CHILADOLESCENT

Santa Cruz County
Behavioral Health Services

Child and Adolescent Needs and Strengths – Early Childhood

version 2.0

Ages Birth thru 5 Years Old

Praed Foundation 2022, 1999

2022
REFERENCE
GUIDE

ACKNOWLEDGEMENTS

The Santa Cruz County Behavioral Health Services Child and Adolescent Needs and Strengths-Early Childhood (CANS-EC) comes largely from the Standard Comprehensive Child Adolescent Needs and Strengths—Early Childhood version. This information integration tool is designed to support individual case planning and the planning and evaluation of service systems. The CANS is an open domain tool for use in multiple child-serving systems that address the needs and strengths of children, adolescents, and their families. The copyright is held by the Praed Foundation to ensure that it remains free to use. Training and annual certification is expected for appropriate use.

The Praed Foundation is committed to creating a diverse and inclusive environment. It is important to consider how we are precisely and inclusively using individual words. As such, this reference guide uses the gender-neutral pronouns “they/them/themselves” in the place of “he/him/himself” and “she/her/herself.”

Additionally, the term “child” is being utilized to refer to “infant,” “toddler” or “child.” This is done to make this guide easier to use.

For specific permission to use this tool, please contact the Praed Foundation. For more information on the CANS-EC contact:

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INTRODUCTION

THE CANS

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

SIX KEY PRINCIPLES OF THE CANS

1. **Items were selected because they are each relevant to action/treatment planning**. An item exists because it might lead you down a different pathway in terms of planning actions.
2. **Each item uses a 4-level rating system**. Those levels are designed to translate immediately into action levels. Different action levels exist for needs and strengths. For a description of these action levels please see below.
3. **Rating should describe the child, not the child in services.** If an intervention is present that is masking a need but must stay in place, this should be factored into the rating consideration and would result in a rating of an "actionable" need (i.e., '2' or '3').
4. **Culture and development should be considered prior to establishing the action levels.** Cultural sensitivity involves considering whether cultural factors are influencing the expression of needs and strengths. Ratings should be completed considering the child's developmental and/or chronological age depending on the item. In other words, anger control is not relevant for a very young child but would be for an older child or youth regardless of developmental age. Alternatively, school achievement should be considered within the framework of expectations based on the child's developmental age.
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." While most items are purely descriptive, there are a few items that consider cause and effect; see individual item descriptions for details on when the "why" is considered in rating these items.
6. A 30-day window is used for ratings **in order to make sure assessments stay relevant to the child's present circumstances.** The 30-day time frame should be considered in terms of whether an item is a need within the time frame; it is NOT whether a specific behavior occurred during the time frame. The action levels assist in understanding whether or not a need is current even when no specific behavior has occurred during the time frame.

HISTORY AND BACKGROUND OF THE CANS

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

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

The CANS is made of domains that focus on various areas in a child's life, and each domain is made up of a group of specific items. There are domains that address how the child functions in everyday life, on specific emotional or behavioral concerns, on risk behaviors, on strengths and on skills needed to grow and develop. There is also a domain that asks about the family's beliefs and preferences, and about general family concerns. The care provider, along with the child and family as well as other stakeholders, gives a number rating to each of these items. These ratings help the provider, child and family understand where intensive or immediate action is most needed, and also where a child has assets that could be a major part of the treatment or service plan.

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

HISTORY

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

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

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

MEASUREMENT PROPERTIES

Reliability

Strong evidence from multiple reliability studies indicates that the CANS can be completed reliably by individuals working with children and families. A number of individuals from different backgrounds have been trained and certified to use the CANS reliably including health and mental health providers, child welfare case workers, probation officers, and family advocates. With approved training, anyone with a bachelor's degree can learn to complete the tool reliably, although some applications or more complex versions of the CANS require a higher educational degree or relevant experience. The average reliability of the CANS is 0.78 with vignettes across a sample of more than 80,000 trainees. The reliability is higher (0.84) with case records, and can be above 0.90 with live cases (Lyons, 2009). The CANS is auditable and audit reliabilities demonstrate that the CANS is reliable at the item level (Anderson et al., 2001). Training and certification with a reliability of at least 0.70 on a test case vignette is required for ethical use. In most jurisdictions, re-certification is annual. A full discussion on the reliability of the CANS assessment is found in Lyons (2009) *Communimetrics: A Communication Theory of Measurement in Human Service Settings*.

Validity

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

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

RATING NEEDS & STRENGTHS

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

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

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

Basic Design for Rating Needs

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

Basic Design for Rating Strengths

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

The rating of 'N/A' for 'not applicable' is available for a few items under specified circumstances (see reference guide descriptions). For those items where the 'N/A' rating is available, it should be used only in the rare instances where an item does not apply to that particular child.

To complete the CANS, a CANS trained and certified care coordinator, case worker, clinician, or other care provider should read the anchor descriptions for each item and then record the appropriate rating on the CANS Comprehensive form (or electronic record). This process should be done collaboratively with the child, family and other stakeholders.

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

The CANS is an information integration tool, intended to include multiple sources of information (e.g., child and family, referral source, treatment providers, school, and observation of the rater). As a strength-based approach, the CANS supports the belief that children and families have unique talents, skills, and life events, in addition to

specific unmet needs. Strength-based approaches to assessment and service or treatment planning focus on collaborating with children and their families to discover individual and family functioning and strengths. Failure to demonstrate a child's skill should first be viewed as an opportunity to learn the skill as opposed to the problem. Focusing on the child's strengths instead of weaknesses with their families may result in enhanced motivation and improved performance. Involving the family and child in the rating process and obtaining information (evidence) from multiple sources is necessary and improves the accuracy of the rating. Meaningful use of the CANS and related information as tools (for reaching consensus, planning interventions, monitoring progress, psychoeducation, and supervision) support effective services for children, youth and families.

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

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

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

HOW IS THE CANS USED?

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

IT IS AN ASSESSMENT STRATEGY

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

IT GUIDES CARE AND TREATMENT/SERVICE PLANNING

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

IT FACILITATES OUTCOMES MEASUREMENT

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

IT IS A COMMUNICATION TOOL

When a client leaves a treatment program, a closing CANS may be completed to define progress, measure ongoing needs and help us make continuity of care decisions. Doing a closing CANS, much like a discharge summary,

integrated with CANS ratings, provides a picture of how much progress has been made, and allows for recommendations for future care which ties to current needs. And finally, it allows for a shared language to talk about our child and creates opportunities for collaboration. It is our hope that this guide will help you to make the most out of the CANS and guide you in filling it out in an accurate way that helps you make good clinical decisions.

CANS: A STRATEGY FOR TRANSFROMATIONAL CHANGE

The CANS is an excellent strategy in addressing children's wellness. As it is meant to be an outcome of an assessment, it can be used to organize and integrate the information gathered from clinical interviews, records reviews, and information from screening tools and other measures.

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

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

MAKING THE BEST USE OF THE CANS

Children have families involved in their lives, and their family can be a great asset to their treatment. To increase family involvement and understanding, it is important to talk to them about the assessment process and describe the CANS and how it will be used. The description of the CANS should include teaching the child and family about the needs and strengths rating scales, identifying the domains and items, as well as how the actionable items will be used in treatment or serving planning. When possible, share with the child and family the CANS domains and items (see the CANS Core Item list on page 12) and encourage the family to look over the items prior to your meeting with them. The best time to do this is your decision—you will have a sense of the timing as you work with each family. Families often feel respected as partners when they are prepared for a meeting or a process. A copy of the completed CANS ratings should be reviewed with each family. Encourage families to contact you if they wish to change their answers in any area that they feel needs more or less emphasis.

LISTENING USING THE CANS

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

★ **Use nonverbal and minimal verbal prompts.** Head nodding, smiling and brief "yes," "and"—things that encourage people to continue.

★ **Be nonjudgmental and avoid giving person advice.** You may find yourself thinking "If I were this person, I would do x" or "That's just like my situation, and I did x." But since you are not that person, what you would do is not particularly relevant. Avoid making judgmental statements or telling them what you would do. It's not really about you.

★ **Be empathic.** Empathy is being warm and supportive. It is the understanding of another person from their point of reference and acknowledging feelings. You demonstrate empathetic listening when you smile, nod, maintain eye contact. You also demonstrate empathetic listening when you follow the person's lead and acknowledge when something may be difficult, or when something is great. You demonstrate empathy when you summarize information correctly. All of this demonstrates to the child that you are with them.

★ **Be comfortable with silence.** Some people need a little time to get their thoughts together. Sometimes, they struggle with finding the right words. Maybe they are deciding how they want to respond to a question. If you are concerned that the silence means something else, you can always ask "Does that make sense to you?" Or "Do you need me to explain that in another way?"

★ **Paraphrase and clarify—avoid interpreting.** Interpretation is when you go beyond the information given and infer something—in a person's unconscious motivations, personality, etc. The CANS Comprehensive is not a tool to come up with causes. Instead, it identifies things that need to be acted upon. Rather than talk about causation, focus on paraphrasing and clarifying. Paraphrasing is restating a message very clearly in a different form, using different words. A paraphrase helps you to (1) find out if you really have understood an answer; (2) clarify what was said, sometimes making things clearer; and (3) demonstrate empathy. For example, you ask the questions about health, and the person you are talking to gives a long description. You paraphrase by saying "Ok, it sounds like . . . is that right? Would you say that is something that you feel needs to be watched, or is help needed?"

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

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

ACKNOWLEDGE FEELINGS

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

WRAPPING IT UP

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

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

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

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

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SANTA CRUZ COUNTY CANS-EC BASIC STRUCTURE

The Santa Cruz County Behavioral Health Services Child and Adolescent Needs and Strengths—Early Childhood items are noted below.

Strengths Domain

Family	Curiosity	Spiritual/Religious - Family
Extended Family Relationships	Playfulness	Natural Supports
Interpersonal/Social Connectedness	Creativity/Imagination	Resiliency - Persistence & Adaptability
Relationship Permanence	Special Skills/Talents and Interests	Self-Esteem/Self-Confidence

Life Functioning Domain

Intellectual/Developmental (IQ)*	Medical/Physical*	Sleep
Cognitive	*Primary Care Physician Connected*	Parent/Child Interaction
Communication	Sensory	Early Education
Self-Care/Daily Living Skills	Family Functioning	Transportation
	Social and Emotional Functioning	

Cultural Factors-Family Domain

Language	Traditions and Rituals	Cultural Stress

Caregiver Domain

Care Intensity & Organization	***Caregiver Resources & Needs cont'd***	***Caregiver Resources & Needs cont'd***
Service Intensity	Knowledge	Mental Health
Service Coordination	Organization	Substance Use
Service Access/Availability	Financial Resources	Developmental
Cultural Appropriateness of Services	Social Resources	Knowledge of Service Options
	Housing/Residential Stability	Access to Childcare
Caregiver Resources & Needs	Safety	Caregiver Emotional Responsiveness
Supervision	Family Stress	Caregiver Resourcefulness
Involvement with Care	Empathy for Child	CG Adjust. to Traumatic Experiences
Medical/Physical Health	Family Relationship to the System	Legal Involvement

Mental Health/Behavioral and Emotional Needs & Challenges Domain

Attachment	Atypical Behavior	Oppositional Behavior
Impulsivity/Hyperactivity	Depression	Regulatory
Aggression	Anxiety	Adjustment to Trauma

Potentially Traumatic/Adverse Childhood Experiences

Neglect	Disrupt. in Caregiving/Attchmnt Losses	Witness to Comm/School Violence
Emotional Abuse	Parent Criminal Behaviors	War/Terrorism Affected
Physical Abuse	Parent/Caregiver Mental Illness	Natural or Manmade Disaster
Sexual Abuse	Parent/Caregiver Substance Abuse	Victim/Witness to Criminal Activity
Witness to Family Violence	Medical Trauma	

Risk Behaviors Domain

Self-Harm	Labor and Delivery	Victimization/Exploitation
Prenatal Care	Exposure	Failure to Thrive
Birth Weight		

A rating of '1', '2', or '3' on this item triggers the completion of specific Individualized Assessment Modules*

STRENGTHS DOMAIN

This domain describes the assets of the child that can be used to advance healthy development. It is important to remember that strengths are NOT the opposite of needs. Increasing a child's strengths while also addressing their behavioral/emotional needs leads to better functioning, and better outcomes, than does focusing just on their needs. Identifying areas where strengths can be built is a significant element of service planning. In these items the 'best' assets and resources available to the child are rated based on how accessible and useful those strengths are. These are the only items that use the Strength Rating Scale with action levels.

Question to Consider for this Domain: What child strengths can be used to support a need?

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

0 Well-developed, centerpiece strength; may be used as a centerpiece in an intervention/action plan.

1 Identified and useful strength. Strength will be used, maintained or built upon as part of the plan. May require some effort to develop strength into a centerpiece strength.

2 Strengths have been identified but require strength-building efforts before they can be effectively utilized as part of a plan. Identified but not useful.

3 An area in which no current strength is identified; efforts may be recommended to develop a strength in this area.

FAMILY

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

Questions to Consider	Ratings and Descriptions
• How does the child get along with siblings or other children in the household? • How does the child get along with caregivers or other adults in the household? • Is the child particularly close to one or more members of the family?	0 *Well-developed, centerpiece strength; may be used as a centerpiece in an intervention/ action plan.* Family has strong relationships and significant family strengths. This level indicates a family with much love and respect for one another. There is at least one family member who has a strong loving relationship with the child and is able to provide significant emotional or concrete support. Child is fully included in family activities. 1 *Identified and useful strength. Strength will be used, maintained or built upon as part of the plan. May require some effort to develop strength into a centerpiece strength.* Family has some good relationships and good communication. Family members are able to enjoy each other's company. There is at least one family member who has a strong, loving relationship with the child and is able to provide limited emotional or concrete support. [continues]

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

EXTENDED FAMILY RELATIONSHIPS

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

	Ratings and Descriptions
Questions to Consider: • Does the child's extended family play a part in their life? • What types of activities do the child and extended family members do together? • How would you describe the importance of these relationships to family and to the child?	0 *Well-developed, centerpiece strength; may be used as a centerpiece in an intervention/ action plan.* The child has at least one relationship with an extended family member that consistently supports their caregiver and their own development in a positive manner.
	1 *Identified and useful strength. Strength will be used, maintained or built upon as part of the plan. May require some effort to develop strength into a centerpiece strength..* The child experiences an overall positive relationship with an extended family member but the relationship could benefit from having this person provide more support to the caregiver or child.
	2 *Strengths have been identified but require strength-building efforts before they can be effectively utilized as part of a plan. Identified by not useful.* A relationship between the child and an extended family member is present and positive at times but needs development to be the basis of a strength-based plan.
	3 *An area in which no current strength is identified; efforts may be recommended to develop a strength in this area.* There is no relationships with extended family members, or there is a relationship but it may be described as detrimental to either the caregiver or the child.

INTERPERSONAL/SOCIAL CONNECTEDNESS

This item is used to identify a child's social and relationship skills. For young children and infants, this strength indicates that the child is developing useful skills and behaviors for initiating interaction with others and relating with others.

Questions to Consider

- How does the child interact with other children and adults?
- How does the child do in social settings?

Ratings and Descriptions

0 *Well-developed, centerpiece strength; may be used as a centerpiece in an intervention/ action plan.*

Significant interpersonal strengths. Child has a prosocial or "easy" temperament and is interested in initiating relationships with others. If an infant, exhibits anticipatory behavior when fed or held.

1 *Identified and useful strength. Strength will be used, maintained or built upon as part of the plan. May require some effort to develop strength into a centerpiece strength.*

Child has formed a positive interpersonal relationship with at least one non-caregiver. Child responds positively to social initiation by adults but may not initiate interactions themselves.

2 *Strengths have been identified but require strength-building efforts before they can be effectively utilized as part of a plan. Identified but not useful.*

Child requires strength building to learn to develop good relational skills. Child may be shy or uninterested in interactions with others, or – if still an infant -- child may have a temperament that makes attachment to others a challenge.

3 *An area in which no current strength is identified; efforts may be recommended to develop a strength in this area.*

There is no evidence of observable interpersonal skills. Child does not exhibit age appropriate gestures (social smile, cooperative play, etc.). An infant who constantly exhibits gaze aversion would be rated here.

RELATIONSHIP PERMANENCE

This item refers to the stability and consistency of significant relationships in the child's life. This likely includes family members but may also include other adults and/or peers.

Questions to Consider

- Has anyone consistently been in the child's life since birth?
- Are there other significant adults in the child's life?
- Has the child been in multiple home placements?

Ratings and Descriptions

0 *Well-developed, centerpiece strength; may be used as a centerpiece in an intervention/ action plan.*

Child has very stable relationships. Family members, friends, and community have been stable for most of their life and are likely to remain so in the foreseeable future. Child is involved with their parents.

1 *Identified and useful strength. Strength will be used, maintained or built upon as part of the plan. May require some effort to develop strength into a centerpiece strength.*

Child has 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 *Strengths have been identified but require strength-building efforts before they can be effectively utilized as part of a plan. Identified but not useful.*

Child has had at least one stable relationship over their lifetime but has experienced other instability through factors such as divorce, moving, removal from home, and death.

3 *An area in which no current strength is identified; efforts may be recommended to develop a strength in this area.*

Child does not have any stability in relationships. Independent living or adoption must be considered.

Supplemental Information: Young children experience their world as an environment of relationships, and these relationships affect virtually all aspects of their development – intellectual, social, emotional, physical, behavioral, and moral. The quality and stability of a child's human relationships in the early years lay the foundation for a wide range of later developmental outcomes that really matter. Stated simply, relationships are the "active ingredients" of the environment's influence on healthy human development. They incorporate the qualities that best promote competence and well-being – individualized responsiveness, mutual action-and-interaction, and an emotional connection to another human being, be it a parent, peer, grandparent, aunt, uncle, neighbor, teacher, coach, or any other person who has an important impact on the child's early development. Although young children certainly can establish healthy relationships with more than one or two adults, prolonged separations from familiar caregivers and repeated "detaching" and "re-attaching" to people who matter are emotionally distressing and can lead to enduring problems (National Scientific Council on the Developing Child, 2004).

FOR REFERENCE TO DC 0-5 (ZTT, 2016) IF APPLICABLE

Axis IV: Information gathered as part of assessing Relationship Permanence can be used as part of documenting concerns within Axis IV: Psychosocial Stressors.

CURIOSITY

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

Questions to Consider:

- Does the child seem interested in the world around them?
- Does the child seem aware of changes in the settings they are in?
- Is the child eager to explore?
- Does the child show interest in trying a new task or activity?

Ratings and Descriptions

0 *Well-developed, centerpiece strength; may be used as a centerpiece in an intervention/ action plan.*

The child consistently demonstrates curiosity and takes action to explore their environment.

1 *Identified and useful strength. Strength will be used, maintained or built upon as part of the plan. May require some effort to develop strength into a centerpiece strength.*

The child demonstrates curiosity much of the time and will take action to explore their environment some of the time.

2 *Strengths have been identified but require strength-building efforts before they can be effectively utilized as part of a plan. Identified but not useful.*

The child, with encouragement, will explore and demonstrate interest in novelty or change.

3 *An area in which no current strength is identified; efforts may be recommended to develop a strength in this area.*

The child does not demonstrate curiosity or exploration of their environment.

PLAYFULNESS

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

Questions to Consider

- Is the child easily engaged in play?
- Does the child initiate play? Can the child sustain play?
- Does the child need adult support in initiating and sustaining play more than what is developmentally appropriate?
- Does the child experience opportunities for play on a regular basis?

Ratings and Descriptions

0 *Well-developed, centerpiece strength; may be used as a centerpiece in an intervention/ action plan.*

The child consistently demonstrates the ability to make use of play to further their development. Their play is consistently developmentally appropriate, spontaneous, self-initiated and enjoyable.

1 *Identified and useful strength. Strength will be used, maintained or built upon as part of the plan. May require some effort to develop strength into a centerpiece strength.*

The child demonstrates play that is developmentally appropriate, self-initiated, spontaneous and enjoyable much of the time. Child needs some assistance making full use of play.

2 *Strengths have been identified but require strength-building efforts before they can be effectively utilized as part of a plan. Identified but not useful.*

The child demonstrates the ability to enjoy play and use it to support their development some of the time or with support of a caregiver. Even with this in place there does not appear to be investment and enjoying in the child.

3 *An area in which no current strength is identified; efforts may be recommended to develop a strength in this area.*

The child does not demonstrate the ability to play in a developmentally appropriate or quality manner.

CREATIVITY/IMAGINATION

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

Questions to Consider:

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

Ratings and Descriptions

0 *Well-developed, centerpiece strength; may be used as a centerpiece in an intervention/ action plan.*

The child consistently demonstrates a significant level of creativity. This appears interwoven into the normal routines and chosen activities.

1 *Identified and useful strength. Strength will be used, maintained or built upon as part of the plan. May require some effort to develop strength into a centerpiece strength.*

The child demonstrates a level of creativity that can be useful to the child. The child could benefit from further development in this area before it is considered a significant strength.

2 *Strengths have been identified but require strength-building efforts before they can be effectively utilized as part of a plan. Identified by not useful.*

The child shows creativity and/or imagination when caregivers provide support.

3 *An area in which no current strength is identified; efforts may be recommended to develop a strength in this area.*

The child does not demonstrate creativity or imagination.

SPECIAL SKILLS/TALENTS AND INTERESTS

This item refers to special talents or specific interests that bring the child positive experiences.

Questions to Consider

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

Ratings and Descriptions

0 *Well-developed, centerpiece strength; may be used as a centerpiece in an intervention/ action plan.*

Child has a talent that provides them with pleasure and/or self-esteem. A child with significant creative/artistic/athletic strengths would be rated here.

1 *Identified and useful strength. Strength will be used, maintained or built upon as part of the plan. May require some effort to develop strength into a centerpiece strength.*

Child has a talent, interest, or hobby that has the potential to provide them with pleasure and self-esteem. This level indicates a child with a notable talent. For example, a child who loves to sing, read, draw, or who is athletic would be rated here.

2 *Strengths have been identified but require strength-building efforts before they can be effectively utilized as part of a plan. Identified but not useful.*

Child has shown some interest in one particular area (e.g., reading, music, physical play, drawing) but effort is needed to help the child draw pleasure and self-esteem from this activity.

3 *An area in which no current strength is identified; efforts may be recommended to develop a strength in this area.*

There is no evidence of identified talents, interests or hobbies at this time.

SPIRITUAL/RELIGIOUS - FAMILY

This item refers to the family's experience of receiving comfort and support from religious or spiritual involvement. This item rates the presence of beliefs that could be useful to the family; however, an absence of spiritual and/or religious beliefs does not represent a need for the family. **For infants and young children, this strength is rated with regard to the child's family.**

Questions to Consider

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

Ratings and Descriptions

0 *Well-developed, centerpiece strength; may be used as a centerpiece in an intervention/ action plan.*

This level indicates a family with strong moral and spiritual strengths. Family may be very involved in a religious community or may have strongly held spiritual or religious beliefs that can sustain or comfort them in difficult times.

1 *Identified and useful strength. Strength will be used, maintained or built upon as part of the plan. May require some effort to develop strength into a centerpiece strength.*

Family is involved in and receives some comfort and/or support from spiritual and/or religious beliefs, practices and/or community.

2 *Strengths have been identified but require strength-building efforts before they can be effectively utilized as part of a plan. Identified but not useful.*

Family has expressed some interest in spiritual or religious belief and practices and may have little contact with religious institutions.

3 *An area in which no current strength is identified; efforts may be recommended to develop a strength in this area.*

There is no evidence of identified spiritual or religious beliefs, nor does the family show any interest in these pursuits at this time.

NATURAL SUPPORTS

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

Questions to Consider

- Who do family members consider to be a support?
- Does the child have non-family members in their life that are positive influences or supports?

Ratings and Descriptions

0 *Well-developed, centerpiece strength; may be used as a centerpiece in an intervention/ action plan.*

Child has significant natural supports that contribute to helping support the child's healthy development.

1 *Identified and useful strength. Strength will be used, maintained or built upon as part of the plan. May require some effort to develop strength into a centerpiece strength.*

Child has identified natural supports that provide some assistance in supporting the child's healthy development.

2 *Strengths have been identified but require strength-building efforts before they can be effectively utilized as part of a plan. Identified but not useful.*

Child has some identified natural supports, however, these supports are not actively contributing to the child's healthy development.

3 *An area in which no current strength is identified; efforts may be recommended to develop a strength in this area.*

Child has no known natural supports (outside of family and paid caregivers).

RESILENCY (PERSISTENCE AND ADAPTABILITY)

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

Questions to Consider

- Does child show ability to hang in there even when frustrated by a challenging task?
- Does child routinely require adult support in trying a new skill/activity?
- Can child easily and willingly transition between activities?
- What type of support does the child require to adapt to changes in schedules?

Ratings and Descriptions

0 *Well-developed, centerpiece strength; may be used as a centerpiece in an intervention/ action plan.*

The child consistently has a strong ability to adjust to changes and transitions and continues an activity when challenged or meeting obstacles. This supports further growth and development and can be incorporated into a service plan as a centerpiece strength.

1 *Identified and useful strength. Strength will be used, maintained or built upon as part of the plan. May require some effort to develop strength into a centerpiece strength.*

The child has some ability to continue an activity that is challenging. An ambulatory child who does not walk to interesting objects, but who will actively explore them when presented to them, would be rated here. The child demonstrates a level of adaptability and ability to continue in an activity that is challenging. The child could benefit from further development in this area before it is considered a significant strength.

2 *Strengths have been identified but require strength-building efforts before they can be effectively utilized as part of a plan. Identified but not useful.*

The child has limited ability to continue a challenging task with primary support from caregivers.

3 *An area in which no current strength is identified; efforts may be recommended to develop a strength in this area.*

The child has difficulty coping with challenges and this places their development at risk. Child may seem frightened of new information, changes or environments.

SELF-ESTEEM/SELF-CONFIDENCE

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

Questions to Consider:

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

Ratings and Descriptions

NA Child is not a toddler or a school aged child.

0 *Well-developed, centerpiece strength; may be used as a centerpiece in an intervention/ action plan.*

The child consistently demonstrates a significant level of self-esteem/self-confidence. This self-confidence consistently supports the child in their development and functioning.

1 *Identified and useful strength. Strength will be used, maintained or built upon as part of the plan. May require some effort to develop strength into a centerpiece strength.*

The child demonstrates self-esteem/self-confidence that is of benefit to the child. This area could be further developed to consider it a centerpiece strength.

2 *Strengths have been identified but require strength-building efforts before they can be effectively utilized as part of a plan. Identified by not useful.*

The child shows self-esteem/self-confidence when supported by caregivers.

3 *An area in which no current strength is identified; efforts may be recommended to develop a strength in this area.*

The child does not demonstrate self-esteem/self-confidence.

LIFE FUNCTIONING DOMAIN

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

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

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

0 No evidence of any needs; no need for action.

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

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

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

INTELLECTUAL/DEVELOPMENTAL (IQ)*

This item describes the child's development as compared to standard developmental milestones, as well as rates the presence of any developmental or intellectual disabilities or delays. It includes Intellectual Developmental Disorder (IDD) and Autism Spectrum Disorders.

Questions to Consider:

- Does the child demonstrate age-appropriate feeding, grooming, toileting and other self-care tasks?

Ratings and Descriptions

0 *No evidence of any needs; no need for action.*

No evidence of developmental delay and/or child has no developmental problems or intellectual disability.

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

There are concerns about possible developmental delay. Child may have low IQ, a documented delay, or documented borderline intellectual disability (i.e., FSIQ 70-85). Mild deficits in adaptive functioning or development are indicated.

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

Child has mild developmental delays (e.g., deficits in social functioning, inflexibility of behavior causing functional problems in one or more settings) and/or mild to moderate Intellectual Disability/Intellectual Disability Disorder. (If available, FSIQ 55-69.) IDD impacts communication, social functioning, daily living skills, judgment, and/or risk of manipulation by others.

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

Child has severe to profound intellectual disability (FSIQ, if available, less than 55) and/or Autism Spectrum Disorder with marked to profound deficits in adaptive functioning in one or more areas: communication, social functioning and self-care across multiple environments.

A rating of '1,' '2' or '3' on this item triggers the Intellectual/Developmental Module.

INTELLECTUAL/DEVELOPMENTAL MODULE

Complete this section if the Intellectual/Developmental item (above) is rated '1', '2' or '3.'

For the **Intellectual/Developmental Module**, use the following categories and action levels:

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

COGNITIVE

This item rates any needs related to the cognitive or intellectual functioning of the child. Cognitive functions include child understanding and awareness of the world around them and the ability of young children to learn, think and remember.

Questions to Consider

- Does the caregiver have any concerns about the child's ability to learn?
- How does the child do with "picking up" routines and recognizing familiar people?

Ratings and Descriptions

0	The child has no apparent cognitive delays.
1	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	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	Child has significant delays in cognitive functioning that are seriously interfering with their functioning. Child is completely reliant on caregiver to function.

Supplemental Information: This area of development is important to assess due to its impact on all other areas of development. A child that is impaired in their cognitive functioning will demonstrate limitations in other areas of development especially their language development and self-help skills. This is an area in which early intervention is critical.

Assessment of Cognitive Functioning in early childhood: The following table presents a list of developmental milestones for functioning (ZTT, 2016). It is important to remember that the following table lists just some examples of general developmental milestones. While milestones can provide a general range of time when certain aspects of development may occur, every child develops at their own unique pace.

In addition, the range of "normal development" is highly influenced by family and community culture. Some items in the table below may not be appropriate markers of normal development in every family or community, and it may be helpful to create cultural adaptations of specific milestones, depending on the cultural context. For example, an item that addresses the child's ability to feed themselves with a fork may not be relevant in cultures in which chopsticks are the primary eating utensil. An obvious substitution for some families may be chopsticks; however, children may not master this skill until later than eating with a spoon because families may not encourage children to feed themselves until they are older and eating with chopsticks may require more advanced fine motor and cognitive skills than eating with a spoon (ASQ, 2014). [continues]

DEVELOPMENTAL/COGNITIVE DELAY: Supplemental Information continued

By 3 Months	• Follows people and objects with eyes • Loses interest or protests if activity does not change
By 6 Months	• Tracks moving objects with eyes from side to side • Experiments with cause and effect (e.g., bangs spoon on table) • Smiles and vocalizes in response to own face in mirror image • Recognizes familiar people and things at a distance • Demonstrates anticipation of certain routine activities (e.g., shows excitement in anticipation of being fed)
By 9 Months	• Mouths or bangs objects • Tries to get objects that are out of reach • Looks for things they see others hide (e.g., toy under a blanket)
By 12 Months	• Watches the path of something as it falls • Has favorite objects (e.g., toys, blanket) • Explores objects and how they work in multiple ways (e.g., mouthing, touching, dropping) • Fills and dumps containers • Plays with two objects at the same time
By 15 Months	• Imitates complex gestures (e.g., signing) • Finds hidden objects easily • Uses objects for their intended purpose (e.g., drinks from a cup, smooths hair with a brush)
By 18 months	• Enacts play sequences with objects according to their use (e.g., pushing a dump truck and emptying its cargo) • Shows interest in a doll or stuffed animal • Points to at least one body part • Points to self when asked • Plays simple pretend games (e.g., feeding a doll) • Scribbles with crayon, marker, and so forth • Turns pages of book • Recognizes self in mirror
By 2 Years	• Finds things even when hidden under two or three covers or when hidden in one place and moved to another • Begins to sort shapes and colors • Completes sentences and rhymes from familiar books, stories, and songs • Plays simple make-believe games (e.g., pretend meal) • Builds towers of four or more blocks • Follows two-step instructions (e.g., "Pick up your shoes and put them in the closet")
By 3 Years	• Labels some colors correctly • Plays thematic make-believe with objects, animals, and people • Answers simple "Why" questions (e.g., "Why do we need a coat when it's cold outside?") • Shows awareness of skill limitations • Understands "bigger" and "smaller" • Understands concept of "two" • Enacts complex behavioral routines observed in daily life of caregivers, siblings, and peers • Solves simple problems (e.g., obtains a desired object by opening a container) • Attends to a story for 5 minutes • Plays independently for 5 minutes
By 4 Years	• Names several colors and some numbers • Counts to five • Has rudimentary understanding of time • Shares past experiences • Remembers part of a story • Engages in make-believe play with capacity to build and elaborate on play themes • Connects actions and emotions • Responds to questions that require understanding of "same" and "different" • Draws a person with two to four body parts • Understands that actions can influence others' emotions (e.g., tries to make others laugh by telling a joke) [continues]

DEVELOPMENTAL/COGNITIVE DELAY continued

By 4 Years	• Waits for turn in simple game • Plays board or card games with simple rules • Describes what is going to happen next in a book • Talks about right and wrong
By 5 Years	• Counts to 10 or more things • Tells stories with beginning, middle, and end • Draws a person with at least six body parts • Acknowledges own mistakes or misbehaviors and can apologize • Distinguishes fantasy from reality most of the time • Names four colors correctly • Follows rules in simple games • Knows functions of every day household objects (e.g., money, cooking utensils) • Attends to group activity for 15 minutes (e.g., circle time, storytelling)

FOR REFERENCE TO DC 0-5 (ZTT, 2016) IF APPLICABLE

Axis I

A rating of '2' or '3' may be consistent with symptoms of **Global Developmental Delay (GDD)**, if similar levels of functioning are present across developmental domains, including motor, language/communication, social-relational, and adaptive functioning/self-care.

Axis V

The CANS Action Levels for the Developmental/Cognitive Delay item rating can be cross walked with the DC 0-5 Axis V – Cognitive competency domain (see crosswalk below).

DC 0-5 Competency Domain Rating	CANS Category Action Level
Exceeds developmental expectations	0 – No evidence of any needs; no need for action.
Functions at age-appropriate level	
Competencies are inconsistently present or emerging	1 – Identified need that requires monitoring, watchful waiting, or preventive action based on history, suspicion, or disagreement
Not meeting developmental expectations (delay or deviance)	2 – Action is required to ensure that the identified need is addressed; need is interfering with functioning
	3 – Need is dangerous or disabling; requires immediate and/or intensive action.

COMMUNICATION

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

Questions to Consider:

- How does child let others know what they want or need?
- Does the child show others that they understand what is being said to them?
- Does anyone have concerns in this area?

Ratings and Descriptions

0	No evidence of receptive or expressive language problems.
1	There is either a history of receptive or expressive language problems or slow development in either or both areas.
2	The child has delays in either or both receptive or expressive language development.
3	The child exhibits has significant challenges in either receptive or expressive language development.

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

Assessing communication development in early childhood: The following table presents a list of developmental milestones for communication (ZTT, 2016). It is important to remember that the following table lists just some examples of general developmental milestones. While milestones can provide a general range of time when certain aspects of development may occur, every child develops at their own unique pace.

In addition, the range of "normal development" is highly influenced by family and community culture. Some items in the table below may not be appropriate markers of normal development in every family or community, and it may be helpful to create cultural adaptations of specific milestones, depending on the cultural context. For example, an item that addresses the child's ability to feed themselves with a fork may not be relevant in cultures in which chopsticks are the primary eating utensil. An obvious substitution for some families may be chopsticks; however, children may not master this skill until later than eating with a spoon because families may not encourage children to feed themselves until they are older and eating with chopsticks may require more advanced fine motor and cognitive skills than eating with a spoon (ASQ, 2014).

By 3 Months	• Follows sounds (e.g., turning head in response to sound) • Coos and gurgles
By 6 Months	• Copies sounds • Vocalizes excitement and displeasure (e.g., laughs and coos) • Produces distinct cries to show hunger, pain, and being tired
By 9 Months	• Responds to sounds by making sounds or moving body • Imitates speech sounds when prompted • Begins to use non-crying sounds (speech sounds) to get and keep attention • Strings vowels together when babbling (*ah*, *eh*, *oh*) • Makes sounds to show joy or displeasure • Begins to use gestures to communicate wants and needs (e.g., reaches to be picked up) • Follows some routine commands when paired with gestures • Shows understanding of commonly used words [continues]

COMMUNICATION continued	
By 12 Months	• Understands “no” • Responds to own name • Looks in response to “where” questions (e.g., “Where is the doggie?”) • Makes different consonant sounds such as *mamama* and *bababa* • Points to nearby objects • Imitates conventional gestures (e.g., waving bye-bye, clapping) • Responds to simple directives accompanied by gestures such as “Come here” • Has a few words (e.g., “mama,” “dada,” “hi,” “bye-bye,” or “dog”
By 15 Months	• Uses simple gestures such as shaking head “no” or waving “bye” • Responds to gestures of others • Makes sounds with changes in tone (sounds more like speech) • Uses complex communication skills integrating gestures, vocalizations, and eye contact (e.g., looking to parent while taking their hand to bring them a desired toy) • Identifies correct picture or object when it is named • Follows simple requests (e.g., “Pick up the toy” or “Roll the ball”)
By 18 months	• Uses at least 20 words or word approximations such as baba for ball • Shows consistent increases in vocabulary each month • Says and shakes head “no” • Can follow one-step verbal commands without any gestures (e.g., sits down when you say “sit down”) • Combines words, gestures, and eye contact to communicate feelings and requests
By 2 Years	• Enjoys being read to • Names actions • Knows names of familiar people and many body parts • Uses two words together (e.g., “More cookie” or “Dada, bye-bye?”) • Repeats words heard in conversation • Names objects in picture books (e.g., cat, bird, ball, or dog) • Imitates animal sounds such as “meow,” “woof,” “baa,” and “moo” • Uses some self-referential pronouns such as “mine”
By 3 Years	• Clearly uses k, g, f, t, d, and n sounds • Builds logical bridges between ideas using words such as “but” and “because” • Asks questions using words such as “why?” or “how?” • Says first name when asked • Names most familiar objects • Understands words such as “in,” “on,” and “under” • Knows own identifying information (e.g., name, age) • Identifies peers by name • Uses some plurals (e.g., “cars,” dogs,” “cats”) • Uses labels “mine,” “I,” “you,” “me,” “theirs” accurately • Speaks well enough for familiar listeners to understand most of the time • Carries on conversation using two or three sentences • Uses sentences that are at least three to four words [continues]

COMMUNICATION continued	
By 4 Years	• Relates experience from school or outside home • Describes events or things using four or more sentences at a time • Identifies rhyming words such as “cat-hat” or “ping-ring” • Recognizes and understands basic rules of grammar (e.g., plurals, tense) • Sings a song or says a poem from memory (e.g., “Itsy Bitsy Spider,” “Wheels on the Bus”) • Tells stories • Says first and last name when asked • Uses words or adjectives to describe or talk about themselves • Understands, uses, and respond to questions of “how” or “when” • Uses words to talk about time • Speech is generally understood by non-family members
By 5 Years	• Makes all speech sounds. May make mistakes on more difficult sounds such as *ch*, *sh*, *th*, l, v, and z • Understands words denoting order such as “first,” “second,” “third,” “next,” and “last” • Uses “today,” “yesterday,” “tomorrow,” “last week,” and “before” correctly • Discriminates rhyming and non-rhyming words • Recognizes words with same beginning sound • Identifies individual sounds within words (e.g., “dog”: d-o-g) • Tells a simple story using full sentences • Uses future tense (“Gramma will be here”) • Says full name and address

FOR REFERENCE TO DC 0-5 (ZTT, 2016) IF APPLICABLE

Axis I

- A rating of ‘2’ or ‘3’’ may correspond with a diagnosis of **Developmental Language Disorder (DCD).**
- A rating of ‘2’ or ‘3’ may correspond with symptoms of **Global Developmental Delay (GDD)**, if similar levels of functioning are present across developmental domains, including motor, cognitive, social-relational, and adaptive functioning/self-care.
- Children who are able to speak and do not present with any global difficulties with expression or comprehension, but consistently fail to speak in social situations may meet the criteria for diagnosis of **Selective Mutism** *(see Anxiety item).*

Axis V

The CANS Action Level on the Communication, Comprehension and Expression item rating can be cross walked with the DC 0-5 Axis V – Language & Communication competency domain rating, at clinician’s discretion (see crosswalk below).

DC 0-5 Competency Domain Rating	CANS Category Action Level
Exceeds developmental expectations	0 - No evidence of any needs; no need for action.
Functions at age-appropriate level	
Competencies are inconsistently present or emerging	1 - Identified need that requires monitoring, watchful waiting, or preventive action based on history, suspicion or disagreement
Not meeting developmental expectations (delay or deviance)	2 - Action is required to ensure that the identified need is addressed; need is interfering with functioning
	3 - Need is dangerous or disabling; requires immediate and/or intensive action.

SELF-CARE/DAILY LIVING SKILLS

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

Questions to Consider:

- Does the child demonstrate age appropriate feeding, grooming, toileting and other self-care tasks?

Ratings and Descriptions

0	No evidence of problems with self-care/daily living skills.
1	There is either a history of self-care/daily living skill problems, or slow development in this area.
2	The child does not meet developmental milestones related to self-care/daily living skills and experiences problems in functioning in this area.
3	The child has significant challenges in self-care/daily living and is in need of intensive or immediate help in this area.

Supplemental Information: Self-care refers to several tasks that reflect a child's growing ability to take care of their own physical needs and to become responsible for dressing, doing household chores, eating, toileting, and preparing for sleeping. In some fields, self-care skills may be referred to as adaptive skills or activities of daily living (ADLs). Self-care is often reflective of cognitive and motor abilities, as well as temperament and sensory processing. Self-care skills are important to assess and monitor due to the limitations that this places on children when they may not develop at a normative pace. Children are at times excluded from some environments if skills in this area are not present. This area, if underdeveloped, can causes challenges in parenting that are often overwhelming. However, it is important to remember that, like all areas of child development, perspectives on the healthy development of self-care skills are largely informed by family and community culture; milestones of "normal" self-care in one culture will not be the same across all cultures (Bornstein, 2015).

Assessing Self-Care and daily functioning in early childhood: The following table presents a list of developmental milestones for self-care and daily functioning (CSLOT). It is important to remember that the following table lists just some examples of general developmental milestones. While milestones can provide a general range of time when certain aspects of development may occur, every child develops at their own unique pace.

In addition, the range of "normal development" is highly influenced by family and community culture. Some items in the table below may not be appropriate markers of normal development in every family or community, and it may be helpful to create cultural adaptations of specific milestones, depending on the cultural context. For example, an item that addresses the child's ability to feed themselves with a fork may not be relevant in cultures in which chopsticks are the primary eating utensil. An obvious substitution for some families may be chopsticks; however, children may not master this skill until later than eating with a spoon because families may not encourage children to feed themselves until they are older and eating with chopsticks may require more advanced fine motor and cognitive skills than eating with a spoon (ASQ, 2014).

Developmental Milestones for Self-Care and Daily Functioning (CSLOT)

12 months	• Cooperates with dressing by holding out arms and legs. • Finger feeds small pieces of food and begins to drink from sippy cup. • Indicates discomfort when wet or soiled, has regular bowel movements, and will sit on toilet supervised.
24 months	• Removes unfastened coats and shirts, socks, shoes, and pulled down pants; unbuttons large buttons. • Able to spoon feed, drinks from a straw, and begins to drink from an open cup independently. • Toilet regulated by an adult and may need help getting on the toilet. • Washes hands and brushes teeth with assistance.
36 months	• Dresses with assistance to orient clothing; pulls down pants independently; unzips separating zippers; buttons large buttons; uses snaps on the front of clothing; unbuckles shoes or belts. • Begins to stab food with fork. • Goes to the bathroom independently but may need assistance to wipe and fasten clothing. • Washes hands independently and begins to wash face.
48 months	• Undresses independently; orients clothes; laces shoes; buckles shoes and belts; puts belts through loops; zips separating zippers. • Washes face and brushes teeth independently; begins to comb and brush hair; bathes with assistance.
60 months	• Dresses unsupervised and learns to tie and untie knots. • Begins using a knife to cut food. • Completely independent with toileting. • Combs and brushes hair independently.

SELF-CARE/DAILY LIVING SKILLS continued

FOR REFERENCE TO DC 0-5 (ZTT, 2016) IF APPLICABLE

Axis I

- A rating of '2' or '3' related to problems with motor coordination may be consistent with a diagnosis of **Developmental Coordination Disorder (DCD)**.
- A rating of '2' or '3' may be consistent with symptoms of **Global Developmental Delay (GDD)**, if similar levels of functioning are present across developmental domains, including cognitive, motor, language/communication, and social-relational.

End of Intellectual/Developmental Module

MEDICAL/PHYSICAL*

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

Questions to Consider

- Is the child generally healthy?
- Does the child have any medical problems?
- How much does the health or medical issue this interfere with the child's life?

Ratings and Descriptions

0 *No evidence of any needs; no need for action.*
No evidence that the child has any medical or physical problems, and/or they are healthy.

1 *Identified need that requires monitoring, watchful waiting, or preventive action based on history, suspicion or disagreement.*
Child has mild, transient or well-managed physical or medical problems. These include well-managed chronic conditions like juvenile diabetes or asthma.

2 *Action is required to ensure that the identified need is addressed; need is interfering with functioning.*
Child has serious medical or physical problems that require medical treatment or intervention. Or child has a chronic illness or a physical challenge that requires ongoing medical intervention.

3 *Need is dangerous or disabling; requires immediate and/or intensive action.*
Child has life-threatening illness or medical/physical condition. Immediate and/or intense action should be taken due to imminent danger to child's safety, health, and/or development.

A rating of '1,' '2' or '3' on this item triggers the Medical/Physical Module.

Supplemental Information: Most transient, treatable conditions would be rated as a '1.' Most chronic conditions (e.g., diabetes, severe asthma, HIV) would be rated a '2.' The rating '3' is reserved for life threatening medical conditions. If a child is experiencing any medical conditions, obtaining information regarding the impact to the child and the impact to the caregiver in monitoring and treating this condition are both needed to make the assessment of how to rate this item. A child may have a medical condition that is considered a chronic condition, but this is managed well by the child and family and therefore not causing problems in their functioning. A child's nutritional and physical condition should be considered in this rating as well. A child may not have a medical condition but appears tired, reports feeling badly or misses school frequently.

FOR REFERENCE TO DC 0-5 (ZTT, 2016) IF APPLICABLE

Axis III: Information gathered as part of assessing the Medical/Physical item may be included as part of Axis III: Physical Health Conditions & Considerations.

MEDICAL/PHYSICAL MODULE

Complete this section if the Medical/Physical item (above) is rated '1', '2'' or '3'.

For the **Medical/Physical Module**, use the following categories and action levels:

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

PRIMARY CARE PHYSICIAN (PCP) CONNECTED

This item focuses on whether the child is connected to a primary care physician.

Questions to Consider	Ratings and Descriptions	
• Is the child connected to a primary care physician? • When was the last time the child saw their PCP?	0	Child has a PCP and has been seen by the provider in the past 180 days.
	1	Child has a PCP but has not been seen by the provider in over 180 days.
	2	Child has a PCP but does not know the doctor's name nor when they were last seen.
	3	Child does not have a PCP.

End of Medical/Physical Module

SENSORY

This item rates the child's ability to use the senses of sound, sight, touch, taste and smell.

Questions to Consider:

- Has anyone noticed a problem with child's vision or hearing?
- Has the child had an occupational therapy evaluation or services?
- Are there any problems with eating or dressing that might indicate a sensory delay?

Ratings and Descriptions

0	*No evidence of any needs; no need for action.* Child's hearing, sight, sense of touch, taste and smell are functioning and developing normally.
1	*Identified need that requires monitoring, watchful waiting, or preventive action based on history, suspicion or disagreement.* Child has impairment on a single sense (e.g., mild hearing deficits, correctable vision problems).
2	*Action is required to ensure that the identified need is addressed; need is interfering with functioning.* Child has an impairment that impacts their functioning in at least one life domain, e.g., moderate impairment on a single sense or mild impairment on multiple senses.
3	*Need is dangerous or disabling; requires immediate and/or intensive action.* Child has significant impairment in one or more senses (e.g., profound hearing or vision loss) that could be dangerous or debilitating without intervention.

Supplemental Information: Sensory processing refers to taking in information through the senses. All children have neurological processes that help them organize the information coming in from their environment along with sensations from their bodies. A child's ability to use this information to respond appropriately to the environment—including sounds, lights, textures, motion, and gravity—is known as sensory integration. Children differ in their ability to process and respond to information from the environment while engaging in activities. For example, one child may have difficulty sitting still during group time; another may move little during free play outside. They react in different ways because they integrate the information obtained through their senses from the environment differently. Most children process their daily experiences and regulate their responses with ease. But when a child is consistently having difficulty maintaining a level emotional state or engaging appropriately in activities, the child may be having difficulties with sensory processing or integration (Thompson & Raisor, 2013).

Assessing sensory responses in early childhood (ZTT, 2016):

- ***Over-Responsivity***: intense emotional or behavioral responses when exposed to stimuli that evoke sensation (disproportionate to intensity of stimulus) and/or avoidance of contact with routine sensory stimuli
- ***Under-Responsivity***: muted behavioral or emotional response to intense stimuli and/or unresponsiveness to routine sensory stimuli expected to provoke a strong response (e.g., lack of response even when injured)
- ***Atypical Responsivity*****:** atypical response to stimuli that may be characterized by extended sensory exploration of stimuli that is not typically observed (e.g., licking walls or doorknobs)

FOR REFERENCE TO DC 0-5 (ZTT, 2016) IF APPLICABLE

Axis I

- A rating of '2' or '3' related to *over*, *under*, and/or *atypical responsivity* may be consistent with symptoms of **Autism Spectrum Disorder (ASD)** or **Early Atypical Autism Spectrum Disorder (EAASD).**
- For children <u>WITHOUT</u> a diagnosis of ASD or EAASD, a rating or '2' or '3' related to *over-responsivity* may be consistent with a diagnosis of **Sensory Over-Responsivity Disorder**, and a Sensory rating of 2 or 3 resulting from *under-responsivity* may be consistent with a diagnosis of **Sensory Under-Responsivity Disorder.**

FAMILY FUNCTIONING

This item rates the child's relationships with those who are in their family. The description of family should come from the child's perspective (i.e., who the child describes as their family). In the absence of this information, consider biological and adoptive relatives and their significant others with whom the child is still in contact. For children involved with child welfare, family refers to the person(s) fulfilling the permanency plan. When rating this item, take into account the relationships and interactions the child has with their family, and the relationship of the family as a whole.

Questions to Consider

- How does the child get along with siblings or other children in the household?
- How does the child get along with parents or other adults in the household?
- Is the child particularly close to one or more members of the family?

Ratings and Descriptions

0 *No evidence of any needs; no need for action.*

No evidence of problems in relationships with family members, and/or child is doing well in relationships with family members.

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

History or suspicion of problems, and/or child is doing adequately in relationships with family members, although some problems may exist. For example, some family members may have problems in their relationships. Relationship stress may be common but does not result in major problems.

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

Child's problems with parents, siblings and/or other family members are impacting their functioning. Frequent relationship stress, difficulty maintaining positive relationships may be observed.

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

Child's problems with parents, siblings, and/or other family members are debilitating, placing them at risk. This would include problems of domestic violence, absence of any positive relationships, etc.

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

The stability, predictability, and emotional quality of relationships among family members for a child are important predictors of the child's functioning. Children develop important relationships not only with their primary caregivers, but also with other family members who may either participate in a co-parenting relationship or may impact the primary caregivers' quality of functioning. Infants/young children are keen observers of how adults who are central in their lives relate to one another and to other people, including other children in the family or people outside the family. They often learn by imitation, adopting the behaviors they observe. The affective tone and adult interactions they witness in turn influence the infant/young child's emotional regulation, trust in relationships, and freedom to explore (ZTT, 2016).

Assessing Family & Caregiving Functioning in early childhood: Key dimensions of family and caregiving functioning may include (ZTT, 2016):

- Problem solving
- Conflict resolution
- Role allocation
- Communication
- Emotional investment
- Behavioral regulation & coordination
- Sibling harmony [continues]

FAMILY FUNCTIONING continued

FOR REFERENCE TO DC 0-5 (ZTT, 2016) IF APPLICABLE

Axis II: The Axis II – Caregiving Environment level can be cross walked with the CANS Action Levels for the Family item, at the clinician's discretion (see crosswalk below).

DC 0-5 Axis II - Caregiving Environment	CANS Category/Action Level
Level 1: Well-Adapted to Good-Enough	0 - No evidence of any needs; no need for action.
Level 2: Strained to Concerning	1 - Identified need that requires monitoring, watchful waiting, or preventive action based on history, suspicion or disagreement.
Level 3: Compromised to Disturbed	2 - Action is required to ensure that the identified need is addressed; need is interfering with functioning.
Level 4: Disordered to Dangerous	3 - Need is dangerous or disabling; requires immediate and/or intensive action.

Axis IV: Specific aspects of the Family item construct may be included as part of Axis IV – Psychosocial Risk Factors, including but not limited to: domestic violence, abuse or neglect, parent or caregiver discord or conflict, severe discord or violence by sibling, unpredictable home environment, and/or unstable family constellation.

SOCIAL AND EMOTIONAL FUNCTIONING

This item rates the child's social and relationship functioning. This includes age-appropriate behavior and the ability to engage and interact with others. When rating this item, consider the child's level of development.

Questions to Consider

- How does the child get along with others?
- Can an infant engage with and respond to adults? Can a toddler interact positively with peers?
- Does the child interact with others in an age-appropriate manner?

Ratings and Descriptions

0 *No evidence of any needs; no need for action.*

No evidence of problems with social functioning; child has positive social relationships.

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

Child is having some problems in social relationships. Infants may be slow to respond to adults, toddlers may need support to interact with peers and preschoolers may resist social situations.

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

Child is having problems with their social relationships. Infants may be unresponsive to adults, and unaware of other infants. Toddlers may be aggressive and resist parallel play. Preschoolers may argue excessively with adults and peers and lack ability to play in groups even with adult support.

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

Child is experiencing disruptions in their social relationships. Infants show no ability to interact in a meaningful manner. Toddlers are excessively withdrawn and unable to relate to familiar adults. Preschoolers show no joy or sustained interaction with peers or adults, and/or aggression may be putting others at risk.

Supplemental Information: The following table presents a list of developmental milestones for social functioning (ZTT, 2016). It is important to remember that the following table lists just some examples of general developmental milestones. While milestones can provide a general range of time when certain aspects of development may occur, every child develops at their own unique pace.

In addition, the range of "normal development" is highly influenced by family and community culture. Some items in the table below may not be appropriate markers of normal development in every family or community, and it may be helpful to create cultural adaptations of specific milestones, depending on the cultural context. For example, an item that addresses the child's ability to feed themselves with a fork may not be relevant in cultures in which chopsticks are the primary eating utensil. An obvious substitution for some families may be chopsticks; however, children may not master this skill until later than eating with a spoon because families may not encourage children to feed themselves until they are older and eating with chopsticks may require more advanced fine motor and cognitive skills than eating with a spoon (ASQ, 2014). [continues]

SOCIAL AND EMOTIONAL FUNCTIONING continued	
Social Functioning Developmental Milestones	
By 3 Months	• Smiles responsively (i.e., social smile) • Imitates simple facial expressions (e.g., smiling, sticking tongue out) • Looks at caregiver's face • Coos responsively • Localizes to familiar voices and sounds • Shows interest in facial expressions • Is comforted by proximity of caregiver
By 6 Months	• Imitates some movements and facial expressions (e.g., smiling, frowning) • Engages in socially reciprocal interactions (e.g., playing simple back-and-forth games) • Seeks social engagement with vocalizations, emotional expressions, or physical contact • Watches face closely • Responds to affection with smiling, cooing, or settling • Recovers from distress when comforted by caregiver
By 9 months	• Distinguishes between familiar and unfamiliar voices • Shows some stranger wariness • Demonstrates preference for caregivers • Protests separation from caregiver • Enjoys extended play with others • Engages in back-and-forth, two-way communication using vocalizations and eye movement • Mimics other's simple gestures • Follows other's gaze and pointing
By 12 months	• Looks to caregiver for information about new situations and environments • Looks to caregiver to share emotional experiences • Responds to other people's emotions (e.g., displays somber, serious face in response to sadness in parent, smiles when parent laughs) • Offers object to imitated interaction (e.g., hands caregiver a book to hear a story) • Plays interactive games (e.g., peek-a-boo, patty-cake) • Looks at familiar people when they are named • Gives object to seek help (e.g., hands shoe to parent) • Extends arm or leg to assist with dressing
By 15 months	• Seeks and enjoys attention from others, especially caregivers • Shows affection with kisses (without pursed lips) • Demonstrates cautious or fearful behavior such as clinging to or hiding behind caregiver • Engages in parallel play with peers • Presents a book or toy when they want to hear a story or play • Repeats sounds or actions to get attention • Enjoys looking at picture books with caregiver • Initiates joint attention (e.g., points to show something interesting or to get others' attention)
By 18 months	• Shares humor with peers or adults (e.g., laughs at and makes funny faces or nonsense rhymes) • Likes to hand things to others during play • Engages in reciprocal displays of affection (e.g., hugs or kisses with a pucker) • Asserts autonomy (e.g., "Me do") • Reacts with concern when someone appears hurt • Leaves caregiver's side to explore nearby objects or settings • Engages in teasing behavior such as looking at caregiver and doing something "forbidden" • When pointing, looks back at caregiver to confirm joint attention [continues]

SOCIAL AND EMOTIONAL FUNCTIONING continued

Social Functioning Developmental Milestones

By 24 months	• Exhibits empathy (e.g., offers comfort when someone is hurt) • Attempts to exert independence frequently • Imitates others' complex actions, especially adults and older children (e.g., putting plates on a table, posture, gesture) • Enjoys being with other young children • Takes pride and pleasure in accomplishments • Primarily plays in proximity to young children; notices and imitates other young children's play • Responds to being corrected or praised
By 36 months	• Expresses affection openly and verbally • Shows affection to peers without prompting • Shares without prompts • Can wait turn in playing games • Shows concern for crying peers by taking action • Engages in associate play with peers (e.g., participate in similar activities without formal organization but with some interaction) • Shares accomplishments with others • Helps with simple household chores
By 48 months	• Pretends to play "Mom" or "Dad" or other relevant caregivers • Asks about or talks about caregiver when separated • Engages in cooperative play with other young children • Has a preferred friend • Expresses interests, likes, and dislikes
By 60 months	• Shows increased confidence associated with greater independence and autonomy • Wants to please friends • Emulates role models, real and imaginary • Values rules in social interactions • Participates in group activities that require assuming roles (e.g., Follow the Leader) • Modulates or modifies voice correctly depending on situation or listener (adult, another child, younger child)

FOR REFERENCE TO DC 0-5 (ZTT, 2016) IF APPLICABLE

Axis I

- Following a traumatic experience, a rating of '2' or '3' that represents a negative change in typical social functioning (e.g., decreased interest in social interactions) may be consistent with symptoms of **PTSD** *(see Adjustment to Trauma item)*.
- A rating of ''2 or '3' may be consistent with social-communication symptoms of **Autism Spectrum Disorder (ASD)** and **Early Atypical Autism Spectrum Disorder (EAASD)**. DC 0-5 specifies three social-communication symptoms, including:
    - Limited or atypical social-emotional responsivity, sustained social attention, or social reciprocity
    - Deficits in nonverbal social-communication behaviors
    - Peer interaction difficulties

Axis I

- A rating of '2' or '3' related to demonstration of fear/anxiety-based social functioning issues (freezing, withdrawing, hiding, avoiding, refusing to speak) in situations with unfamiliar people may be consistent with symptom of various anxiety disorders, including **Social Anxiety Disorder**, **Selective Mutism**, and **Inhibition to Novelty Disorder** *(see Anxiety item).*
- For children who have experienced severe social neglect and/or institutionalized care, a rating of '3' related to withdrawn, inhibited behavior with adult caregivers (e.g., absent or significantly reduced interest in interacting, reduced response to comfort) may be consistent with symptoms of **Reactive Attachment Disorder (RAD)**. This disorder is extremely rare and is usually not reported in community settings *(see Attachment item).*

Axis V: The DC 0-5 Axis V – Social-Relational competency domain rating can be cross walked with the CANS Action Levels for the Social Functioning item rating (see crosswalk below). [continues]

SOCIAL AND EMOTIONAL FUNCTIONING continued

DC 0-5 Competency Domain Rating	CANS Category Action Level
Exceeds developmental expectations	0 – No evidence of any needs; no need for action.
Functions at age-appropriate level	
Competencies are inconsistently present or emerging	1 – Identified need that requires monitoring, watchful waiting, or preventive action based on history, suspicion or disagreement
Not meeting developmental expectations (delay or deviance)	2 – Action is required to ensure that the identified need is addressed; need is interfering with functioning
	3 – Need is dangerous or disabling; requires immediate and/or intensive action.

SLEEP

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

Questions to Consider

- Does the child appear rested?
- Is the child often sleepy during the day?
- Does the child have frequent nightmares or difficulty sleeping?
- How many hours does the child sleep each night?

Ratings and Descriptions

0 *No evidence of any needs; no need for action.*
Child gets a full night's sleep each night.

1 *Identified need that requires monitoring, watchful waiting, or preventive action based on history, suspicion, or disagreement.*
Child has some problems sleeping. Generally, child gets a full night's sleep but at least once a week problems arise. This may include occasionally awakening or bed wetting or having nightmares.

2 *Action is required to ensure that the identified need is addressed; need is interfering with functioning.*
Child is having problems with sleep. Sleep is often disrupted and child seldom obtains a full night of sleep.

3 *Need is dangerous or disabling; requires immediate and/or intensive action.*
Child is generally sleep deprived. Sleeping is almost always difficult and the child is not able to get a full night's sleep.

NA Child is younger than 12 months old.

Supplemental Information Sleep is one of the primary reason families seek intervention. This is often due to the impact that this has on parents/caregivers and siblings. The bed-time routine and actual amount of time spent asleep may be of concern to caregivers. Sleep habits can be influenced by several different factors, including family and community culture, individual temperament, environmental factors, and developmental stage (Grow by WebMD, 2020). Changes in sleep habits are common when young children are growing (physically) or developmentally, such as when they are learning a new skill, like walking or talking (ZTT, ND).

[continues]

SLEEP continued

Age	Typical Sleep Patterns
1-4 Weeks	Newborns typically sleep about 15 to 18 hours a day, but only in short periods of two to four hours. Premature babies may sleep longer, while colicky babies may sleep less. Since newborns do not yet have an internal biological clock, or circadian rhythm, their sleep patterns are not related to the daylight and nighttime cycles. In fact, they tend not to have much of a pattern at all.
1-4 Month	By 6 weeks of age, babies are beginning to settle down a bit, and more regular sleep patterns may emerge. The longest periods of sleep run four to six hours and now tends to occur more regularly in the evening.
4-12 Months	While up to 15 hours is ideal, most infants up to 11 months old get only about 12 hours of sleep. Babies typically have three naps and drop to two at around 6 months old, at which time (or earlier) they are physically capable of sleeping through the night. Establishing regular naps generally happens at the latter part of this time frame, as the biological rhythms mature.
1-3 Years	As children moves past the first year toward 18-21 months of age, they will likely lose their morning and early evening nap and nap only once a day. While toddlers need up to 14 hours a day of sleep, they typically get only about 10. Most children from about 21 to 36 months of age still need one nap a day, which may range from one to three and a half hours long.
3-6 Years	Children at this age typically get 10-12 hours of sleep a day. At age 3, most children are still napping, while at age 5, most are not. Naps gradually become shorter, as well.

Assessing sleep in early childhood: Sleep problems that may present in young children include (ZTT, 2016):

- ***Hyposomnia***: sleeping too much.
- ***Sleep refusal***
- ***Sleep disturbances***, including:
    - *Difficulty falling asleep*: child requires more than 30 minutes to fall asleep.
    - *Night waking*: multiple or prolonged awakenings, accompanied by signaling.
    - *Nightmares*: bad dreams or sudden awakenings with distress that occur most often in the second half of the sleep period. The child may or may not recall or report content.
    - *Sleep terrors*: recurrent episodes of sudden arousals from sleep, although not to a fully awakened state. Episodes are associated with screaming and signs of distress, and usually occur within the first few hours of sleep. Children do not readily respond to efforts to arouse them.
    - *Sleep walking*: episodes of arising from bed and walking around home.

Source: Zero to Three. (2016). DC:0-5: Diagnostic classification of mental health and developmental disorders of infancy and early childhood.

FOR REFERENCE TO DC 0-5 (ZTT, 2016) IF APPLICABLE

Axis I

- Following a stressful or traumatic event (including the permanent loss of a primary caregiver), a rating of '2' or '3' related to sleep refusal and/or sleep disturbances may be consistent with symptoms of **Post-Traumatic Stress Disorder, Adjustment Disorder,** or **Complicated Grief Disorder of Early Childhood** *(see Adjustment to Trauma item).*
- A rating of '2' or '3' related to either hyposomnia and other sleep disturbances may be consistent with symptoms of **Depressive Disorder of Early Childhood** *(see Depression item).*
- A rating of '2' or '3' related to sleep disturbances may be consistent with symptoms of **Generalized Anxiety Disorder** *(see Anxiety item).*
- A rating of '2' or '3' related to sleep refusal specifically without the presence of a caregiver may be consistent with symptoms of **Separation Anxiety Disorder** *(see Attachment item).*
- As part of a larger pattern of pervasive and persistent noncompliance, a rating of '2' or '3' related to sleep refusal may be a symptom of **Disorder of Dysregulated Anger and Aggression of Early Childhood (DDAA)**, or, if expressed only in one caregiving relationship, a **Relationship Specific Disorder.**
- When sleep disturbances are not better explained by other disorders or medical problems and medication side effects, a rating of '2' or '3' related to sleep disturbances may be consistent with a diagnosis of Sleep Disorders, including **Sleep Onset Disorder**, **Night Waking Disorder**, **Partial Arousal Sleep Disorder**, and/or **Nightmare Disorder of Early Childhood**.

PARENT/CHILD INTERACTION

This item rates the way that the parent/child dyad interacts and its impact on the child's growth and development.

Questions to Consider

- How would you describe the child's style in getting the parents' attention?
- What are the activities the parent likes and dislikes to do with their child?
- Does the parent feel as if they have enough enjoyable moments with their child?
- Are there concerns about the way the child relates to their parent?

Ratings and Descriptions

0 *No evidence of any needs; no need for action.*
No evidence of problems with parent/child interaction.

1 *Identified need that requires monitoring, watchful waiting, or preventive action based on history, suspicion or disagreement.*
There is either a history of problems or suboptimal functioning in parent/child interaction. There may be current inconsistent or indications that interaction is not optimal that has not yet resulted in problems.

2 *Action is required to ensure that the identified need is addressed; need is interfering with functioning.*
The parent/child dyad interacts in a way that is problematic and has led to interference with the child's growth and development.

3 *Need is dangerous or disabling; requires immediate and/or intensive action.*
The parent/child dyad is having significant problems that can be characterized as abusive or neglectful.

Supplemental Information: The day-to-day interactions between infants and young children and their parents help drive their emotional, physical, and intellectual development. When parents are sensitive and responsive to children's cues, they contribute to the coordinated back and forth of communication between parent and child. These interactions help children develop a sense of self and emotional regulation skills (e.g., self-calming and self-control skills).

Parents do not have to be perfectly attuned to their child at every moment. When parent and child misunderstand each other's signals, as they will from time to time, there will be a temporary disruption in their interaction. This gives them both a chance to learn how to handle brief moments of distress and to reach out for each other and reconnect again. When misunderstandings become the norm, however, and the child cannot count on a parent's responsiveness, the child's development may be thrown off course.

Parent-child interactions are affected by each child's individual qualities, and by the fit of the child's temperament with the parents. For example, a very active child may be exhausting for any parent, especially one who is already stressed. In addition, positive parent-child interactions may look quite distinct in different families. A wide range of caregiving styles, playful interactions, and emotional responses support healthy child development. Parents' responses to children's cues and behaviors differ. This may depend on their own temperament, personal history, current life situation, and their cultural goals and beliefs (NCPFCE, 2013).

Assessing parent-child relationship in early childhood:

It can be helpful to assess the following aspects of parent-child interactions:

- What emotions are present in the parent and the child during the interaction?
- What sort of verbal and non-verbal communication do the parent and child demonstrate?
- What is the balance of positive to negative interactions?
- What are the typical routines and activities of the parent/child?
- Does the parent-child dyad seem comfortable and interested in one another?
- Do the interactions seem smooth and in sync with one another?
- Do the parent and child respond to each other's cues?
- Is the parent comfortable with the child taking the lead in play?
- Do the parent and child demonstrate nurturing touch and behaviors toward one another?
- How does the child respond to limit setting?
- Does the parent-child dyad demonstrate appropriate boundaries and expectations of one another?
- Does the parent comfort the child when the child is hurt or upset?
- Can the parent accept the child's display of feelings, both positive and negative ones?
- Does the parent support the child in exploration? [continues]

PARENT/CHILD INTERACTION continued

FOR REFERENCE TO DC 0-5 (ZTT, 2016) IF APPLICABLE

Axis II: The CANS Action Levels for the Parent/Child Interaction item rating can be cross walked with the Axis II – Caregiving Relationship level (see crosswalk below).

DC 0-5 Axis II – Caregiving Relationship	**CANS Category/Action Level**
Level 1: Well-Adapted to Good-Enough	0 - No evidence of any needs; no need for action.
Level 2: Strained to Concerning	1 - Identified need that requires monitoring, watchful waiting, or preventive action based on history, suspicion or disagreement.
Level 3: Compromised to Disturbed	2 - Action is required to ensure that the identified need is addressed; need is interfering with functioning.
	3 - Need is dangerous or disabling; requires immediate and/or intensive action.

EARLY EDUCATION

This item rates the child's experiences in educational settings (such as daycare and preschool) and the child's ability to get their needs met in these settings. This item also considers the presence of problems within these environments in terms of attendance, progress, support from the school staff to meet the child's needs, and the child's behavioral response to these environments. ***Children under 5 who are not in any congregate learning settings (Early HeadStart, HeadStart, Preschool, Pre-K) would be rated a '0' here.***

Questions to Consider

- What is the child's experience in preschool/daycare?
- Does the child have difficulties with learning new skills, social relationships or behavior?

Ratings and Descriptions

0 *No evidence of any needs; no need for action.*
No evidence of problem with functioning in current educational environment.

1 *Identified need that requires monitoring, watchful waiting, or preventive action based on history, suspicion or disagreement.*
History or evidence of problems with functioning in current daycare or preschool environment. Child may be enrolled in a special program.

2 *Action is required to ensure that the identified need is addressed; need is interfering with functioning.*
Child is experiencing difficulties maintaining their behavior, attendance, and/or progress in educational setting.

3 *Need is dangerous or disabling; requires immediate and/or intensive action.*
Child's problems with functioning in the daycare or preschool environment place them at immediate risk of being removed from program due to their behaviors, lack of progress, or unmet needs.

Supplemental Information: Infants, toddlers and preschoolers often spend most 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. The same parenting practices and care-giving techniques that are taught to parents need to be promoted within early care/education settings. These experiences are often critical in supporting growth and development and allowing the child to feel positive about relationships with others outside of the home. Early care and education settings have the potential to impact a child's development, school success and overall life success.

The quality of the day care environment is important to consider, as well as the day care's ability to meet the needs of the individual within a larger care-giving context. It is important for infants and children to be supported in ways that appreciates their individual needs and strengths.

Indicators of a high-quality early care/educational setting:

- Infant or child seems comfortable with caregivers and environment
- Environment has sufficient space and materials for child it serves
- Environment offers a variety of experiences and opportunities [continues]

EARLY EDUCATION continued

Indicators of a high-quality early care/educational setting:

- 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

TRANSPORTATION

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

Questions to Consider:

- How does caregiver get their child to their services?
- How often is transportation a problem for caregiver?
- Does the child have any specific transportation needs, such as a special vehicle?

Ratings and Descriptions

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

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

CULTURAL FACTORS – FAMILY DOMAIN

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

Health care disparities are differences in health care quality, affordability, access, utilization and outcomes between groups. Culture in this domain is described broadly to include cultural groups that are racial, ethnic or religious, or are based on age, sexual orientation, gender identity, socio-economic status and/or geography. Literature exploring issues of health care disparity states that race and/or ethnic group membership may be a primary influence on health outcomes.

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

Question to Consider for this Domain: How does the child/family's membership in a particular cultural group impact their stress and well-being?

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

0 No evidence of any needs; no need for action.

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

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

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

LANGUAGE

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

Questions to Consider	Ratings and Descriptions
• What language does the family speak at home? • Does the family have any special needs related to communication (e.g., ESL, ASL, Braille, or assisted technology)?	0 *No evidence of any needs; no need for action.* No evidence that there is a need or preference for an interpreter and/or the child and family speak and read the primary language where the child or family lives. 1 *Identified need that requires monitoring, watchful waiting, or preventive action based on history, suspicion or disagreement.* Child and/or family speak or read the primary language where the child or family lives, but potential communication problems exist because of limited vocabulary or comprehension of the nuances of the language. [continues]

LANGUAGE continued

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

Child and/or significant family members do not speak the primary language where the child or family lives. Translator or family's native language speaker is needed for successful intervention; a qualified individual(s) can be identified within natural supports.

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

Child and/or significant family members do not speak the primary language where the child or family lives. Translator or family's native language speaker is needed for successful intervention; no such individual is available from among natural supports.

For Early Childhood: Please rate the above item from the perspective of the family.

TRADITIONS AND RITUALS

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

Questions to Consider

- What holidays does the family celebrate?
- What traditions are important to the family?
- Does the family fear discrimination for practicing their traditions and rituals?

Ratings and Descriptions

0 *No evidence of any needs; no need for action.*

Child and/or family are consistently able to practice their chosen traditions and rituals consistent with their cultural identity.

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

Child and/or family are generally able to practice their chosen traditions and rituals consistent with their cultural identity; however, they sometimes experience some obstacles to the performance of these practices.

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

Child and/or family experience significant barriers and are sometimes prevented from practicing their chosen traditions and rituals consistent with their cultural identity.

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

Child and/or family are unable to practice their chosen traditions and rituals consistent with their cultural identity.

For Early Childhood: Please rate the above item from the perspective of the family.

CULTURAL STRESS

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

Questions to Consider

- What does the family believe is their reality of discrimination? How do they describe discrimination or oppression?
- Does this impact their functioning as a family?

Ratings and Descriptions

0 *No evidence of any needs; no need for action.*

No evidence of stress between the child's cultural identity and current environment or living situation.

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

Some occasional stress resulting from friction between the child's cultural identity and current environment or living situation.

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

Child is experiencing cultural stress that is causing problems of functioning in at least one life domain. Child needs support to learn how to manage culture stress.

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

Child is experiencing a high level of cultural stress that is making functioning in any life domain difficult under the present circumstances. Child needs immediate plan to reduce culture stress.

For Early Childhood: Please rate the above item from the perspective of the family's cultural stress.

CAREGIVER DOMAIN

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

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

For the **Caregiver Domain**, use the following categories and action levels:

0 No current need; no need for action. This may be a resource for the child.

1 Identified need that requires monitoring, watchful waiting, or preventive action based on history, suspicion or disagreement. This may be an opportunity for resource building.

2 Need is interfering with the provision of care; action is required to ensure that the identified need is addressed.

3 Need prevents the provision of care; requires immediate and/or intensive action.

CARE INTENSITY & ORGANIZATION

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

Questions to Consider:
- What types of services are needed for the child?
- How often does the child receive services, including medication?
- What has to be done to make sure that the child receives the services needed?

Ratings and Descriptions

0 *No current need; no need for action. This may be a resource for the child.*
The child has no behavioral/physical/medical treatment needs that the parent/primary caregiver must manage.

1 *Identified need that requires monitoring, watchful waiting, or preventive action based on history, suspicion or disagreement. This may be an opportunity for resource building.*
Child requires weekly behavioral/physical/medical treatment that the parent/primary caregiver must manage.

2 *Need is interfering with the provision of care; action is required to ensure that the identified need is addressed.*
Child requires daily behavioral/physical/medical treatment that the parent/primary caregiver must manage. This would include ensuring the child takes daily medication.

3 *Need prevents the provision of care; requires immediate and/or intensive action.*
Child requires multiple and complex daily behavioral/physical/medical treatment that the parent/primary caregiver must manage (complicated treatment cases).

SERVICE COORDINATION

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

Questions to Consider:

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

Ratings and Descriptions

0 *No current need; no need for action. This may be a resource for the child.*

Caregiver is able to coordinate the child's services.

1 *Identified need that requires monitoring, watchful waiting, or preventive action based on history, suspicion or disagreement. This may be an opportunity for resource building.*

Caregiver has had challenges with coordinating the child's services in the past, OR caregiver is currently inconsistent in their ability to coordinate the child's services.

2 *Need is interfering with the provision of care; action is required to ensure that the identified need is addressed.*

The caregiver's challenges in coordinating the child's services has impacted the child's functioning in at least one life domain.

3 *Need prevents the provision of care; requires immediate and/or intensive action.*

Caregiver is unable to coordinate the child's services which impacts the child's functioning and places them at risk and/or their development in danger.

SERVICE ACCESS/AVAILABILITY

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

Questions to Consider:

- Have there been services that the child needs that are not available to the caregiver?
- What types of problems does caregiver encounter when trying to access services?
- Were services previously available to caregiver that now are not?
- Are there any restrictions that caregiver is aware of keeping the child from getting needed services?

Ratings and Descriptions

0 *No current need; no need for action. This may be a resource for the child.*

Caregiver has access to and has obtained services for the child.

1 *Identified need that requires monitoring, watchful waiting, or preventive action based on history, suspicion or disagreement. This may be an opportunity for resource building.*

Caregiver is currently encountering some challenges to accessing and securing services for the child, OR caregiver has had difficulties in securing services for the child in the past which resulted in the child not receiving the services that they needed.

2 *Need is interfering with the provision of care; action is required to ensure that the identified need is addressed.*

Caregiver has encountered barriers to accessing and securing services for the child. The child's functioning has been impacted by not being able to receive the services and supports that are needed.

3 *Need prevents the provision of care; requires immediate and/or intensive action.*

Caregiver is unable to access or secure services for the child, placing the child at risk and/or their development in danger.

CULTURAL APPROPRIATENESS OF SERVICES

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

Questions to Consider:

- Do service providers show family that they understand family's beliefs and practices?
- Has family been unhappy with services because of lack of cultural sensitivity?
- Do recommendations that family is given fit within their beliefs?
- Is there anything special that family would like service providers to know about their culture, beliefs or practices?

Ratings and Descriptions

0 *No current need; no need for action. This may be a resource for the child.*

Caregiver identifies the services and supports that the child is receiving as respectful of the family's cultural beliefs and practices.

1 *Identified need that requires monitoring, watchful waiting, or preventive action based on history, suspicion or disagreement. This may be an opportunity for resource building.*

Caregiver is concerned that the services and supports the child is receiving may not be respectful of the family's beliefs and practices, OR the child has received services in the past that were insensitive to the family's cultural beliefs and practices that made it difficult for the child to engage or benefit from care.

2 *Need is interfering with the provision of care; action is required to ensure that the identified need is addressed.*

Caregiver views the services and supports the child is receiving as not consistently culturally responsive to the family's beliefs and practices. The child's needs are not adequately addressed in this care setting and their functioning is impacted.

3 *Need prevents the provision of care; requires immediate and/or intensive action.*

Caregiver views the services and supports the child is receiving as culturally insensitive, unresponsive and disrespectful of the family's cultural beliefs and practices. The child is unable to participate and/or benefit from services and is at risk.

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

CAREGIVER RESOURCES & NEEDS

SUPERVISION

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

Questions to Consider

- How does the caregiver feel about their ability to keep an eye on and discipline the child?
- Does the caregiver need some help with these issues?

Ratings and Descriptions

0 *No current need; no need for action. This may be a resource for the child.*

No evidence caregiver needs help or assistance in monitoring or disciplining the child, and/or caregiver has good monitoring and discipline skills.

1 *Identified need that requires monitoring, watchful waiting, or preventive action based on history, suspicion or disagreement. This may be an opportunity for resource building.*

Caregiver generally provides adequate supervision but is inconsistent. Caregiver may need occasional help or assistance.

2 *Need is interfering with the provision of care; action is required to ensure that the identified need is addressed.*

Caregiver supervision and monitoring are very inconsistent and frequently absent. Caregiver needs assistance to improve supervision skills.

3 *Need prevents the provision of care; requires immediate and/or intensive action.*

Caregiver is unable to monitor or discipline the child. Caregiver requires immediate and continuing assistance. Child is at risk of harm due to absence of supervision or monitoring.

INVOLVEMENT WITH CARE

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

Questions to Consider

- How involved are the caregivers in services for the child?
- Is the caregiver an advocate for the child?
- Would the caregiver like any help to become more involved?

Ratings and Descriptions

0 *No current need; no need for action. This may be a resource for the child.*

No evidence of problems with caregiver involvement in services or interventions, and/or caregiver is actively involved in planning and is able to act as an effective advocate for child.

1 *Identified need that requires monitoring, watchful waiting, or preventive action based on history, suspicion or disagreement. This may be an opportunity for resource building.*

Caregiver is consistently involved in the planning and/or implementation of services for the child but is not an active advocate on behalf of the child. Caregiver is open to receiving support, education, and information.

2 *Need is interfering with the provision of care; action is required to ensure that the identified need is addressed.*

Caregiver is minimally involved in the child's services and/or interventions intended to assist the child. Caregiver may drop child off for appointments, or visit during out of home placement, but does not participate in service planning or delivery.

3 *Need prevents the provision of care; requires immediate and/or intensive action.*

Caregiver is uninvolved with services and wishes for child to be removed from their care.

MEDICAL/PHYSICAL HEALTH

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

Questions to Consider

- How is the caregiver's health?
- Does the caregiver have any health problems that limit their ability to care for the family?

Ratings and Descriptions

0 *No current need; no need for action. This may be a resource for the child.*

No evidence of medical or physical health problems. Caregiver is generally healthy.

1 *Identified need that requires monitoring, watchful waiting, or preventive action based on history, suspicion or disagreement. This may be an opportunity for resource building.*

There is a history or suspicion of and/or caregiver is in recovery from medical/physical problems.

2 *Need is interfering with the provision of care; action is required to ensure that the identified need is addressed.*

Caregiver has medical/physical problems that interfere with the capacity to parent the child.

3 *Need prevents the provision of care; requires immediate and/or intensive action.*

Caregiver has medical/physical problems that make parenting the child impossible at this time.

KNOWLEDGE

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

Questions to Consider

- How does the caregiver understand the child's needs?
- Does the caregiver have the necessary information to meet the child's needs?

Ratings and Descriptions

0 *No current need; no need for action. This may be a resource for the child.*
No evidence of caregiver knowledge issues. Caregiver is fully knowledgeable about the child's strengths and needs, talents and limitations.

1 *Identified need that requires monitoring, watchful waiting, or preventive action based on history, suspicion or disagreement. This may be an opportunity for resource building.*
Caregiver, while being generally knowledgeable about the child, has some deficits in knowledge or understanding of the child's needs, talents, skills and assets.

2 *Need is interfering with the provision of care; action is required to ensure that the identified need is addressed.*
Caregiver does not know or understand the child well and significant deficits exist in the caregiver's ability to relate to the child's needs and strengths.

3 *Need prevents the provision of care; requires immediate and/or intensive action.*
Caregiver has little or no understanding of the child's current condition. Caregiver's lack of knowledge about the child's strengths and needs place the child at risk of significant negative outcomes.

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

ORGANIZATION

This item is used to rate the caregiver's ability to organize and manage their household within the context of intensive community services.

Questions to Consider

- Do caregivers need or want help with managing their home?
- Do they have difficulty getting to appointments or managing a schedule?
- Do they have difficulty getting their child to appointments or school?

Ratings and Descriptions

0 *No current need; no need for action. This may be a resource for the child.*
Caregiver is well organized and efficient.

1 *Identified need that requires monitoring, watchful waiting, or preventive action based on history, suspicion or disagreement. This may be an opportunity for resource building.*
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 *Need is interfering with the provision of care; action is required to ensure that the identified need is addressed.*
Caregiver has moderate difficulty organizing and maintaining household to support needed services.

3 *Need prevents the provision of care; requires immediate and/or intensive action.*
Caregiver is unable to organize household to support needed services.

FINANCIAL RESOURCES

This item rates the family's financial situation.

Questions to Consider:

- Has caregiver struggled financially?
- Does caregiver ever worry that they won't have enough money to meet family's needs?

Ratings and Descriptions

0 *No current need; no need for action. This may be a resource for the child.*

Caregiver has sufficient financial resources to raise the child.

1 *Identified need that requires monitoring, watchful waiting, or preventive action based on history, suspicion or disagreement. This may be an opportunity for resource building.*

Caregiver has some financial resources that actively help with raising the child. History of struggles with sufficient financial resources would be rated here.

2 *Need is interfering with the provision of care; action is required to ensure that the identified need is addressed.*

Caregiver has limited financial resources that may be able to help with raising the child.

3 *Need prevents the provision of care; requires immediate and/or intensive action.*

Caregiver has no financial resources to help with raising the child. Caregiver needs financial resources.

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

SOCIAL RESOURCES

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

Questions to Consider

- Does family have extended family or friends who provide emotional support?
- Can they call on social supports to watch the child occasionally?

Ratings and Descriptions

0 *No current need; no need for action. This may be a resource for the child.*

Caregiver has significant social and family networks that actively help with caregiving.

1 *Identified need that requires monitoring, watchful waiting, or preventive action based on history, suspicion or disagreement. This may be an opportunity for resource building.*

Caregiver has some family or friends or social network that actively helps with caregiving.

2 *Need is interfering with the provision of care; action is required to ensure that the identified need is addressed.*

Work needs to be done to engage family, friends or social network in helping with caregiving.

3 *Need prevents the provision of care; requires immediate and/or intensive action.*

Caregiver has no family or social network to help with caregiving.

HOUSING/RESIDENTIAL STABILITY

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

Questions to Consider

- Has caregiver moved around much in the past?
- Is caregiver's current housing situation stable?
- Does the current housing adequately meet caregiver's needs?
- Does caregiver have any concerns that they might have to move in the near future?

Ratings and Descriptions

0 *No current need; no need for action. This may be a resource for the child.*
Caregiver has stable housing with no known risks of instability.

1 *Identified need that requires monitoring, watchful waiting, or preventive action based on history, suspicion or disagreement. This may be an opportunity for resource building.*
Caregiver has relatively stable housing but either has moved in the recent past or there are indications of housing problems that might force housing disruption.

2 *Need is interfering with the provision of care; action is required to ensure that the identified need is addressed.*
Caregiver has moved multiple times in the past year. Housing is unstable.

3 *Need prevents the provision of care; requires immediate and/or intensive action.*
Family is homeless, or has experienced homelessness in the recent past.

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

SAFETY

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

Questions to Consider

- Is the caregiver able to protect the child from harm in the home?
- Are there individuals living in the home or visiting the home that may be abusive to the child?

Ratings and Descriptions

0 *No current need; no need for action. This may be a resource for the child.*
No evidence of safety issues. Household is safe and secure. Child is not at risk from others.

1 *Identified need that requires monitoring, watchful waiting, or preventive action based on history, suspicion or disagreement. This may be an opportunity for resource building.*
Household is safe but concerns exist about the safety of the child due to history or others who might be abusive.

2 *Need is interfering with the provision of care; action is required to ensure that the identified need is addressed.*
Child is in some danger from one or more individuals with access to the home.

3 *Need prevents the provision of care; requires immediate and/or intensive action.*
Child is in immediate danger from one or more individuals with unsupervised access.

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

FAMILY STRESS
This item refers to the impact of managing the child's behavioral and emotional needs on the family's stress level.

Questions to Consider
- Do caregivers find it stressful at times to manage the challenges in dealing with the child's needs?
- Does the stress ever interfere with ability to care for the child?

Ratings and Descriptions

0 *No current need; no need for action. This may be a resource for the child.*
No evidence of caregiver having difficulty managing the stress of the child's needs and/or caregiver is able to manage the stress of child's needs.

1 *Identified need that requires monitoring, watchful waiting, or preventive action based on history, suspicion or disagreement. This may be an opportunity for resource building.*
There is a history or suspicion and/or caregiver has some problems managing the stress of child's needs.

2 *Need is interfering with the provision of care; action is required to ensure that the identified need is addressed.*
Caregiver has notable problems managing the stress of child's needs. This stress interferes with their capacity to provide care.

3 *Need prevents the provision of care; requires immediate and/or intensive action.*
Caregiver is unable to manage the stress associated with child's needs. This stress prevents caregiver from parenting.

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

Questions to Consider
- Is the caregiver able to empathize with the child?
- Is the caregiver able to respond to the child's needs in an emotionally appropriate manner?
- Is the caregiver's level of empathy impacting the child's development?

Ratings and Descriptions

0 *No current need; no need for action. This may be a resource for the child.*
Caregiver is emotionally empathic and attends to the child's emotional needs.

1 *Identified need that requires monitoring, watchful waiting, or preventive action based on history, suspicion or disagreement. This may be an opportunity for resource building.*
The caregiver can be emotionally empathic and typically attends to the child's emotional needs. There are times, however, when the caregiver is not able to attend to the child's emotional needs.

2 *Need is interfering with the provision of care; action is required to ensure that the identified need is addressed.*
The caregiver is often not empathic and frequently is unable to attend to the child's emotional needs.

3 *Need prevents the provision of care; requires immediate and/or intensive action.*
The caregiver has significant difficulties with emotional responsiveness. They are not empathic and rarely attend to the child's emotional needs.

FAMILY RELATIONSHIP TO THE SYSTEM

This item describes the degree to which the family's apprehension to engage with child serving systems (health care, child welfare, early intervention) creates a barrier to receipt of care. For example, if a family refuses to participate in team meetings because of their mistrust of the intentions of the providers on the team, providers must consider this apprehension and understand its possible impact on the delivery/receipt of services. These complicated factors may translate into generalized discomfort with any or all child serving systems and may require the care provider to reconsider their approach.

Questions to Consider

- Does the caregiver express any hesitancy in engaging in formal services?
- How does the caregiver's hesitancy impact their engagement in care for their child?

Ratings and Descriptions

0 *No current need; no need for action. This may be a resource for the child.*

The caregiver expresses no concerns about engaging with the formal helping system.

1 *Identified need that requires monitoring, watchful waiting, or preventive action based on history, suspicion or disagreement. This may be an opportunity for resource building.*

The caregiver expresses some hesitancy to engage with the formal helping system that is easily rectified with clear communication about intentions or past issues engaging with the formal helping system.

2 *Need is interfering with the provision of care; action is required to ensure that the identified need is addressed.*

The caregiver expresses hesitancy to engage with the formal helping system that requires significant discussions and possible revisions to the treatment plan.

3 *Need prevents the provision of care; requires immediate and/or intensive action.*

The caregiver's hesitancy to engage with the formal helping system prohibits the family's engagement with the treatment team at this time. When this occurs, the development of an alternate treatment plan may be required.

MENTAL HEALTH

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

Questions to Consider

- Does caregiver have any challenges with emotional issues, such as depression or anxiety?
- If so, does this make it difficult for the caregiver to interact with their child or others?
- Has the caregiver had any challenges in the past?

Ratings and Descriptions

0 *No current need; no need for action. This may be a resource for the child.*
No evidence of caregiver mental health difficulties.

1 *Identified need that requires monitoring, watchful waiting, or preventive action based on history, suspicion or disagreement. This may be an opportunity for resource building.*
There is a history or suspicion of mental health difficulties, and/or caregiver is in recovery from mental health difficulties.

2 *Need is interfering with the provision of care; action is required to ensure that the identified need is addressed.*
Caregiver's mental health difficulties interfere with their capacity to parent.

3 *Need prevents the provision of care; requires immediate and/or intensive action.*
Caregiver has mental health difficulties that make it impossible to parent the child at this time.

Supplemental Information: Infants and young children are primarily in need of parents that are emotionally available, reciprocal in their interactions and capable of providing for their needs. When a parent is challenged with difficult symptoms associated with mental health challenges all of these needs may be poorly or intermittently met. Much research has taken place regarding how depression in parents affects children. Carter, Osofsky & Hahn (1991) substantiate the disturbances in infant patterns of regulating affect when experiencing parental depression. In addition, Murray and Cooper (1997) report that two negative interaction patterns, withdrawn-hostile and hostile-intrusive, have been observed in their research with depressed mothers. These two patterns have been demonstrated to interfere with the cognitive and emotional development of their infants. Anxiety or trauma related challenges in parents also have the potential to cause a number of difficulties for children. Children with parents that are anxious can experience anxiety themselves due to their response to the social cues of their parents or the interference with the care-giving routine.
Serious mental illness would be rated '2' or '3' unless the individual is in recovery.

SUBSTANCE USE

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

Questions to Consider

- If caregiver uses alcohol or illegal drugs, do they feel that this is a problem for them?
- Do others feel that it is a problem?
- If so, does caregiver think it impacts their parenting in any way?
- Would caregiver like some help in this area?

Ratings and Descriptions

0 *No current need; no need for action. This may be a resource for the child.*
No evidence of caregiver substance use issues.

1 *Identified need that requires monitoring, watchful waiting, or preventive action based on history, suspicion or disagreement. This may be an opportunity for resource building.*
There is a history, suspicion or mild use of substances and/or caregiver is in recovery from substance use difficulties where there is no interference in their ability to parent.

2 *Need is interfering with the provision of care; action is required to ensure that the identified need is addressed.*
Caregiver has some substance use difficulties that interfere with their capacity to parent.

3 *Need prevents the provision of care; requires immediate and/or intensive action.*
Caregiver has substance use difficulties that make it impossible to parent the child at this time.

Supplemental Information: It is important to note that what typically puts infants at greater risk related to substance abusing parents is the exposure to the multiple risks that usually are associated with substance abuse. Due to the effects of substance abuse, parents often experience poverty, disorganized and chaotic lifestyles, stress, exposure to violence (Lester & Tronick, 1994). Due to the critical importance of forming a secure attachment relationship within the first few years of life, a young child with substance abusing parents may be at considerable risk. In addition, it has also been determined that when the combination of prenatal drug exposure and ongoing substance use in parents occurs, a child is at high risk for learning and behavior problems (Lester & Tronick, 1994; Kaplan-Sanoff, 1996).
Substance-related disorders would be rated '2' or '3' unless the individual is in recovery.

DEVELOPMENTAL

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

Questions to Consider

- Does the caregiver have developmental challenges that make parenting/ caring for the child difficult?
- Does the caregiver have services?

Ratings and Descriptions

0 *No current need; no need for action. This may be a resource for the child.*
No evidence of caregiver developmental disabilities or challenges. Caregiver has no developmental needs.

1 *Identified need that requires monitoring, watchful waiting, or preventive action based on history, suspicion or disagreement. This may be an opportunity for resource building.*
Caregiver has developmental challenges. The developmental challenges do not currently interfere with parenting.

2 *Need is interfering with the provision of care; action is required to ensure that the identified need is addressed.*
Caregiver has developmental challenges that interfere with the capacity to parent the child.

3 *Need prevents the provision of care; requires immediate and/or intensive action.*
Caregiver has severe developmental challenges that make it impossible to parent the child at this time.

KNOWLEDGE OF SERVICE OPTIONS

This item refers to the choices the family might have for specific treatments, interventions or other services that might help the family address their needs, or the needs of one of their family members.

Questions to Consider

- Does the caregiver have an understanding of the services that are available to them and their child?

Ratings and Descriptions

0 *No current need; no need for action. This may be a resource for the child.*
Caregiver has strong understanding of service options.

1 *Identified need that requires monitoring, watchful waiting, or preventive action based on history, suspicion or disagreement. This may be an opportunity for resource building.*
Caregiver has understanding of service options but may still require some help in learning about certain aspects of these services.

2 *Need is interfering with the provision of care; action is required to ensure that the identified need is addressed.*
Caregiver requires assistance in identifying and understanding service options.

3 *Need prevents the provision of care; requires immediate and/or intensive action.*
Caregiver is unable to identify or understand service options and requires substantial assistance.

ACCESS TO CHILDCARE
This item describes the access or availability that the family/caregiver has to childcare services.

Questions to Consider:
- Who cares for the child during the day?
- Does the family have any concerns about the cost, quality, or location of that care?

Ratings and Descriptions

0 *No current need; no need for action. This may be a resource for the child.*
Caregiver has access to sufficient childcare services or does not have a need (i.e., caregiver is the sole care provider and does not require additional care services).

1 *Identified need that requires monitoring, watchful waiting, or preventive action based on history, suspicion or disagreement. This may be an opportunity for resource building.*
Caregiver has some access to childcare services; care needs are minimally met by available services.

2 *Need is interfering with the provision of care; action is required to ensure that the identified need is addressed.*
Caregiver limited access to childcare services. Current services do not meet caregiver/ family needs.

3 *Need prevents the provision of care; requires immediate and/or intensive action.*
Caregiver has no access to needed childcare services.

CAREGIVER EMOTIONAL RESPONSIVENESS
This item rates the ability of the caregiver and child to interact in a safe, caring, consistent manner.

Questions to Consider
- Is the caregiver able to empathize with the child?
- Is the caregiver able to respond to the child's needs in an emotionally appropriate manner?
- Does the child seek comfort and safety from the caregiver?

Ratings and Descriptions

0 *No current need; no need for action. This may be a resource for the child.*
Caregiver is emotionally responsive and attends to the child's emotional needs; child consistently seeks comfort, safety, and response from caregiver.

1 *Identified need that requires monitoring, watchful waiting, or preventive action based on history, suspicion or disagreement. This may be an opportunity for resource building.*
The caregiver can be responsive to the child's emotional needs and bids for comfort and attention. There are times, however, when the caregiver is not able to attend to the child's emotional needs or the child is not able to seek support from the caregiver.

2 *Need is interfering with the provision of care; action is required to ensure that the identified need is addressed.*
The caregiver and child have a pattern of interacting in unhealthy ways or of avoiding interaction. This pattern is interfering with the child's functioning.

3 *Need prevents the provision of care; requires immediate and/or intensive action.*
The caregiver has significant difficulties with emotional responsiveness. They are not empathic and rarely attend to the child's emotional needs. Child seeks attention in unhealthy ways or avoids interaction with caregiver. This relationship pattern is dangerous or disabling for the child.

CAREGIVER RESOURCEFULNESS

This item refers to the caregiver's ability to recognize their environmental strengths and apply them to support the healthy development of their child. This includes ways of getting their needs met in a positive manner. Examples include: accessing community and other resources for self, the child or the family.

Questions to Consider:

- When there is an individual or family need, does the caregiver know where to go for assistance?
- Does the caregiver have a good understanding of what services or concrete resources are available in their community?

Ratings and Descriptions

0 *No current need; no need for action. This may be a resource for the child.*
Caregiver is skilled at finding and using the necessary resources to aid the child in managing challenges.

1 *Identified need that requires monitoring, watchful waiting, or preventive action based on history, suspicion or disagreement. This may be an opportunity for resource building.*
Caregiver has some challenges in finding the necessary resources to aid the child in achieving a healthy lifestyle, and sometimes requires assistance with identifying and accessing these resources.

2 *Need is interfering with the provision of care; action is required to ensure that the identified need is addressed.*
Caregiver has limited skills at finding necessary resources required to aid the child in achieving a healthy lifestyle, and requires temporary assistance both with identifying and accessing these resources.

3 *Need prevents the provision of care; requires immediate and/or intensive action.*
Caregiver has no skills in finding the necessary resources required to aid the child in achieving a healthy lifestyle, and requires ongoing assistance both with identifying and accessing these resources.

CAREGIVER ADJUSTMENT TO TRAUMATIC EXPERIENCES

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

Questions to Consider

- Has the caregiver experienced a traumatic event?
- Does the caregiver experience frequent nightmares?
- Are they troubled by flashbacks?
- What are the caregiver's current coping skills?

Ratings and Descriptions

0 *No current need; no need for action. This may be a resource for the child.*
There is no evidence that the caregiver has experienced trauma, OR there is evidence that the caregiver has adjusted well to their traumatic experiences.

1 *Identified need that requires monitoring, watchful waiting, or preventive action based on history, suspicion or disagreement. This may be an opportunity for resource building.*
The caregiver has mild adjustment problems and exhibits some signs of distress, OR caregiver has a history of having difficulty adjusting to traumatic experiences.

2 *Need is interfering with the provision of care; action is required to ensure that the identified need is addressed.*
The caregiver has marked adjustment problems and is symptomatic in response to a traumatic event (e.g., anger, depression, and anxiety).

3 *Need prevents the provision of care; requires immediate and/or intensive action.*
The caregiver has post-traumatic stress difficulties. Symptoms may include intrusive thoughts, hyper-vigilance, constant anxiety, and other common symptoms of Post-Traumatic Stress Disorder (PTSD).

LEGAL INVOLVEMENT

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

Questions to Consider	Ratings and Descriptions
• Is one or more of the caregivers incarcerated or on probation? • Is one or more of the caregivers struggling with immigration or legal documentation issues? • Is the caregiver involved in civil disputes, custody, family court?	0 *No current need; no need for action. This may be a resource for the child.* Caregiver has no known legal difficulties.
	1 *Identified need that requires monitoring, watchful waiting, or preventive action based on history, suspicion or disagreement. This may be an opportunity for resource building.* Caregiver has a history of legal problems but currently is not involved with the legal system.
	2 *Need is interfering with the provision of care; action is required to ensure that the identified need is addressed.* Caregiver has some legal problems and is currently involved in the legal system.
	3 *Need prevents the provision of care; requires immediate and/or intensive action.* Caregiver has serious current or pending legal difficulties that place them at risk for incarceration. Caregiver needs an immediate, comprehensive and community-based intervention. A caregiver who is incarcerated would be rated here.

MENTAL HEALTH/BEHAVIORAL AND EMOTIONAL NEEDS & CHALLLENGES DOMAIN

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

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

For the **Mental Health/Behavioral and Emotional Needs & Challenges Domain**, use the following categories and action levels:

0 No evidence of any needs; no need for action.

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

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

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

These items should be considered within what is appropriate given the child's age and development.

ATTACHMENT

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

Questions to Consider

- Does the child approach or attach to strangers in indiscriminate ways?
- Does the child have the ability to make healthy attachments to appropriate adults or are their relationships marked by intense fear or avoidance?
- Does the child have separation anxiety issues that interfere with ability to engage in childcare or preschool?

Ratings and Descriptions

0 *No evidence of any needs; no need for action.*
No evidence of attachment problems. Caregiver-child relationship is characterized by mutual satisfaction of needs and child's development of a sense of security and trust. Child seeks age-appropriate contact with caregiver for both nurturing and safety needs.

1 *Identified need that requires monitoring, watchful waiting, or preventive action based on history, suspicion or disagreement.*
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 *Action is required to ensure that the identified need is addressed; need is interfering with functioning.*
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. [continues]

ATTACHMENT continued

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

Infant/child may be unable to separate or be calmed following a separation from caregiver. Older children may have disabling separation anxiety or exhibit extremely controlling behaviors with caregiver. Children whose indiscriminant boundaries put them in danger would be rated here. Children diagnosed with Reactive Attachment Disorder would be rated here.

Supplemental Information: Attachment refers to the special relationship between a child and their primary caregiver(s) 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(s). 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. Levy (1998) summarizes these benefits as promoting 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 attachment with their own children when they become adults. However, it is important to note that most studies on attachment and its impacts have been done with Western, middle-class families (Keller, 2018).

Potential presenting symptoms of attachment issues in early childhood:

- 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 the caregiver-child relationship

It is important to remember that individual children, and children from different cultures and family backgrounds, may show secure or insecure attachment differently. Adults should observe children to see how they express whether they feel secure or not, but recognize that in some cultures and families, feelings may not be expressed as openly as in other cultures. In addition, some cultures encourage their children to be independent, so for these children, playing independently may not mean that they are withdrawing from relationships (Wittmer, 2011).

FOR REFERENCE TO DC 0-5 (ZTT, 2016) IF APPLICABLE

Axis I

- When following the permanent loss of a primary caregiver/attachment figure, a rating of '2' or '3' related to poor ability to tolerate separation may be a symptom of **Complicated Grief Disorder of Early Childhood.**
- A rating of '2' or '3' related to poor ability to tolerate separation may be consistent with a diagnosis of **Separation Anxiety Disorder.**
- A rating of '2' or '3' related to indiscriminate affection with unfamiliar adults may be consistent with a diagnosis of **Disinhibited Social Engagement Disorder.**
- A rating of '2' or '3' specific to one caregiver may be consistent with a diagnosis of **Relationship Specific Disorder.**
- When following severe social neglect, a rating of '3' may be consistent with symptoms of **Reactive Attachment Disorder.**

IMPULSIVITY/HYPERACTIVITY

Problems with impulse control and impulsive behaviors, including motoric disruptions, are rated here. This includes behavioral symptoms associated with Attention-Deficit Hyperactivity Disorder (ADHD) and Impulse-Control Disorders as indicated in the DSM-5. Children with impulse problems tend to engage in behavior without thinking, regardless of the consequences.

Questions to Consider

- Is the child unable to sit still for a length of time that is developmentally typical?
- Is the child able to control their behavior at a developmentally appropriate level?

Ratings and Descriptions

0 *No evidence of any needs; no need for action.*
No evidence of symptoms of loss of control of behavior.

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

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

3 *Need is dangerous or disabling; requires immediate and/or intensive action.*
Clear evidence of a dangerous level of hyperactivity and/or impulsive behavior that places the child at risk of physical harm. This indicates a child with frequent and significant levels of impulsive behavior that carries considerable safety risk (e.g., running into the street, dangerous physical play). The child may be impulsive on a nearly continuous basis. The child endangers self or others with impulsive behaviors.

Supplemental Information: Symptoms of ADHD are among the most common reasons for referral to mental health professionals in early childhood. Although young children have higher levels of inattention, hyperactivity, and impulsivity than older children, some young children present with extremes of these patterns even at early ages.

Potential presenting symptoms of inattention in early childhood (ZTT, 2016)

- Being inattentive to details in play, activities of daily living or structured activities (e.g., makes developmentally unexpected accidents or mistakes)
- Having a hard time maintaining focus on activities or play
- Failing to attend to verbal requests/demands, especially when engaged in a preferred activity (e.g., caregiver needs to call the young child's name multiple times before the child notices)
- Getting derailed when attempting to follow multistep instructions and does not complete the activity
- Having a hard time executing age-appropriate sequential activities (e.g., getting dressed, following routines in childcare or home)
- Avoiding or objecting to activities that require prolonged attention (e.g., reading a book with a parent, or working on a puzzle)
- Losing track of things that are used regularly (e.g., favorite stuffed animal, shoes)
- Getting distracted by sounds and sights (e.g., sounds from another room or objects or activities outside the window)
- Seeming to forget what they are doing in common routine activities [continues]

IMPULSIVITY/HYPERACTIVITY continued

Potential presenting symptoms of hyperactivity/impulsivity in early childhood (ZTT, 2016)

- Squirming or fidgeting when expected to be still, even for short periods of time
- Getting up from seat during activities when sitting is expected (e.g., circle time, mealtime, worship)
- Climbing on furniture or other inappropriate objects
- Making more noise than other young children, and having difficulty playing quietly
- Showing excessive motor activity and non-directed energy (as if "driven by a motor")
- Talking too much
- Having a hard time taking turns in conversation or interrupts others in conversation (e.g., talks over others)
- Having difficulty taking turns in activities or waiting for needs to be met
- Being intrusive in play or other activities (e.g., takes over toys or activities from other young children, interrupts an established game)

FOR REFERENCE TO DC 0-5 (ZTT, 2016) IF APPLICABLE

Axis I

- Following a traumatic event, a rating of '2' or '3' related to Inattention and/or Hyperactivity may be consistent with symptoms of **Post-Traumatic Stress Disorder (PTSD)** *(see Adjustment to Trauma item).*
- A rating of '2' or '3' related to both Inattention and Hyperactivity may be consistent with a diagnosis of **Attention Deficit Hyperactivity Disorder (ADHD) or Overactivity Disorder of Toddlerhood (OADT).**
- A rating of '2' or '3' related to Inattention may be consistent with symptoms of **Depressive Disorder of Early Childhood** *(see Depression/Sadness item).*

AGGRESSION

This item rates the child's violent or aggressive behavior. The intention of this behavior is to cause significant bodily harm to others. A rating of '2' or '3' would indicate that caregivers are unable to shape/control the child's aggressive behaviors. **Child must be at least 24 months old to rate this item.**

Questions to Consider

- Has the child ever tried to injure another person or animal on purpose?
- Do they hit, kick, bite, or throw things at others with intent to hurt them?

Ratings and Descriptions

0 *No evidence of any needs; no need for action.*
No evidence or history of aggressive behaviors or significant verbal aggression towards others (including people and animals).

1 *Identified need that requires monitoring, watchful waiting, or preventive action based on history, suspicion or disagreement.*
History of aggressive behavior toward people or animals or concern expressed by caregivers about aggression.

2 *Action is required to ensure that the identified need is addressed; need is interfering with functioning.*
Clear evidence of aggressive behavior toward people or others in the past 30 days. Caregiver's attempts to redirect or change behaviors have not been successful.

3 *Need is dangerous or disabling; requires immediate and/or intensive action.*
The child exhibits a current, dangerous level of aggressive behavior that involves the threat of harm to animals or others. Caregivers are unable to mediate this dangerous behavior.

NA Child is younger than 24 months of age.

Supplemental Information: In the early childhood period, infants and young children are learning important skills about asserting themselves, communicating their likes and dislikes, and acting independently (as much as they can!). At the same time, they still have limited self-control. As a result, aggressive behaviors in early childhood are not uncommon, and are often the reason parents seek assistance for their children. [continues]

AGGRESSION continued

Like most aspects of development, there is a wide variation among children when it comes to acting out aggressively. Children who are intense and "big reactors" tend to have a more difficult time managing their emotions than children who are by nature more easygoing. Big reactors rely more heavily on using their actions to communicate their strong feelings. In addition, patterns of aggressive behaviors can change over the course of development; aggression (hitting, kicking, biting, etc.) usually peaks around age two, a time when toddlers have very strong feelings but are not yet able to use language effectively to express themselves. In some cases, aggressive behaviors may emerge when a child is experiencing emotional distress, such as after an experience of trauma or within the context of relational challenges with caregivers.

Aggressive moments can be extremely challenging for parents, as parents may expect that their child is capable of more self-control than they really are. This stage of development can be very confusing for parents because while a young child may be able to tell you what the rule is, they still do not always have the impulse control to stop themselves from doing something they desire. In these moments, it is important for caregivers to try to recognize the child's feeling or goal that may be prompting the aggressive behavior and use the moment as an opportunity for modeling or teaching emotional regulation skills (Lerner & Parlakian, 2016).

FOR REFERENCE TO DC 0-5 (ZTT, 2016) IF APPLICABLE

Axis I

- A rating of '2' or '3' may be consistent with symptoms of **Disorder of Dysregulated Anger & Aggression (DDAA).**
- A rating of '2' or '3' specific to interaction with one caregiver may be consistent with symptoms of a **Relationship Specific Disorder.**

ATYPICAL BEHAVIORS

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

Questions to Consider

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

Ratings and Descriptions

0 *No evidence of any needs; no need for action.*
No evidence of atypical behaviors (repetitive or stereotyped behaviors) in the child.

1 *Identified need that requires monitoring, watchful waiting, or preventive action based on history, suspicion or disagreement.*
Atypical behaviors (repetitive or stereotyped behaviors) reported by caregivers or familiar individuals that may have mild or occasional interference in the child's functioning.

2 *Action is required to ensure that the identified need is addressed; need is interfering with functioning.*
Atypical behaviors (repetitive or stereotyped behaviors) generally noticed by unfamiliar people and have notable interference in the child's functioning.

3 *Need is dangerous or disabling; requires immediate and/or intensive action.*
Atypical behaviors (repetitive or stereotyped behaviors) occur with high frequency, and are disabling or dangerous.

Supplemental Information: Restricted and repetitive behaviors (RRBs) have long been considered one of the core characteristics of autism. In the past, RRBs were thought to be rare in preschoolers or toddlers with autism. This assumption has been challenged in recent studies that reported the presence of RRBs in preschoolers, toddlers, and even infants as young as 8 months later diagnosed with autism. However, at young ages, RRBs are not unique to children with autism spectrum disorders (ASD) but are also present in children with other disorders, such as intellectual disabilities and language disorders, and are present in typically developmentally children as well (Kim & Lord, 2010). [continues]

ATYPICAL BEHAVIORS continued

FOR REFERENCE TO DC 0-5 (ZTT, 2016) IF APPLICABLE

Axis I

- A rating of '2' or '3' may be consistent with symptoms of **Autism Spectrum Disorder (ASD)** or **Early Atypical Autism Spectrum Disorder (EAASD)**.
- When children are engaging in atypical behaviors in order to reduce distress or anxiety, a rating of '2' or '3' may be consistent with symptoms of **Obsessive-Compulsive Disorder (OCD)**. Some of the most common atypical behaviors associated with OCD, called compulsions, are: washing, checking, repeating, ordering/arranging, counting, tapping, and rubbing.
- A rating of '2' or '3' related to hair pulling or skin picking may be consistent with diagnoses of **Trichotillomania** and/or **Skin Picking Disorder of Early Childhood**, respectively.
- When atypical behaviors are nonrhythmic (tics), a rating of '2' or '3' may be consistent with a diagnosis of **Tourette's Disorder** or **Motor or Vocal Tic Disorder.**

DEPRESSION

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

Questions to Consider

- Is there concern about possible depression or chronic low mood and irritability for the child?
- Has the child withdrawn from normal activities?
- Does the child seem listless, sad or socially withdrawn?

Ratings and Descriptions

0 *No evidence of any needs; no need for action.*
No evidence of problems with depression.

1 *Identified need that requires monitoring, watchful waiting, or preventive action based on history, suspicion or disagreement.*
History or suspicion of depression or evidence of depression associated with a recent negative life event with minimal impact on life domain functioning. Brief duration of depression, irritability, or impairment of peer or family interactions, or learning that does not lead to pervasive avoidance behavior. Infants may appear withdrawn and slow to engage at times; young children may be irritable or demonstrate constricted affect.

2 *Action is required to ensure that the identified need is addressed; need is interfering with functioning.*
Clear evidence of depression associated with either depressed mood or significant irritability. Depression has interfered significantly in child's ability to function in at least one life domain.

3 *Need is dangerous or disabling; requires immediate and/or intensive action.*
Clear evidence of disabling level of depression that makes it virtually impossible for the child to function in any life domain. This rating is given to a child with a severe level of depression. This would include a child who withdraws from activity (school, play) or interaction (with family, peers, significant adults) due to depression. Disabling forms of depressive diagnoses would be rated here. [continues]

DEPRESSION continued

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

Potential presenting symptoms of depression in early childhood (ZTT, 2016)

- Depressed mood or irritability: sadness, crying, flat affect, and/or tantrums.
- Anhedonia: diminished interest in activities, such as play and interactions with caregivers. In young children, anhedonia may present as decreased engagement, responsivity, and reciprocity.
- Significant change in appetite or failure to grow along the expected growth curve.
- Insomnia/sleep disturbances (trouble falling or staying asleep) or hyposomnia.
- Psychomotor agitation or sluggishness.
- Fatigue or loss of energy.
- Feelings of worthlessness, excessive guilt, or self-blame in play or speech.
- Diminished ability to concentrate, persist, and make choices across activities.
- Preoccupation with themes of death or suicide or attempts at self-harm demonstrated in speech, play, and/or behavior.

FOR REFERENCE TO DC 0-5 (ZTT, 2016) IF APPLICABLE

Axis I

- A rating of '2' or '3' may be consistent with a diagnosis of **Depressive Disorder of Early Childhood.**
- When following the permanent loss of a caregiver, a rating of 2 or 3 may be consistent with symptoms of **Complicated Grief Disorder of Early Childhood** *(see Adjustment to Trauma item).*

ANXIETY

This item rates symptoms associated with DSM-5 Anxiety Disorders characterized by excessive fear and anxiety and related behavioral disturbances (including avoidance behaviors).

Questions to Consider

- Does the child have any problems with anxiety or fearfulness?
- Is the child avoiding normal activities out of fear?
- Does the child act frightened or afraid?

Ratings and Descriptions

0 *No evidence of any needs; no need for action.*
No evidence of anxiety symptoms.

1 *Identified need that requires monitoring, watchful waiting, or preventive action based on history, suspicion or disagreement.*
There is a history, suspicion, or evidence of some anxiety associated with a recent negative life event. This level is used to rate either a phobia or anxiety problem that is not yet causing the child significant distress or markedly impairing functioning in any important context. Anxiety or fear is present, but child is able to be soothed and supported.

2 *Action is required to ensure that the identified need is addressed; need is interfering with functioning.*
Clear evidence of anxiety associated with either anxious mood or significant fearfulness. Anxiety has interfered in the child's ability to function in at least one life domain. Child may show irritability or heightened reactions to certain situations, significant separation anxiety, or persistent reluctance or refusal to cope with fear-inducing situation(s).

3 *Need is dangerous or disabling; requires immediate and/or intensive action.*
Clear evidence of debilitating level of anxiety that makes it virtually impossible for the child to function in any life domain.

Supplemental Information: Until recently, distressing anxiety in infants and young children was regarded either as a normative phase of development or a temperament style imparting risk for anxiety disorders, depression, and other mental health disorders later in life. It is now clear that early childhood anxiety and associated symptoms can reach clinical significance, cause significant impairment in young children and their families, and increase risk for anxiety and depression later in childhood and adulthood.

Potential presenting symptoms of anxiety in early childhood (ZTT, 2016)

- Worry about certain events
- Agitation
- Fatigability
- Inattention
- Irritability (e.g., easily frustrated)
- Muscle tension and difficulty relaxing
- Sleep disturbances
- Avoidance: fear, reluctance, or refusal to engage in certain activities
- Withdrawing: freezing, shrinking, or clinging/hiding
- Failing to speak
- Crying and/or tantruming
- Negative affect
- Physical symptoms such as stomachaches, headaches, excessive sweating, increased heart rate, increased blinking, or dizziness

FOR REFERENCE TO DC 0-5 (ZTT, 2016) IF APPLICABLE

Axis I:

- Following a stressful event, traumatic experience, and/or permanent loss of a primary caregiver, a rating of '2' or '3' may be consistent with symptoms of **Adjustment Disorder**, **PTSD**, and **Complicated Grief Disorder of Early Childhood**, respectively *(see Adjustment to Trauma item).*
- When anxiety is related to interference with a child's compulsions (repetitive behaviors that children are driven to perform according to rigid rules), a rating of '2' or '3' may be consistent with symptoms of **Obsessive-Compulsive Disorder.**
- When anxiety is related to separation from the primary caregiver, a rating of '2' or '3' may be consistent with a diagnosis of **Separation Anxiety Disorder** *(see Attachment).*
- When anxiety is related to social or performance situations that involve exposure to unfamiliar people or possible scrutiny by others, a rating of '2' or '3' may be consistent with a diagnosis of **Social Anxiety Disorder (Social Phobia).** [continues]

ANXIETY continued

Axis I:

- When anxiety manifests as a failure to speak in specific social situations (despite being able to speak in other situations), a rating of '2' or '3' may be consistent with a diagnosis of **Selective Mutism.**
- When anxiety is related to the presence of novel/unfamiliar objects, people, and situations, a rating of '2' or '3' may be consistent with **Inhibition to Novelty Disorder.**
- When anxiety and worry occur during two or more activities or settings and within two or more relationships, a rating of '2' or '3' may be consistent with a diagnosis of **Generalized Anxiety Disorder (GAD).**

OPPOSITIONAL BEHAVIOR

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

Questions to Consider

- Does the child follow their caregivers' rules?
- Have teachers or other adults reported that the child does not follow rules or directions?
- Does the child argue with adults when they try to get the child to do something?
- Does the child do things that they have been explicitly told not to do?

Ratings and Descriptions

0 *No evidence of any needs; no need for action.*
No evidence of oppositional behaviors.

1 *Identified need that requires monitoring, watchful waiting, or preventive action based on history, suspicion or disagreement.*
There is a history or evidence of mild level of defiance towards authority figures that has not yet begun to cause functional impairment.

2 *Action is required to ensure that the identified need is addressed; need is interfering with functioning.*
Clear evidence of oppositional and/or defiant behavior towards authority figures that is currently interfering with the child's functioning in at least one life domain. Behavior causes emotional harm to others. A child whose behavior meets the criteria for Oppositional Defiant Disorder in DSM-5 would be rated here.

3 *Need is dangerous or disabling; requires immediate and/or intensive action.*
Clear evidence of a dangerous level of oppositional behavior involving the threat of physical harm to others. This rating indicates that the child has severe problems with compliance with rules or adult instruction or authority.

REGULATORY

This item refers to all dimensions of self-regulation, including the quality and predictability of sucking/feeding, sleeping, elimination, activity level/intensity, sensitivity to external stimulation, the ability to moderate intense emotions without the use of aggression, and ability to be consoled.

Questions to Consider

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

Ratings and Descriptions

0 *No evidence of any needs; no need for action.*

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

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

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

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

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

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

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

Supplemental Information: Early childhood is a period of rapid brain development that paves the way for growth of self-regulation skills. Supporting self-regulation development in early childhood is an investment in later success, because stronger self-regulation predicts better performance in school, better relationships with others, and fewer behavioral difficulties. Moreover, the ability to regulate thoughts, feelings, and actions helps children successfully negotiate many of the challenges they face, promoting resilience in the face of adversity.

During the first years of life, caregivers are particularly central to development. Young children are dependent upon their caregivers to create a safe, nurturing, and appropriately stimulating environment so they can learn about the world around them. There are three broad categories of support that caregivers can provide to young children to help them develop the foundational self-regulatory skills that they will need to get the best start in life. Together, these describe the supportive process of "co-regulation" between adults and children:

- Provide a warm, responsive relationship
- Structure the environment to make self-regulation manageable
- Teach and coach self-regulation skills through modeling, instruction, and opportunities for practice (Rosanbalm & Murray, 2017).

ADJUSTMENT TO TRAUMA

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

Questions to Consider

- Has the child experienced a traumatic event?
- Does the child experience frequent nightmares?
- Is the child troubled by flashbacks? Does the child repeatedly 'play out' or 'act out' traumatic experiences?
- What are the child's current coping skills?

Ratings and Descriptions

0 *No evidence of any needs; no need for action.*

No evidence that child has experienced a traumatic life event, OR child has adjusted well to traumatic/adverse experiences.

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

The child has experienced a traumatic event and there are some changes in their behavior that are managed or supported by caregivers. These symptoms are expected to ease with the passage of time and therefore no current intervention is warranted. Child may be in the process of recovering from a more extreme reaction to a traumatic experience, which may require a need to watch these symptoms or engage in preventive action.

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

Clear evidence of adjustment problems associated with traumatic life event(s). Symptoms can vary widely and may include sleeping or eating disturbances, regressive behavior, behavior problems or problems with attachment. Adjustment is interfering with child's functioning in at least one life domain.

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

Clear evidence of debilitating level of trauma symptoms that makes it virtually impossible for the child to function in any life domain including symptoms such as flashbacks, nightmares, significant anxiety, intrusive thoughts, and/or re-experiencing trauma (consistent with PTSD).

Supplemental Information: Young children are at a particularly high risk for exposure to potentially traumatic events due to their dependence on parents and caregivers, with an estimate that more than half of young children experiencing a severe stressor. Young children are especially vulnerable to adverse effects of trauma due to rapid developmental growth during this stage. Historically, a widely held misconception has been that infants and young children lack the perception, cognition, and social maturity to remember or understand traumatic events. Today, it is widely accepted that children have the capacity to perceive and remember traumatic events; young children may experience symptoms of mental illness immediately after a trauma, but in some cases, symptoms do not emerge until years later. PTSD, anxiety disorders, behavior disorders, substance abuse, and other physical health conditions have all been linked to traumatic events experienced during early childhood.

Children younger than 6 years of age are experiencing rapid developmental changes, which can make the process of identifying symptoms of trauma more challenging. In addition, trauma reactions can manifest in many ways in young children with variance from child to child. A number of factors that influence how experience of trauma may affect young children, including:

- economic resources & residential stability
- parental stress and mental health
- parenting practices
- family functioning
- safety and stability of family environment
- temperament and emotional regulation skills
- age and developmental stage
- type and duration of traumatic experiences [continues]

ADJUSTMENT TO TRAUMA continued

Potential presenting symptoms of Traumatic Stress in young children (ZTT, 2016)

- **Re-experiencing** the traumatic event
  - Play or behavior that reenacts aspect of the trauma
  - Repeated statements or questions about the trauma
  - Repeated nightmares, content may or may not be linked to traumatic event
  - Distress at reminders of traumatic event
  - Physiological reaction (sweating, agitated breathing, change in color) at reminders of the event
  - Dissociative episodes: child freezes, stills, or stares and is unresponsive to environmental stimuli
- **Avoiding** people, places, activities, conversations, or interpersonal situations that are reminders of the event
- **Dampening of positive emotional affect**
  - Increased social withdrawal
  - Reduced expression of positive emotions
  - Reduced interest in activities such as play and social interaction
  - Increased fearfulness or sadness
- **Hyperarousal**
  - Sleep refusal and/or other sleep disturbances (including trouble falling asleep, night waking, etc.)
  - Difficulty concentrating
  - Hypervigilance
  - Exaggerated startle response
  - Irritability, anger, extreme fussiness, and/or temper tantrums

FOR REFERENCE TO DC 0-5 (ZTT, 2016) IF APPLICABLE

Axis I

- Following a traumatic event, a rating of '2' or '3' may be consistent with a diagnosis of **Posttraumatic Stress Disorder (PTSD).**
- Following the permanent loss of a primary attachment figure/caregiver, a rating of '2' or '3' may be consistent with symptoms of **Complicated Grief Disorder of Early Childhood.**
- For infants or young children who do not meet the diagnostic criteria for PTSD or Complicated Grief, a rating of '2' may be consistent with a diagnosis of **Adjustment Disorder.**

Axis IV

- Information gathered as part of assessing traumatic events the child may have experienced can be used as part of documenting concerns within Axis IV: Psychosocial Stressors.

POTENTIALLY TRAUMATIC/ADVERSE CHILDHOOD EXPERIENCES DOMAIN

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

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

Rate these items within the child's lifetime.

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

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

NEGLECT

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

Questions to Consider

- Is the child receiving adequate supervision?
- Has the child been denied their needs for food and shelter?
- Is the child allowed access to necessary medical care? Education?

Ratings and Descriptions

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

EMOTIONAL ABUSE

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

Questions to Consider	Ratings and Descriptions	
• Is the child subject to name calling or shaming in their home?	No	There is no evidence that child has experienced emotional abuse.
	Yes	Child has experienced emotional abuse, or there is a suspicion that they have experienced emotional abuse (mild to severe, for any length of time) including: insults or occasionally being referred to in a derogatory manner, being denied emotional attention or completely ignored, or threatened/terrorized by others.

PHYSICAL ABUSE

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

Questions to Consider	Ratings and Descriptions	
• Is physical discipline used in the home? What forms? • Has the child ever received bruises, marks, or injury from discipline?	No	There is no evidence that the child has experienced physical abuse.
	Yes	Child has experienced or there is a suspicion that they experienced physical abuse – mild to severe, or repeated physical abuse with sufficient physical harm requiring medical treatment.

SEXUAL ABUSE

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

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

WITNESS TO FAMILY VIOLENCE
This item describes exposure to violence within the child's home or family.

Questions to Consider

- Is there frequent fighting in the child's family?
- Does the fighting ever become physical?

Ratings and Descriptions

No	There is no evidence the child has witnessed family violence.
Yes	Child has witnessed, or there is a suspicion that they witnessed family violence – single, repeated, or severe episodes. This includes episodes of family violence but no significant injuries (i.e., requiring emergency medical attention) and episodes in which significant injuries have occurred as a direct result of the violence.

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

Questions to Consider

- Has the child ever lived apart from their caregivers?
- Have there ever been changes in the relationship status of the child's caregiver(s)?
- What happened that resulted in the child living apart from their caregivers?

Ratings and Descriptions

No	There is no evidence that the child has experienced disruptions in caregiving and/or attachment losses.
Yes	Child has been exposed to, or there is suspicion that they were exposed to, at least one disruption in caregiving with familiar alternative caregivers or unknown caregivers (this includes placement in foster or other out-of-home care such as residential care facilities). Child may or may not have had ongoing contact with primary attachment figure(s) during this disruption. Shift in caregiving may have been temporary or permanent.

Supplemental Information: Children who have been exposed to disruptions in caregiving involving separation from primary attachment figure(s) and/or attachment losses would be rated here. **This includes parent/caregiver divorce or separation.**

PARENTAL CRIMINAL BEHAVIORS
This item describes the criminal behavior of both biological and stepparents, and other legal guardians, but not foster parents.

Questions to Consider

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

Ratings and Descriptions

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

PARENT/CAREGIVER MENTAL ILLNESS

This item describes whether or not the child has a history of living with a parent/caregiver with mental illness prior to the age of 18.

Questions to Consider	Ratings and Descriptions	
• Has the child ever lived with a parent/caregiver who had mental health issues (e.g., depression, schizophrenia, bipolar disorder, PTSD, or an anxiety disorder)?	No	There is no evidence that the child has a history of living with a parent/caregiver with mental illness
	Yes	Prior to the age of 18, child lived with a parent/caregiver with mental illness or there is a suspicion that they did.

PARENT/CAREGIVER SUBSTANCE ABUSE

This item describes whether or not there is a history of a parent/caregiver abusing alcohol and/or illegal drugs, and/or misusing prescription medications before the child was 18 years old.

Questions to Consider	Ratings and Descriptions	
• Did the child's parent or any caregiver ever have a problem with alcohol, illegal drugs or prescription medication use?	No	There is no evidence that the parent/caregiver struggled with substance use.
	Yes	Prior to the age of 18, the child lived with parents/caregiver who abused alcohol and/or illegal drugs, and/or misused prescription medications, or there is a suspicion that this occurred.

MEDICAL TRAUMA

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

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

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

WITNESS TO COMMUNITY/SCHOOL VIOLENCE
This item describes the exposure to incidents of violence the child has witnessed or experienced in their community. This includes witnessing violence at the child's school setting or educational setting.

Questions to Consider

- Does the child live in a neighborhood with frequent violence?
- Has the child witnessed or directly experienced violence at their school?

Ratings and Descriptions

No	There is no evidence that the child has witnessed violence in their community or school setting.
Yes	Child has witnessed or experienced violence in their community or school, such as: fighting; friends/family injuries as a result of violence; severe and repeated instances of violence and/or the death of another person in their community/school as a result of violence; is the direct victim of violence/criminal activity in the community/school that was life threatening; or has experienced chronic/ongoing impact as a result of community/school violence (e.g., family member injured and no longer able to work). A suspicion that the child has witnessed or experienced violence in the community would be rated here.

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

Questions to Consider

- Has the child or their family lived in a war-torn region?
- How close were they to war or political violence, torture, or terrorism?
- Was the child displaced?

Ratings and Descriptions

No	No evidence that the child has been exposed to war, political violence, torture, or terrorism.
Yes	Child has experienced, or there is suspicion that they have experienced or been affected by war, terrorism, or political violence. Examples include: Family members directly related to the child may have been exposed to war, political violence, or torture resulting in displacement, injury or disability, or death; parents may have been physically or psychologically disabled from the war and are unable to adequately care for the child; child may have spent an extended amount of time in a refugee camp, or feared for their own life during war or terrorism due to bombings or shelling very near to them; child may have been directly injured, tortured, or kidnapped in a terrorist attack; child may have served as a soldier, guerrilla, or other combatant in their home country. Also included is a child who did not live in war or terrorism-affected region or refugee camp, but whose family was affected by war.

Supplemental Information: Terrorism is defined as "the calculated use of violence or the threat of violence to inculcate fear, intended to coerce or to intimidate governments or societies in the pursuit of goals that are generally political, religious or ideological."

NATURAL OR MANMADE DISASTER
This item describes the child's exposure to either natural or manmade disasters.

Questions to Consider
- Has the child been present during a natural or manmade disaster?
- Does the child watch television shows containing these themes?

Ratings and Descriptions

No — There is no evidence that the child has experienced, been exposed to or witnessed natural or manmade disasters.

Yes — Child has experienced, been exposed to or witnessed natural or manmade disasters either directly or second-hand (e.g., on television, hearing others discuss disasters). This includes disasters such as a fire or earthquake or manmade disaster; car accident, plane crashes, or bombings; observing a caregiver who has been injured in a car accident or fire or watching a neighbor's house burn down; a disaster that caused significant harm or death to a loved one; or there is an ongoing impact or life disruption due to the disaster (e.g., caregiver loses job). A suspicion that the child has experienced, been exposed to or witnessed natural or manmade disasters either directly or second-hand would be rated here.

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

Questions to Consider
- Has the child or someone in their family ever been the victim of a crime?
- Has the child seen criminal activity in the community or home?

Ratings and Descriptions

No — There is no evidence that the child has been victim of or a witness to criminal activity.

Yes — Child has been victimized, or there is suspicion that they have been victimized or have witnessed criminal activity. This includes a single instance, multiple instances, or chronic and severe instances of criminal activity that was life threatening or caused significant physical harm, or child has witnessed the death of a family friend or loved one.

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

RISK BEHAVIORS DOMAIN

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

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

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

0 No history of developmental risk factor; no need for attention or intervention.

1 Suspicion of developmental risk factor; requires monitoring, watchful waiting, or preventive activities.

2 Evidence that developmental risk factor occurred in the child's history and is impacting functioning; requires action or intervention to ensure that the need is addressed.

3 Evidence of dangerous or disabling impact of developmental risk factor; requires immediate and/or intensive action.

SELF-HARM

This item rates the presence of repetitive behaviors, like head-banging or biting/hitting oneself, that result in physical harm to the child. **The child must be 12 months of age to rate this item.**

Questions to Consider

- Has the child head banged or done other self-harming behaviors?
- If so, does the caregiver's support help stop the behavior?

Ratings and Descriptions

0 *No history of developmental risk factor; no need for attention or intervention.*
There is no evidence of self-harm behaviors.

1 *Suspicion of developmental risk factor; requires monitoring, watchful waiting, or preventive activities.*
History, suspicion or some evidence of self-harm behaviors. These behaviors are controllable by caregiver.

2 *Evidence that developmental risk factor occurred in the child's history and is impacting functioning; requires action or intervention to ensure that the need is addressed.*
Child's self-harm behaviors, such as head banging, cannot be impacted by supervising adult and interferes with their functioning.

3 *Evidence of dangerous or disabling impact of developmental risk factor; requires immediate and/or intensive action.*
Child's self-harm behavior puts their safety and well-being at risk.

NA Child is younger than 12 months of age.

Supplemental Information: Self-harm, oftentimes referred to as Self-Injurious Behavior (or SIB), is known to occur in young children; in fact, studies from the 1980s and 1990s found that about 15% of young children demonstrated some instances of SIB during the first five years of life. While early-onset SIB generally resolves before age 5, it is more likely to persist in children with developmental delays (Kurtz et al., 2012). The most common SIBs for young children are head banging, hand-to-head hitting, skin picking/scratching, hair pulling, throwing self to floor, self-biting, and eye poking. [continues]

SELF-HARM continued

In most cases, SIB in young children is a way to self-stimulate, self-comfort, or release frustration. In some cases, SIB may emerge when a child is experiencing emotional distress, such as after an experience of trauma or within the context of relational challenges with caregivers. Like other "aggressive" behaviors in early childhood, it is important for caregivers to try to recognize the child's feeling or goal that may be prompting the SIB and help children learn emotional regulation skills that they can use in these situations (Lerner & Parlakian, 2016).

Several factors have been associated with SIB in early childhood, including (Kurtz et al., 2012):

- Intellectual or developmental disability (such as Austin Spectrum Disorder)
- Certain genetic disorders (such as Fragile X Syndrome)
- Experience of pain-related events during early childhood
- Sensory processing difficulties, including low vestibular stimulation (the vestibular system is located within the inner ear and responds to movement and gravity)
- Communication difficulties
- Isolated caregiving environments

FOR REFERENCE TO DC 0-5 (ZTT, 2016) IF APPLICABLE

Axis I

- A rating of '2' or '3' may be consistent with symptoms of **Depressive Disorder of Early Childhood** or **Disorder of Dysregulated Anger and Aggression of Early Childhood (DDAA).**
- A rating of '2' or '3' specific to interactions with one caregiver may be a consistent with symptoms of **Relationship Specific Disorder**.

PRENATAL CARE

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

Questions to Consider

- What kind of prenatal care did the biological mother receive?
- Did the mother have any unusual illnesses or risks during pregnancy?

Ratings and Descriptions

0 *No history of developmental risk factor; no need for attention or intervention.*

Child's biological mother had adequate prenatal care (e.g., 10 or more planned visits to a physician) that began in the first trimester. Child's mother did not experience any pregnancy-related illnesses.

1 *Suspicion of developmental risk factor; requires monitoring, watchful waiting, or preventive activities.*

Child's biological mother had some shortcomings in prenatal care, or had a mild form of a pregnancy-related illness. A child whose mother had 6 or fewer planned visits to a physician would be rated here; her care must have begun in the first or early second trimester. A child whose mother had a mild or well-controlled form of pregnancy-related illness such as gestational diabetes, or who had an uncomplicated high-risk pregnancy, would be rated here.

2 *Evidence that developmental risk factor occurred in the child's history and is impacting functioning; requires action or intervention to ensure that the need is addressed.*

Child's biological mother received poor prenatal care, initiated only in the last trimester, or had a moderate form of pregnancy-related illness. A child whose mother had 4 or fewer planned visits to a physician would be rated here. A mother who experienced a high-risk pregnancy with some complications would be rated here.

3 *Evidence of dangerous or disabling impact of developmental risk factor; requires immediate and/or intensive action.*

Child's biological mother had no prenatal care, or had a severe form of pregnancy-related illness. A mother who had toxemia/preeclampsia would be rated here.

BIRTH WEIGHT

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

Questions to Consider

- How did the child's birth weight compare to typical averages?

Ratings and Descriptions

0 *No history of developmental risk factor; no need for attention or intervention.*
Child within normal range for weight at birth. A child with a birth weight of 2500 grams (5.5 pounds) or greater would be rated here.

1 *Suspicion of developmental risk factor; requires monitoring, watchful waiting, or preventive activities.*
Child born underweight. A child with a birth weight of between 1500 grams (3.3. pounds) and 2499 grams would be rated here.

2 *Evidence that developmental risk factor occurred in the child's history and is impacting functioning; requires action or intervention to ensure that the need is addressed.*
Child considerably under-weight at birth to the point of presenting a development risk to them. A child with a birth weight of 1000 grams (2.2 pounds) to 1499 grams would be rated here.

3 *Evidence of dangerous or disabling impact of developmental risk factor; requires immediate and/or intensive action.*
Child extremely under-weight at birth to the point of threatening their life. A child with a birth weight of less than 1000 grams (2.2 pounds) would be rated here.

LABOR AND DELIVERY

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

Questions to Consider

- Where there any unusual circumstances related to the labor and delivery of the child?

Ratings and Descriptions

0 *No history of developmental risk factor; no need for attention or intervention.*
Child and mother had normal labor and delivery. A child who received an Apgar score of 7-10 at birth would be rated here.

1 *Suspicion of developmental risk factor; requires monitoring, watchful waiting, or preventive activities.*
Child or mother had some mild problems during delivery, but there is no history of adverse impact. An emergency C-section or a delivery-related physical injury (e.g., shoulder displacement) to the baby is rated here.

2 *Evidence that developmental risk factor occurred in the child's history and is impacting functioning; requires action or intervention to ensure that the need is addressed.*
Child or mother had problems during delivery that resulted in temporary functional difficulties for the child or mother. Extended fetal distress, postpartum hemorrhage, or uterine rupture would be rated here. A child who received an Apgar score of 4-7 or needed some resuscitative measures at birth is rated here.

3 *Evidence of dangerous or disabling impact of developmental risk factor; requires immediate and/or intensive action.*
Child had severe problems during delivery that have long-term implications for development (e.g., extensive oxygen deprivation, brain damage). A child who received an Apgar score of 3 or lower or who needed immediate or extensive resuscitative measures at birth would be rated here.

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

Questions to Consider

- Was the child exposed to substances during the pregnancy? If so, what substances?

Ratings and Descriptions

0 *No history of developmental risk factor; no need for attention or intervention.*
Child had no in utero exposure to environmental toxins, alcohol or drugs, and there is currently no exposure in the home.

1 *Suspicion of developmental risk factor; requires monitoring, watchful waiting, or preventive activities.*
Child had either some in utero exposure (e.g., mother ingested alcohol or tobacco in small amounts fewer than four times during pregnancy, or exposure to lead at home), or there is current alcohol and/or drug use in the home or environmental toxins in the home or community.

2 *Evidence that developmental risk factor occurred in the child's history and is impacting functioning; requires action or intervention to ensure that the need is addressed.*
Child was exposed to significant environmental toxins, alcohol or drugs in utero. Any ingestion of illegal drugs during pregnancy (e.g., heroin, cocaine), significant use of alcohol or tobacco, or exposure to environmental toxins would be rated here.

3 *Evidence of dangerous or disabling impact of developmental risk factor; requires immediate and/or intensive action.*
Child was exposed to environmental toxins, alcohol or drugs in utero and continues to be exposed in the home or community. Any child who evidenced symptoms of substance withdrawal at birth (e.g., crankiness, feeding problems, tremors, weak and continual crying) would be rated here. A child who ingested lead paint and exhibited symptoms would be rated here.

VICTIMIZATION/EXPLOITATION

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

Questions to Consider

- Has the child ever been victimized in any way (e.g., abused, victim of a crime, etc.)?
- Are there concerns that they have been or are currently being taken advantage of by peers or other adults?
- Is the child currently at risk of being victimized by another person?

Ratings and Descriptions

0 *No history of developmental risk factor; no need for attention or intervention.*
No evidence of a history of exploitation OR no evidence of recent exploitation and no significant history of victimization within the past year. Child is not presently at risk for re-victimization.

1 *Suspicion of developmental risk factor; requires monitoring, watchful waiting, or preventive activities.*
Suspicion or history of exploitation, but the child has not been exploited during the past year. Child is not presently at risk for re-victimization.

2 *Evidence that developmental risk factor occurred in the child's history and is impacting functioning; requires action or intervention to ensure that the need is addressed.*
Child has been recently exploited (within the past year) but is not at acute risk of re-exploitation. This might include experiences of physical or sexual abuse, significant psychological abuse by family or friends or violent crime.

3 *Evidence of dangerous or disabling impact of developmental risk factor; requires immediate and/or intensive action.*
Child has recently been exploited and is at acute risk of re-exploitation.

FAILURE TO THRIVE

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

Questions to Consider

- Does the child have any problems with weight gain or growth either now or in the past?
- Are there any concerns about the child's eating habits?
- Does the child's doctor have any concerns about the child's growth or weight gain?

Ratings and Descriptions

0 *No history of developmental risk factor; no need for attention or intervention.*
No evidence of failure to thrive.

1 *Suspicion of developmental risk factor; requires monitoring, watchful waiting, or preventive activities.*
The child may have experienced past problems with growth and ability to gain weight and is currently not experiencing problems. The child may presently be experiencing slow development in this area.

2 *Evidence that developmental risk factor occurred in the child's history and is impacting functioning; requires action or intervention to ensure that the need is addressed.*
The child is experiencing problems in their ability to maintain weight or growth. The child may be below the 5th percentile for age and sex, may weigh less than 80% of their ideal weight for age, have depressed weight for height, or have a rate of weight gain that causes a decrease in two or more major percentile lines over time (75th to 25th).

3 *Evidence of dangerous or disabling impact of developmental risk factor; requires immediate and/or intensive action.*
The child has one or more of all of the above and is currently at serious medical risk.