

The Diagnostic Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood: Revised Edition (DC: 0-3R, Zero to Three, 2005) states that all of the following criteria must be present to consider an anxiety disorder substantiated:

- The anxiety or fear causes the child distress or leads the child to avoid activities or settings associated with the anxiety or fear
- Occurs during two or more everyday activities or within two or more relationships (pervasive)
- Is uncontrollable at least some of the time
- Impairs the child's functioning related to expected development
- The anxiety or fear is persistent

Evidence of Anxiety in Young Children

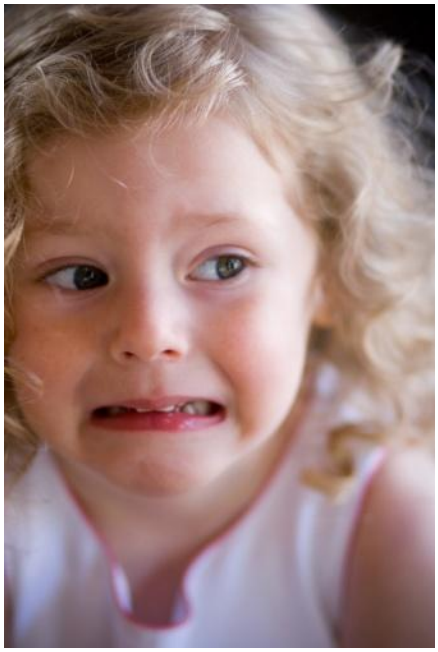
- Excessive distress when separated from caregiver may be seen as excessive crying, inability to be consoled, inability to be distracted, self injurious behavior and statements of worry or fear
- Persistent and excessive worry regarding separation from caregiver may be seen in scanning the environment, clingy behavior, statements regarding possibility of something bad happening, lack of exploratory behavior
- Frequent startle reactions, hypervigilance
- Nightmares, poor ability to go to sleep and stay asleep
- Somatic (physical) complaints

Anxiety Discussion Points:

- **Does your child have any problems with fear or anxiety?***
- **Is s/he avoiding normal activities out of fear?***
- **Does your child act frightened or afraid?***
- **Does your child worry a lot?***

Infants

- Does your infant show fear or worry in situations that you wouldn't expect?
- How easily can you comfort your infant when he/she is upset?
- Are there situations you try to avoid because of how your infant reacts?
- How can you tell that your infant is worried or upset?



Toddlers

- Does your child ever appear nervous or worried?
- Does this keep your child from interacting with others or following normal routines?
- What things have you tried to help your child cope with fears or worries?

Preschoolers

- What words or actions tell you that your child is upset or worried?
- Are there certain times that your child seems worried?
- Has this affected your child's activities or routines?
- What things have you tried to help your child cope with fears or worries?

Atypical Behaviors

This item rates whether the child repeats certain actions over and over again, or demonstrates behaviors that are unusual or difficult to understand.

Ratings	
0	No evidence of atypical behaviors.
1	History or reports of atypical behaviors from others that have not been observed by caregivers.
2	Clear evidence of atypical behaviors reported by caregivers that are observed on an ongoing basis.
3	Clear evidence of atypical behaviors that are consistently present and interfere with the infant's/child's functioning on a regular basis.

Behaviors may include mouthing after 1 year, head banging, smelling objects, spinning, twirling, hand flapping, finger-flicking, rocking, toe walking, staring at lights, or repetitive and bizarre verbalizations. This is important in early childhood to assess due to the possible indication that this may be related to pervasive developmental disorders. Early intervention to assess the etiology of these symptoms is critical. This is important in early childhood to assess due to the possible indication that this may be related to pervasive developmental disorders. Early intervention to assess the etiology of these symptoms is critical.

Atypical Behavior Discussion Points:

Infants

- Do you notice any behaviors that are of concern in your infant?
- Do these behaviors become worse when your infant is tired or hungry?

Toddlers

- Have you or anyone else noticed any behaviors that are of concern in your toddler?
- If behaviors like these are present, have they changed in any way over time?
- Do these behaviors increase or get worse at certain times?

Preschoolers

- Have you or anyone else noticed any behaviors that are of concern in your child?
- If behaviors like these are present, can you tell me when they began and if things have changed in any way over time?
- Have you found anything that has helped with these behaviors?

Impulsivity/Hyperactivity

This item refers to the child's level of difficulty controlling activity level or actions. The child should be 3 years of age or older to rate this item.

Ratings	
0	No evidence
1	Some problems with impulsive, distractible or hyperactive behavior that places the Child at risk of future functioning difficulties.
2	Clear evidence of problems with impulsive, distractible, or hyperactive behavior that interferers with the child's ability to function in at least one life domain. The child may run and climb excessively even with adult redirection. The child may not be able to sit still even to eat and is often into things. The child may blurt out answers to questions without thinking, have difficulty waiting turn and intrude on others space.
3	Clear evidence of a dangerous level of impulsive behavior that can place the Child at risk of physical harm.
NA	Child is younger than 3 years of age.

This item refers to both a child's ability to control impulses as well as his/her activity level. Both of these areas need to be considered as problematic, rated a '2', only when it impairs functioning, is observed in more than one setting and is outside the realm of what is considered normal for the child's age and development. Both of these behaviors may result in disruptions in relationships and interference with the development of new skills if problematic. A '3' on this item is reserved for those whose impulsive behavior has placed them in physical danger during the period of the rating.

Attention Deficit Hyperactivity Disorder(ADHD) is considered appropriate as a diagnosis according to *DSM-5* (APA, 2013, pp. 60) if "6 or more of the following symptoms of hyperactivity and impulsivity have persisted for at least 6 months: often fidgets with or taps hands or feet or squirms in seat, often leaves seat in situations when remaining seated is expected, often runs about or climbs in situations where it is inappropriate, often unable to play or engage in leisure activities quietly, is often 'on the go,' acting as if 'driven by a motor', often talks excessively, often blurts out an answer before a question has been completed, often has difficulty waiting his or her turn, and often interrupts or intrudes on others." Symptoms of inattention may or may not be present.

Impulsivity/Hyperactivity Discussion Points (age 3 and older):

- **Is your child able to sit still for any length of time?***
- **Does he/she have trouble paying attention for more than a few minutes?***
- **Is your child able to control him/herself?***
- **Have other people told you that your child is "hyper"?***

Additional Impulsivity/Hyperactivity Discussion Points:

Toddlers, 3 year olds:

- Describe your child's activity level.
- Do you or others have any concerns in this area?
- Have you needed to find ways to prevent your child from getting hurt due to his/her activity level?
- Does your toddler run and climb excessively?
- Do you or others have trouble controlling your toddler's activity?
- Does your toddler require more supervision than others his/her age?

Preschoolers:

- Describe your child's activity level.
- Do you or others have any concerns in this area?
- Have you needed to find ways to prevent your child from getting hurt due to his/her activity level?
- Does your child need a high level of supervision due to his/her activity level?
- Does your child have trouble taking turns?
- Does s/he blurt out answers in day care or preschool?
- Does your child seem to continue doing things you don't want him/her to do, even though he/she has been taught not to do these things?
- Does your child have difficulty sitting still during mealtimes or activities like "circle time" in day care or preschool?

Oppositional Behavior (Compliance with authority)

This item is intended to capture how the child relates to authority. Oppositional behavior refers to reactions towards adults, not *peers*. **The child should be 3 years of age or older to rate this item.**

Ratings	
0	No evidence
1	History or recent onset (past 6 weeks) of defiance towards authority figures.
2	Clear evidence of oppositional and/or defiant behavior towards authority figures, which is currently interfering with the child's functioning in at least one life domain. Behavior is persistent and caregiver's attempts to change behavior have failed.
3	Clear evidence of a dangerous level of oppositional behavior involving the threat of physical harm to others or problems in more than one life domain that is resulting in interference with child's social and emotional development.
NA	Child is younger than 3 year of age.

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 or cause is not a factor in the rating. Although a child may be experiencing ineffective parenting to explain oppositional behavior, oppositional behavioral may still be 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 with adult requests	• Temper tantrums • Often loses temper • Often argues with adults • Is often angry or vindictive • Blames others for mistakes • Annoys or provokes others

Oppositional Behavior Discussion Points for children age 3 and older:

- **Does your child do what you ask him/her to do?***
- **Has a teacher or other adult told you that your child does not follow rules or directions?***
- **Does your child argue with you when you try to get them to do something?***
- If this is an issue, has anything helped in this area?

Adjustment to Trauma

This item covers the child's reaction to any of a variety of traumatic experiences—such as emotional, physical, or sexual abuse, disasters, neglect, separation from family members, witnessing violence, or the victimization or murder of family members or close friends.

This item should be rated 1 to 3 for young children who have been exposed to a potentially traumatic event in the past or who are exhibiting any symptoms related to a traumatic or adverse experience in their past. The item allows you to rate the overall severity of the broad range of symptoms the child may be experiencing. The remaining items in the CANS will allow you to rate the specific types of symptoms. (Adjustment to Trauma language Adapted from Kisiel, et al., 2011). **If abuse or neglect of the child/youth has been substantiated by child welfare, the rating would be a 1, 2, or 3, requiring further assessment of trauma related needs.**

Ratings	
0	Child has not experienced any significant trauma.
1	History or suspicion of problems associated with traumatic life event/s. Child has some **mild** problems with adjustment due to trauma that might ease with the passage of time. This may include one or mental health difficulty (such as depression, sleep problems) that may be associated with their trauma history. Child may also be in the process of recovering from a more extreme reaction to a traumatic experience.
2	Clear evidence of **moderate** adjustment problems associated with traumatic life event/s. Adjustment is interfering with child's functioning in at least one life domain. Symptoms can vary widely and may include sleeping or eating disturbances, regressive behavior, behavior problems or problems with attachment. Child may have features of one or more diagnoses and may meet full criteria for a specific DSM diagnosis including but not limited to diagnoses of Post-Traumatic Stress Disorder (PTSD) or Adjustment Disorder.
3	Clear evidence of **severe** adjustment problems associated with traumatic life event/s, which may include flashbacks, nightmares, significant anxiety, and intrusive thoughts, re-experiencing trauma (consistent with PTSD). OR Child likely meets criteria for more than one diagnosis or may have several symptoms consistent with complex trauma (e.g. problems with attachment, affect and behavioral regulation, cognition/learning, etc.). Child has severe symptoms as a result of traumatic or adverse childhood experiences that **require intensive** or **immediate attention**.

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 much 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
Adapted from Cornett (2011)

- 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

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 these strengths to their benefit in the face of trauma. If a child is challenged in this capacity, a support 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, adversely affect the growth, structure and functioning in the brain (Blaustein & Kinniburgh, 2010).

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 a feeling of safety and a routine are not present. A child may need the opportunity to process what occurred with an adult to 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.

Young children and youth exposed to single or ongoing incidents of abuse may experience trauma symptoms, poor functioning and increased risks related to the trauma, often differing from post trauma stress (Kisiel, Fehrenbach, Small & Lyons 2009). The exposure of young children to trauma, especially interpersonal violence, is associated with substantial decreases in cognitive functioning and reading achievement (DeLaney-Black, 2002), poor school attendance and academic performance (Hurt, 2001). Abused youth have poorer social functioning than non-abused youth, less pro-social and more aggressive, disruptive and withdrawn behavior (Alink, Cicchetti, Kim & Rogosch, 2012), resulting in increased cortisol and stress symptoms. Exposure to interpersonal violence, especially multiple types of abuse, increase the likelihood that the child will experience subsequent behavioral health symptoms, including depression, substance abuse, PTSD and risk behaviors (Crisler, 2012).

The *Diagnostic Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood: Revised Edition (DC: 0-3R, Zero to Three, 2005)* indicates that the criteria for Traumatic Stress Disorder includes a response to a traumatic event that includes:

1. Symptoms of re-experiencing the trauma in the form of post traumatic play, repeated statements or questions about the trauma, nightmares, distress at exposure or dissociation.
2. A Numbing of responsiveness which may include restricted range of affect, social withdrawal, regression, or constricted play.
3. Increased arousal which may include night terrors, night waking, attentional difficulties, or startle response.
4. Signs of fear or aggression that began after the trauma such as separation anxiety, fear of the dark, aggression towards peers or animals, sudden new fears or enactment.

Experiencing multiple, chronic interpersonal traumas, often referred to as complex trauma exposure, can impact several areas of mental health need and functioning (Ford, Connor & Hawke, 2009; Kisiel, Fehrenbach, Small, & Lyons, 2009). Different levels of trauma related impairments are found among children who have experienced abuse or neglect and multiple placements. Falling short of classical post traumatic stress criteria, trauma related symptoms often have functional consequences which may be resolved with early identification and effective intervention (Kisiel et al.).

As the Adjustment to Trauma item is a "screening" item, for children with suspected or documented history of trauma (including neglect or abuse, significant loss or placement disruptions, rate the item, "1". If there is evidence that the child is experiencing trauma related needs which impact function, rate the item '2'. A rating of '3' is consistent with PTSD or severe symptoms related to complex trauma.

Rating Adjustment to Trauma on the CANS

'0' - No evidence of exposure to trauma

'1' – Suspicion or history of trauma, including neglect, abuse, or interpersonal violence ("keep an eye on it", assess further)

'2' - Trauma related needs that interfere with functioning

'3' – Dangerous or disabling trauma related problems

Adjustment to Trauma Discussion Points:

- **Has the child experienced a traumatic event?***
- **Does s/he experience frequent nightmares?***
- **Is s/he troubled by flashbacks?***
- **I s/he unusually afraid of being alone or of participating in normal activities?***

Infants:

- Do you have any concerns that your infant has had or seen a traumatic situation?
- Has your infant heard gun shots or seen other violent acts in the community?
- Has your infant seen violence on TV or in movies?
- Has your infant experienced the death or loss of someone in the family (loss could be due to hospitalization, incarceration or divorce)?
- Has your infant ever been separated from you for a significant period of time?
- Does your infant appears to be "on guard" or worried at times?
- Have there been any changes in the way your infant acts or responds to you or others?
- Have you noticed any changes in your infant's development since he/she experienced the stressful event?
- Is your infant more easily upset or noticeably quieter since experiencing the stressful event?

Toddlers and Preschoolers:

- Do you have any concerns that your child has experienced or witnessed a traumatic situation?
- Has your child heard gun shots or seen other violent acts in the community?
- Has your child experienced the death or loss of someone in the family (loss could be due to hospitalization, incarceration or divorce)?
- Has your child experienced separations from caregivers?
- Has your child had nightmares or night fears, or changed his/her behavior after a difficult situation?

- Do certain situations make your child uncomfortable or react in a way that is unusual for him/her?
- Have you had to make changes in your child's normal routines due to his/her reactions or fears?

A rating of a "1" or greater would result in the need for further specification of these needs through the completion of the Trauma Module.

The trauma module was taken from the Trauma Experiences and Adjustment version of the CANS which was developed in collaboration with several sites of the **National Child Traumatic Stress Network** (NCTSN). The module includes specification of traumatic experiences that can be associated with PTSD. In addition, specific trauma stress symptoms are described. A child or youth may experience trauma which are not listed, such as death or loss. For children with a history of trauma or loss, consider this detailed information in determining the overall rating for **Adjustment to Trauma.**

TRAUMA MODULE

The Trauma Module includes items regarding lifetime exposure to potentially traumatic or adverse events, and adjustment to trauma experiences (specific trauma related effects), including sexual abuse items.

Guidelines for Rating Lifetime Exposure to Potentially Traumatic or Adverse Events:

0 – No evidence of any trauma of this type
1 – A single incident of trauma occurred or suspicion exists of this type of trauma
2 – Multiple incidents or a moderate degree of trauma of this type
3 – Repeated and severe incidents of trauma of this type

Potentially Adverse Traumatic Experiences

Sexual Abuse

The first item on the Trauma Module is "Sexual Abuse", which describes the child's experience of sexual abuse. Detailed CANS manual descriptions of how to rate this item follow.

Ratings	
0	There is **no evidence** that child has experienced sexual abuse.
1	There is a **suspicion** that the child has experienced sexual abuse **with some degree of evidence** or the child has **experienced "mild" sexual abuse** including but not limited **to direct exposure to sexually explicit materials**. Evidence for suspicion of sexual abuse could include evidence of **sexually reactive behavior** as well as **exposure to a sexualized environment** or **Internet predation**. Children who have experiences secondary sexual abuse (e.g. **witnessing sexual abuse, having a sibling sexually abused**) would also be rated here.
2	Child has experienced **one or a couple of incidents** of sexual abuse that were not chronic or severe. This might include a child who has experienced molestation without penetration on a single occasion.
3	Child has experienced **severe** or **chronic** sexual abuse with **multiple episodes or lasting over an extended period of time**. This abuse may have involved **penetration, multiple perpetrators, and/or associated physical injury**.

If the child scores a 1, 2 or 3 on Sexual Abuse additional items of "Emotional Closeness", 'Frequency of Abuse", "Duration, Physical Force and Reaction to Disclosure" must be completed. *If information is limited, some sexual abuse items could be rated '1', indicating need for further assessment.*

Physical Abuse

This rating describes the child's experience of physical abuse. Detailed CANS manual descriptions of how to rate this item follow.

Ratings	
0	There **is no evidence** that child has experienced physical abuse.
1	There is a **suspicion** that child has experienced physical abuse **but no confirming evidence**. **Spanking** without physical harm or threat of harm also qualifies.
2	Child has experienced **a moderate level of physical abuse** and/or **repeated forms of physical punishment** (e.g. hitting, punching).
3	Child has experienced **severe and repeated physical abuse** with intent to do harm and that causes sufficient physical harm to necessitate hospital treatment.

Neglect

This rating describes the degree of severity of neglect an individual has experienced. Neglect can refer to a lack of food, shelter or supervision (physical neglect) or lack of access to needed medical care (medical neglect), or failure to receive an academic instruction (educational neglect).

Ratings	
0	There is **no evidence** that child has experienced neglect.
1	Child has experienced **minor occasional** neglect. Child may have been l**eft home alone for a short period of time** with no adult supervision or there may be **occasional failure to provide adequate supervision of child.**
2	Child has experienced a **moderate level** of neglect. Child may have been left **home alone overnight** or there may be **occasional failure to provide adequate food, shelter, or clothing with corrective action.**
3	Child has experienced a **severe level of neglect** including multiple and/or prolonged absences by adults, with minimal supervision, and **failure to provide basic necessities of life on a regular basis.**

Emotional Abuse

The rating describes the degree of severity of emotional abuse, including verbal and nonverbal forms. This item includes both "emotional abuse," which would include psychological maltreatment such as insults or humiliation towards a child and "emotional neglect" defined as the denial of emotional attention and /or support from caregivers.

Ratings	
0	There is **no evidence** that child has experienced emotional abuse.
1	Child has experienced **mild** emotional abuse. For instance, child may experience some insults or is **occasionally referred to in a derogatory manner** by caregivers.
2	Child has experienced a **moderate degree of emotional** abuse. For instance, child may be **consistently denied emotional attention** from caregivers, **insulted or humiliated on an ongoing basis**, or **intentionally isolated** from others.
3	Child has experienced **significant or severe** emotional abuse over an extended period of time (at least one year). For instance, child is **completely ignored** by caregivers, or **threatened/terrorized** by others.

Medical Trauma

This rating describes the severity of medical trauma. Not all medical procedures are experienced as traumatic. Medical trauma results when a medical experience is perceived by the child as mentally or emotionally overwhelming. Potential medical trauma includes, but are not limited to the following examples: the onset of a life threatening illness; sudden painful medical events; chronic medical conditions resulting from an injury or illness or another type of traumatic event.

Ratings	
0	There is **no evidence** that child has experienced any medical trauma.
1	Child has had a medical experience that was **mildly overwhelming** for the child. Examples include events that were **acute in nature** and d**id not result in ongoing medical needs and associated distress** such as minor surgery, stitches or bone setting.
2	Child has had a medical experience that was perceived as **moderately** emotionally or mentally overwhelming. Such events **might include** acute injuries and **moderately invasive medical procedures** such as major surgery that require only short term hospitalization.
3	Child has had a medical experience that was perceived as **extremely** emotionally or mentally **overwhelming**. The event itself may have been life **threatening** and may have resulted in chronic health problems that alter the child's physical functioning.

Natural or Manmade Disaster

This rating describes the severity of exposure to natural and manmade disasters.

Ratings	
0	There is **no evidence** that child has experienced any natural or manmade disaster.
1	Child has been **exposed to disasters second-hand** (i.e. on television, hearing others discuss disasters). This would include second –hand exposure to natural disasters such as a fire or earthquake or man-made disaster, including care accident, plane crashes, or bombing.
2	Child has been **directly exposed to a disaster or witnessed the impact of a disaster on a family or friend.** For instance, a child may observe a caregiver who has been injured in a car accident or fire or watch his neighbor's house burn down.
3	Child has been directly exposed to **multiple and severe natural or manmade disasters** and /or 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. house burns down, caregiver loses job).

Witness to Family Violence

This rating describes the severity of exposure to family violence.

Ratings	
0	There is **no evidence** that child has witnessed family violence.
1	Child has witnessed **one episode** of family violence.
2	Child has witnessed **repeated episodes** of family violence but no significant injuries (i.e. requiring emergency medical attention) have been witnessed.
3	Child has witnessed **repeated and severe episodes** of family violence or has had to intervene in episodes of family violence. **Significant injuries** have occurred and have been **witnessed** as a direct result of the violence.

Community Violence

This rating describes the severity of exposure to community violence.

Ratings	
0	There is no **evidence** that child has witnessed violence in the community.
1	Child has witnessed **occasional fighting or other forms of violence** in the community. Child has **not been directly impacted** by the community violence (i.e. violence not directed at self, family, or friends) and exposure has been limited.
2	Child has **witnessed multiple instances** of community violence and/**or the significant injury of others** in his/her community, or has **had friends/family members injured** as a result of violence or criminal activity in the community, or is the **direct victim** of violence/criminal activity that was **not life threatening.**
3	Child has witnessed or experienced **severe and repeated instances** of community violence **and/or the death of another person in his/her community** as a result of violence, or is the **direct victim** of violence/criminal activity in the community that was **life threatening**, **or has experienced chronic/ongoing impact as a result** of community violence (e.g. family member injured and no longer able to work).

Witness/Victim to Criminal Activity

This rating describes the severity of exposure to criminal activity. Criminal behavior includes any behavior for which an adult could go to prison including drug dealing, prostitution, assault, or battery***.***

Ratings	
0	There is **no evidence** that child has been victimized or witness significant criminal activity.
1	There is **a strong suspicion or evidence** that child is a witness of **at least one significant criminal activity.**
2	Child has witnessed **multiple criminal activities** and/or is a **direct victim** of criminal activity or **witnessed the victimization of a family or friend.**
3	Child has been **exposed to chronic and/or severe instances of criminal activity** and/or is a **direct victim** of criminal activity that was **life threatening or caused significant physical harm** or child witnessed the **death of a loved one**.

War Affected

This rating describes the degree of severity of exposure to war, political violence or torture. Violence or trauma related to Terrorism is not included here.

Ratings	
0	There is **no evidence** that child has been exposed to war, political violence, or torture.
1	**Child did not live in war-affected region or refugee camp**, but **family** was affected by war. Family members directly related to the child may **have been exposed to war, political violence or torture**; family may have been forcibly displaced due to the war, or both. This **does not include children who have lost one or both parents** during the war.
2	**Child has been affected by war or political violence**. He or she may have **witnessed others being injured** in the war, may have **family members who were hurt or killed** in the war, and may have lived in an area where bombings or fighting took place. Child may have **lost one or both parents** during the war or one or both **parents may be so physically or psychologically disabled** from war so that they are not able to provide adequate caretaking of child. Child may have spent extended amount of time in **refugee camp.**
3	**Child has experienced the direct affects of war**. Child may have **feared for their own life** during war due to bombings, shelling, very near to them. They may have been **directly injured, tortured or kidnapped**. Some may have served as soldiers, guerrillas or other combatants in their home countries.

Terrorism Affected

This rating describes the degree to which a child has been affected by terrorism. 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).

Ratings	
0	There is **no evidence** that child has been affected by terrorism or terrorist activities.
1	Child's **community has experienced an act of terrorism**, but the **child was not directly impacted** by the violence (e.g. child lives close enough to site of terrorism that they may have visited before or child recognized the location when seen on TV, but child's family and neighborhood infrastructure was not directly affected). **Exposure has been limited to pictures on television.**
2	Child has **been affected** by terrorism within his/her community, **but did not directly witness the attack.** Child may live near the area where attack occurred and be accustomed to visiting regularly in the past, infrastructure of child's **daily life may be disrupted due to attack** (e.g. utilities or school), and child may see signs of the attack in neighborhood (e.g. destroyed building). Child may **know people who were injured** in the attack.
3	Child has **witnessed the death of another person** in a terrorist attack, or **has had friends or family members seriously injured** as a result of terrorism, or has **directly been injured** by terrorism leading to significant injury or lasting impact.

General Trauma Adjustment Items for all Children with Trauma Exposure/Experience

Affect Regulation

These symptoms include difficulties modulating or expressing emotions, intense fear or helplessness, difficulties regulating sleep/wake cycle, and inability to fully engage in activities. This can include difficulties modulating or expressing emotions and energy states such as emotional outbursts or marked shifts in emotions, overly constricted emotional responses, and intense emotional responses, and/or evidence of constricted, hyperaroused, or quickly fluctuating energy level. The child may demonstrate such difficulties with a single type or a wide range of emotions and energy states. This can also include difficulties with regulation of body functions, including disturbances in sleeping, eating and elimination; over-reactivity or under-reactivity to touch and sounds; and physical or somatic complaints.

Ratings	
0	Child has no problems with affect regulation.
1	Child has **mild** to moderate problems with affect regulation. This rating is given to a child with some minor and occasional difficulties with affect/physiological regulation. This child could have some difficulty tolerating intense emotions and become somewhat jumpy or irritable in response to emotionally charged stimuli, or more watchful or hypervigilant in general or have some difficulties with regulating body functions (e.g. sleeping, eating or elimination). This child may also have some difficulty sustaining involvement in activities for any length of time or have some physical or somatic complaints.
2	Child has **moderate** problems with affect /physiological regulation, but is able to control affect at times. Problems with affect regulation interfere with child's functioning in some life domains. This child may be unable to modulate emotional responses or have more persistent difficulties in regulating bodily functions. This child may exhibit marked shifts in emotional responses (e.g. from sadness to irritability to anxiety) or have contained emotions with a tendency to lose control of emotions at various points (e.g. normally restricted affect punctuated by outbursts of anger or sadness). This child may also exhibit persistent anxiety, intense fear or helplessness, lethargy/loss of motivation, or affective or physiological over-arousal or reactivity (e.g. silly behavior, loose active limbs) or underarousal (e.g. lack of movement and facial expressions, slowed walking and talking).
3	Child unable to regulate affect. This rating is given to a child with **severe** and chronic problems with highly dysregulated affective and /or physiological responses. This child may have more rapid shifts in mood and an inability to modulate emotional responses (feeling out of control of their emotions or lacking control over their movement as it relates to their emotional states). This child may also exhibit tightly contained emotions with intense outbursts under stress. Alternately, this child may be characterized by extreme lethargy, loss of motivation or drive, and no ability to concentrate or sustain engagement in activities (i.e. emotionally "shut down"). This child may have more persistent and severe difficulties regulating sleep/wake cycle, eating patterns or with elimination problems.

Re-experiencing Trauma (Intrusions)

These symptoms consist of intrusive memories or reminders of traumatic events, including nightmares, flashbacks, intense reliving of the events, and repetitive play with themes of specific traumatic experiences.

Ratings	
0	This rating is given to a child with **no evidence** of intrusive symptoms.
1	Child experiences some intrusive thoughts of trauma but they do not affect his/her functioning. For example, a child with **some problems with intrusive symptoms, distressing memories**, including occasional nightmares about traumatic events would be rated here.
2	This rating is given to a child with **moderate difficulties with intrusive symptoms/distressing memories**, intrusive thoughts that interfere in his/her ability to function in some, but not all life domains. For example, the child may have **recurrent frightening dreams** with or without recognizable content or recurrent distressing thoughts, images, perceptions or memories of traumatic events. The child may exhibit **trauma-specific reenactments** through **repetitive play** with themes of trauma or **intense physiological reactions** to exposure to **traumatic cues**.
3	This rating is given to a child with repeated and/or severe intrusive symptoms/distressing memories. This child may exhibit **trauma-specific reenactments that include sexually or physically traumatizing other children or sexual play** with adults. This child may also exhibit **persistent flashbacks, illusions or hallucinations** that make it **difficult for the child to function**.

Avoidance

These symptoms include efforts to avoid stimuli associated with traumatic experiences.

Ratings	
0	This rating is given to a child with **no evidence** of avoidance symptoms.
1	This rating is given to a child who exhibits **some avoidance**. The child may experience **one primary avoidant symptom**, including efforts to **avoid thoughts, feelings, or conversations associated with the trauma.**
2	This rating is given to a child with **moderate symptoms of avoidance**. In addition to avoiding thoughts or feelings associated with the trauma, the child may also **avoid activities, places, or people** that arouse recollections of the trauma.
3	This rating is given to a child who exhibits **significant or multiple avoidant symptoms**. This child may **avoid thoughts and feelings as well as situations and people** associated with the trauma and **be unable to recall important aspects of the trauma**.

Increased Arousal

These symptoms include difficulty falling or staying asleep, irritability or outbursts or anger, difficulty concentrating, hypervigilance and/or exaggerated startle response. Children may also manifest physical symptoms such as stomach aches and headaches.

Ratings	
0	There is **no evidence** of increased arousal.
1	This rating is given to a child who exhibits **mild hyperarousal** that does not significantly interfere with his or her day-to-day functioning. Children may also occasionally manifest physical symptoms such as stomach aches or headaches.
2	This rating is given to a child which **moderate symptoms** of hyperarousal or alternations in arousal and reactivity associated with traumatic event(s). Infants appear wide eyed, over reactive to stimuli, and have an exaggerated startle response. The child may exhibit **one significant symptom or a combination of two or more** of the following symptoms: difficulty falling or staying asleep, irritability or outbursts of anger, difficulty concentrating, hypervigilance and/or exaggerated startle response. Children may commonly have physical symptoms such as stomach aches or headaches.
3	This rating is given to a child who exhibits **multipl**e and**/**or **severe hyperarousal symptoms** including alternations in arousal and reactivity associated with traumatic event(s). These may include symptoms listed above; the **intensity or frequency of these symptoms is distressing for the child and leads to frequent problems with day-to-day functioning**.

Numbing of Responsiveness

These symptoms include numbing responses which were not present before the trauma experience(s).

Ratings	
0	There is **no evidence** of numbing of responsiveness.
1	This rating is given to a child who exhibits **some** problems with numbing. This infant or child may have a restricted range of affect or be **unable to express or experience certain emotions** (e.g. anger or sadness).
2	This rating is given to a child with **moderately severe numbing** responses. This child may have a **blunted or flat emotional state** or have **difficulty experiencing intense emotions** or feel **consistently detached** or **estranged** from others following the traumatic experience. Infants and toddlers may appear emotionally subdued, socially withdrawn and constricted in their play. Older children may exhibit all of the same symptoms as well as less spontaneous speech and peer interaction.
3	This rating is given to a child which **significant numbing responses** or m**ultiple symptoms of numbing**. This child may have a **markedly diminished interest** or participation in significant activities. Infant/child demonstrates numbing of responsiveness most of the time and this is impeding development.

Time before Treatment

Ratings	
0	Trauma was recognized and treatment started within one month of initial experience.
1	Trauma was recognized and treatment started within one to six months of initial experience.
2	Trauma was recognized and treatment started within six months to one year of the initial experience.
3	Trauma was not recognized nor treated for more than one year after the initial experience.

Traumatic Grief

This rating describes the level of traumatic grief the child is experiencing due to death or loss/separation from significant caregivers, siblings, or other significant figures.

Ratings	
0	There is **no evidence** that the child is experiencing traumatic grief or separation from the loss of significant caregivers. Either the child has not experienced a traumatic loss (e.g. death of a loved one) or the child has adjusted well to separation.
1	Child is experiencing a **mild level** of traumatic grief due to death or loss/separation from a significant person in a manner that is expected and/or appropriate given the recent nature of loss or separation.
2	Child is experiencing a **moderate level** of traumatic grief or difficulties with separation in a manner that **impairs functioning in some but not all areas**. This could include withdrawal or isolation from others or other problems with day-to-day functioning.
3	Child is experiencing **significant traumatic grief reactions**. Child exhibits **impaired functioning across several areas** (e.g. interpersonal relationships, school) for a significant period of time following the loss or separation. **Symptoms require immediate or intensive intervention**.

If a child has been sexually abused, rate the following items:

Emotional Closeness to Perpetrator

Ratings	
0	Perpetrator was a stranger at the time of the abuse.
1	Perpetrator was known to the child at the time of event but only as an acquaintance.
2	Perpetrator had a close relationship with the child at the time of the event but was not an immediate family member.
3	Perpetrator was an immediate family member (e.g. parent, sibling).

Frequency of Abuse

Ratings	
0	Abuse occurred only one time.
1	Abuse occurred two times.
2	Abuse occurred two to ten times.
3	Abuse occurred more than ten times.

Duration

Ratings	
0	Abuse occurred only one time.
1	Abuse occurred within a six month time period.
2	Abuse occurred within a six-month to one year time period.
3	Abuse occurred over a period of longer than one year.

Force

Ratings	
0	No physical force or threat of force occurred during the abuse episode(s).
1	Sexual abuse was associated with threat of violence but no physical force.
2	Physical force was used during the sexual abuse.
3	Significant physical force/violence was used during the sexual abuse. Physical injuries occurred as a result of the force.

Reaction to Disclosure

Ratings	
0	All significant family members are aware of the abuse and supportive of the child coming forward with the description of his/her abuse experience.
1	Most significant family members are aware of the abuse and supportive of the child for coming forward. One or two family members may be less supportive. Parent may be experiencing anxiety/depression/guilt regarding abuse.
2	Significant split among family members in terms of their support of the child for coming forward with the description of his/her experience.
3	Significant lack of support from close family members of the child for coming forward with the description of his/her abuse experience. Significant relationship (e.g. parent, care-giving grandparent) is threatened.

RISK FACTOR DOMAIN

Birth Weight

This item rates the child's weight as compared to normal development.

Ratings	
0	Child is within normal range for weight and has been since birth. A child 5.5 pounds or over would be rated here.
1	Child was born under weight but is now within normal range or child is slightly beneath normal range. A child with a birth weight of between 3.3 pounds and 5.5 pounds would be rated here.
2	Child is considerably under weight to the point of presenting a developmental risk to the child. A child with a birth weight of 2.2 pounds to 3.3 pounds would be rated here.
3	Child is extremely under weight to the point of the child's life being threatened. A child with a birth weight of less than 2.2 pounds would be rated here.

Birth Weight Discussion Point:

- What was your child's birth weight?
- How has your child's weight gain been since birth?

PICA

Pica refers to the child eating dangerous or unusual materials. This item includes the symptoms of Pica as specified in DSM. The child must be **older than 18 months** to rate this item.

Ratings	
0	No evidence that the child eats unusual or dangerous materials.
1	Child has a history of eating unusual or dangerous materials but has not done so in the last 30 days.
2	Child has eaten unusual or dangerous materials consistent with a diagnosis of Pica in the last 30 days.
3	Child has become physically ill during the past 30 days by eating dangerous materials.
NA	Child is younger than 18 months of age.

Prenatal Care

This item refers to the health care birth circumstances experienced by the child in utero.

Ratings	
0	Child's biological mother received adequate prenatal care that began in the first trimester. Child's mother did not experience any pregnancy related illnesses.
1	Child's biological mother had some short-comings in prenatal care, or had a mild form of a pregnancy related illness.
2	Child's biological mother received poor prenatal care, initiated only in the last trimester or had a moderate form of a pregnancy related illness.
3	Child's biological mother had no prenatal care or had a severe pregnancy related illness.

A child whose mother had 6 or fewer planned visits to a physician (her care must have begun in the first or early in the second trimester), 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 as a '1'. A child whose mother had 4 or fewer planned visits to a physician or who experienced a high-risk pregnancy with some complications would be rated as '2'. A mother who had toxemia/pre-eclampsia would be rated a '3'.

Prenatal Care Discussion Points:

- When did you first receive health care for your pregnancy?
- Did you receive health care throughout your pregnancy?

Labor and Delivery

This item refers to conditions associated with, and consequences arising from, complications and delivery of the child.

Ratings	
0	Child and biological mother had normal labor and delivery.
1	Child or mother had some mild problems during delivery, but child does not appear affected by problems.
2	Child or mother had problems during delivery that resulted in temporary functional difficulties for the child or mother.
3	Child had severe problems during delivery that have resulted in long term implications for development.

Labor & Delivery Discussion Points:

- Describe your labor and delivery experience.
- Describe any difficulties with either you or your child during labor and delivery.

Substance Exposure

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

Ratings	
0	Child had no in utero exposure to alcohol or drugs, and there is no current exposure in the home.
1	Child had either mild in utero exposure or there is current alcohol and/or drug use in the home.
2	Child was exposed to significant alcohol or drugs in utero. Any ingestion of illegal drugs during pregnancy or significant use of alcohol or tobacco would be rated here.
3	Child was exposed to alcohol or drugs in utero and continues to be exposed in the home.

While exposure to substance abuse is a known risk, the associated stressors that often accompany substance abusing parents heighten the concerns. Due to the effects of substance abuse, parents often experience poverty, disorganized and chaotic lifestyles, stress, and 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 Exposure Discussion Points:

- Does your child have a history of being exposed to substances prenatally?
- Are there any concerns that your child is exposed to substances within the home?

Parent/Sibling Problems

This item refers to how the child's parents and older siblings have done/are doing in their respective development and behavioral health.

Ratings	PARENT/SIBLING PROBLEMS Anchor Definitions
0	The child's parents have no developmental disabilities. The child has no siblings, or existing siblings are not experiencing any developmental or behavioral problems.
1	The child's parents have no developmental disabilities. The child has siblings who are experiencing some mild developmental or behavioral problems. It may be that the child has at least one healthy sibling.
2	The child's parents have no developmental disabilities. The child has a sibling who is experiencing a significant developmental or behavioral problem.
3	One or both of the child's parents have been diagnosed with a developmental disability, or the child has multiple siblings who are experiencing significant developmental or behavioral problems.

Discussion Points:

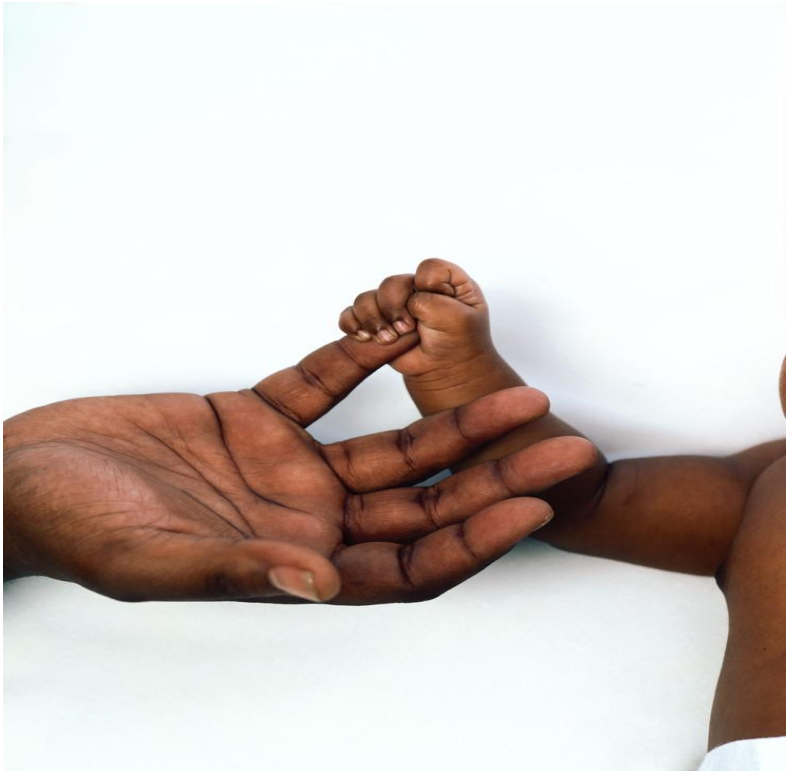
- Are there any developmental or behavioral health problems in parents or siblings?
- Have there been any concerns in the past with parents or siblings?
- If so, describe the concerns.

Parental Availability

This item addresses the primary caretaker's emotional and physical availability to the child in the weeks immediately following the birth. Rate parental availability from birth to 12 weeks post partum.

Ratings	PARENTAL AVAILABILITY Anchor Definitions
0	The child's parent/primary caretaker was emotionally and physically available to the child in the weeks following the birth.
1	The primary caretaker experienced some minor or transient stressors which made the parent slightly less available to the child.
2	The primary caregiver experienced a moderate level of stress sufficient to make him/her significantly less emotionally and physically available to the child in the weeks following the birth.
3	The primary caregiver was unavailable to the child to such an extent that the child's emotional or physical well being was severely compromised.

One of the factors that contribute to early childhood emotional disorders is a parent's inability to be emotionally available to read and respond to infant's cues. Parents may be compromised by limited parenting skills, a lack of social support, physical or mental health issues, substance abuse or interpersonal or external stressors (e.g. poverty or domestic violence).



CHILD RISK BEHAVIOR DOMAIN

Self Harm

This item refers to repetitive behaviors that result in physical injury to the child, e.g. head banging.

Ratings	
0	No evidence
1	Mild level of self harm behavior or history of self harm.
2	Moderate level of self harm behavior such as head banging that cannot be impacted by caregiver and interferes with child's functioning.
3	Severe level of self harm behavior that puts the child's safety and well being at risk.

Aggressive Behavior

This item rates if there have been times when the child hurt or threatened to hurt another child or adult.

Ratings	
0	No evidence of aggressive behavior towards people or animals.
1	There is either a history of aggressive behavior towards people or animals or mild concerns in this area that have not yet interfered with functioning.
2	There is clear evidence of aggressive behavior towards animals or others. Behavior is persistent, and caregiver's attempts to change behavior have not been successful. Help is needed.
3	The child has significant challenges in this area that is characterized as a dangerous level of aggressive behavior that involves harm to animals or others. Caregivers have difficulty managing this behavior.

Aggression is a common reason that parents seek assistance for young children. Early intervention with childhood aggressive problems is critical (Webster-Stratton, 2003). She concluded that effective early intervention could correct the negative trajectory of early conduct problems which could lead to delinquency and antisocial behavior.

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 CANS Aggressive Behavior Item.

Aggression Discussion Points:

Toddlers:

- Have there been situations in which others have been hurt by your child?
- Can you describe the situation? What were the results of this situation?
- Were there things that you or others did that made the situation better?
- How do you correct your toddler if s/he is being verbally or physically aggressive towards another person?
- Have other caregivers ever been uncomfortable caring for your toddler because of your child's aggressive behavior?

Preschoolers:

- Have there been situations in which others have been hurt by your child?
- If so, can you describe the situation?
- What were the results of this situation?
- Were there things that you or others did that made the situation better?
- 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 childcare or school setting because of aggressive behavior?

Intentional Misbehavior (Social Behavior)

This item refers to obnoxious behaviors that force adults to sanction the child. These behaviors occur in such a way that the child is intentionally seeking negative attention, acting out, or the behavior could be seen as a cry for help. It is not necessary that the child have an awareness of the purpose of his/her misbehavior as it is not always conscious or planned. This item should not be rated for children who engage in such behavior solely due to developmental delays or lack of social skill. The child should be 3 years of age or older to rate this item.

Ratings	INTENTIONAL MISBEHAVIOR (SOCIAL BEHAVIOR) Anchor Definitions
0	No evidence of problematic social behavior. Child does not engage in behavior that forces adults to sanction him/her.
1	**Mild** level of problematic social behavior. This might include occasional inappropriate social behavior that forces adults to sanction the child. Infrequent inappropriate comments to strangers or unusual behavior in social settings might be included in this level.
2	**Moderate** level of problematic social behavior. Such behavior is causing problems in the child's life. Child may be intentionally getting in trouble in preschool or at home.
3	**Severe** level of problematic social behavior. This level would be indicated by frequent serious social behavior that forces adults to seriously and/or repeatedly sanction the child. Behaviors are sufficiently severe that they place the child at risk of significant sanctions (e.g., expulsion, removal from the community).
NA	Child is younger than 3 years of age.

The key to rating this behavior is to understand if the child is intentionally trying to force discipline or consequences. These behaviors occur in such a way that the child is intentionally seeking sanctions and negative attention, acting out, or the behavior could also be seen as a cry for help. A rating of '2' could be a child who, several times per week, is intentionally getting into trouble at preschool in order to have his/her caregiver pick him/her up early.

Intentional Misbehavior Discussion Points:

- Does your child ever intentionally do or say things to upset adults?
- Does your child seem to purposely get in trouble by making you or other adults angry with him/her?

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