WISCONSIN DEPARTMENT OF CHILDREN AND FAMILIES

Child and Adolescent Needs and Strengths

WI CANS 2.0

Birth to Age 5

2023 REFERENCE GUIDE

ACKNOWLEDGEMENTS

Many individuals have collaborated in the development of the Standard Comprehensive Child Adolescent Needs and Strengths—Early Childhood. 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 required for appropriate use.

We are 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.

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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 systems— 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 planning. An item exists because it might lead you down a different pathway in terms of planning actions.
2. Each item uses a 4-level rating system designed to translate immediately into action levels. Different action levels exist for needs and strengths. For a description of these action levels please see below.
3. Ratings should describe the individual, not the individual 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 responsivity 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 and young adult 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 to make sure assessments stay relevant to the child’s present circumstances. The CANS is a communication tool and a measure of an individual’s story. The 30-day time frame should be considered in terms of whether an item is a need within the time frame within which the specific behavior may or may not have occurred. The action levels assist in understanding whether a need is currently relevant 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 up of domains that focus on various areas in a child's life, and each domain is made up of a group of specific items. There are domains that address how the child functions in everyday life, on specific emotional or behavioral concerns, on risk behaviors, on strengths and on skills needed to grow and develop. There is also a domain that asks about the family's beliefs and preferences, and about general family concerns. The 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 the assessment 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 CANS assessment tool will provide information as to the appropriateness of the recovery plan and whether individual goals and outcomes are achieved.

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

MEASUREMENT PROPERTIES OF THE CHILD AND ADOLESCENT NEEDS AND STRENGTHS

RELIABILITY

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

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

Each CANS rating suggests different pathways for service 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:

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 'NA' for 'not applicable' is available for a few items under specified circumstances (see reference guide descriptions). For those items where the 'NA' 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, child welfare professional, clinician, or other care provider should read the anchor descriptions for each item and then record the appropriate rating on the CANS 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 individuals 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 an individual's skill should first be viewed as an opportunity to learn the skill as opposed to the problem. Focusing on the individual's strengths instead of weaknesses with their families may result in enhanced motivation and improved performance. Involving the individual and, when appropriate, their families 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 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 assessment. A rating of '2' or '3' on a CANS need suggests that this area must be addressed in the service or treatment plan. A rating of a '0' or '1' identifies a strength that can be used for strength-based planning and a '2' or '3' a strength that should be the focus of strength-building activities, when appropriate. It is important to remember that when developing service and treatment plans for healthy child trajectories, balancing the plan to address risk behaviors/ needs and protective factors/strengths is key. It has been demonstrated in the literature that strategies designed to develop child capabilities are a promising means for development and play a role in reducing risky behaviors.

Finally, the CANS can be used to monitor outcomes. This can be accomplished in two ways. First, CANS items that are initially rated a '2' or '3' are monitored over time to determine the percentage of individuals who move to a rating of '0' or '1' (resolved need, built strength). Dimension scores can also be generated by summing items within each of the domains (Behavioral/Emotional Needs, Risk Behaviors, 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 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 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 CHANGE

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

It is a good idea to know the CANS 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 Strengths, or Caregiver Resources & Needs—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 18) 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 individual 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 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 THE PARENT'S/CAREGIVER'S 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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WI CANS 2.0 STRUCTURE

The Wisconsin CANS 2.0 expands depending upon the needs of the individual. Basic core items are rated for all children. Individualized Assessment Modules are triggered by key core items (see letters below) rated '1', '2', or '3'. Additional questions are required for the modules to function.

CORE ITEMS

Trauma Experiences Domain
Sexual Abuse [A]
Physical Abuse
Neglect
Emotional Abuse
Medical Trauma
Natural or Manmade Disaster
Family Violence
Community Violence
Criminal Activity

Adjustment to Trauma Domain
Emotional and/or Physical Dysregulation
Re-Experiencing Trauma
Avoidance
Increased Arousal
Numbing Response

Life Functioning Domain
Family Functioning – Nuclear
Family Functioning – Extended
Living Situation
Developmental/Intellectual [B]
Medical [C]
Physical
Dental
Daily Functioning
Social and Emotional Functioning
Recreation/Play
Regulatory [D]
Motor
Communication
Sleep
Preschool/Childcare [E]

Child and Family Cultural Factors Domain
Language
Cultural Identity
Traditions and Cultural Rituals
Cultural Stress
Knowledge Congruence
Help Seeking Congruence
Expression of Distress

Child Behavioral/Emotional Needs Domain
Attachment Difficulties
Failure to Thrive
Depression (Withdrawn)
Anxiety
Atypical Behaviors
Impulsivity/Hyperactivity
Oppositional Behavior

Child Risk Factors Domain
Birth Weight
Pica
Prenatal Care
Length of Gestation
Labor and Delivery
Substance Exposure
Parent/Sibling Problems
Maternal Availability

Child Risk Behaviors Domain
Self-Harm
Aggressive Behavior
Intentional Misbehavior

Child Strengths Domain
Relationship Permanence
Family Strengths – Nuclear
Family Strengths – Extended
Interpersonal
Adaptability
Persistence
Curiosity
Resilience

Current Caregiver: Resources & Needs Domain
Supervision
Problem Solving
Involvement with Care
Knowledge
Empathy with Child
Organization
Social Resources
Medical/Physical Health
Mental Health
Substance Use
Developmental
Family Stress
Cultural Congruence

Identified Permanent Resource: Resources & Needs Domain
Residential Stability
Self-Care/Daily Living Skills
Access to Childcare Services
Cultural Stress
Employment/Educational Functioning
Educational Attainment
Financial Resources
Community Connection
Legal
Transportation
Supervision
Problem Solving
Involvement with Care
Knowledge
Empathy with Child
Organization
Social Resources
Medical/Physical Health
Mental Health
Substance Use
Developmental
Family Stress
Cultural Congruence

MODULES

[A] Sexual Abuse
Emotional Closeness to the Perpetrator
Frequency of Abuse
Duration
Physical Force
Reaction to Disclosure
Victim of Sex Trafficking

[B] Developmental Disabilities
Cognitive
Autism Spectrum
Communication
Self-Care Daily Living Skills

[C] Medical Health
Life Threatening
Chronicity
Diagnostic Complexity
Emotional Response
Impairment in Functioning
Treatment Involvement
Intensity of Treatment Support
Organizational Complexity

[D] Regulatory
Eating
Elimination
Sensory Reactivity
Emotional Control

[E] Preschool/Childcare
Attendance
Compatibility
Behavior
Achievement
Relations with Teacher(s)
Relations with Peers

TRAUMA EXPERIENCES DOMAIN

All of the trauma experiences items are static indicators. In other words, these items indicate whether 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 Domain: Has the child experienced adverse or traumatic life events?

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

0 No evidence of any trauma of this type.

1 A single event or one incident of trauma occurred, or a suspicion exists of trauma experiences.

2 Multiple trauma experiences or multiple incidents of trauma.

3 Repeated or chronic, ongoing and/or severe trauma with medical and physical consequences.

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Rate the following items within the child's lifetime.

SEXUAL ABUSE*

This item describes whether or not the child has experienced sexual abuse, or there is suspicion that the child experienced sexual abuse.

Questions to Consider:

- Has the caregiver or child disclosed sexual abuse?
- How often did the abuse occur?
- Did the abuse result in physical injury?

Ratings and Descriptions

0 No evidence of any trauma of this type.
No evidence that the child has experienced sexual abuse.

1 A single event or one incident of trauma occurred, or a suspicion exists of trauma experiences.
Child has experienced one episode of sexual abuse or there is a suspicion that the child has experienced sexual abuse but no confirming evidence.

2 Multiple trauma experiences or multiple incidents of trauma.
Child has experienced repeated sexual abuse.

3 Repeated or chronic, ongoing and/or severe trauma with medical and physical consequences.
Child has experienced severe and repeated sexual abuse. Sexual abuse may have caused physical harm.

***A rating of '1,' '2,' or '3' on this item triggers the completion of the [A] Sexual Abuse Module.**

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[A] SEXUAL ABUSE MODULE

This module is to be completed when the Sexual Abuse item is rated '1,' '2' or '3.'

EMOTIONAL CLOSENESS TO THE PERPETRATOR

This item defines the relationship between the child and the perpetrator of sexual abuse.

Questions to Consider:

- Did the child know the perpetrator?
- Was the perpetrator a member of the family?

Ratings and Descriptions

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

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FREQUENCY OF ABUSE

This item identifies the frequency of the sexual abuse.

Questions to Consider:

- How often did the sexual abuse occur?

Ratings and Descriptions

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

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DURATION

This item identifies the length of time during which the abuse occurred.

Questions to Consider:

- For how long did the sexual abuse occur?

Ratings and Descriptions

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

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PHYSICAL FORCE

This item identifies the severity of physical force or violence used during episodes of sexual abuse.

Questions to Consider:

- Was there physical violence or the threat of physical violence used during the abuse?

Ratings and Descriptions

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

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REACTION TO DISCLOSURE

This item identifies the level of support the child received from family after disclosing the sexual abuse.

Questions to Consider:

- Was the family supportive of the child during the disclosure process?
- Is the family aware of the abuse?

Ratings and Descriptions

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

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VICTIM OF SEX TRAFFICKING

This item identifies whether the child is a victim of sex trafficking.

Questions to Consider:

- Is there any indication that the child has experienced sex trafficking? At what frequency?

Ratings and Descriptions

0	There is no evidence that the child has experienced sex trafficking.
1	Child has experienced one episode of sex trafficking or there is a suspicion that the child has experienced sex trafficking but no confirming evidence.
2	Child has experienced repeated sex trafficking.
3	Child has experienced severe and repeated sex trafficking. Sex trafficking may have caused physical harm.

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End of Sexual Abuse Module

PHYSICAL ABUSE

This item includes one or more episodes of aggressive behavior usually resulting in physical injury to the child. It also includes contact that is intended to cause feelings of intimidation, pain, injury, or other physical suffering or bodily harm.

Questions to Consider:

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

Ratings and Descriptions

0 No evidence of any trauma of this type.

There is no evidence that child has experienced physical abuse.

1 A single event or one incident of trauma occurred, or a suspicion exists of trauma experiences.

Child has experienced one episode of physical abuse, or there is a suspicion that the child has experienced physical abuse but no confirming evidence.

2 Multiple trauma experiences or multiple incidents of trauma.

Child has experienced repeated physical abuse.

3 Repeated or chronic, ongoing and/or severe trauma with medical and physical consequences.

Child has experienced severe and/or repeated physical abuse that caused sufficient physical harm to necessitate hospital or medical treatment.

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

Ratings and Descriptions

0 No evidence of any trauma of this type.

No evidence that the child has experienced neglect.

1 A single event or one incident of trauma occurred, or a suspicion exists of trauma experiences.

Child has experienced minor or occasional neglect. Child may have been left at home alone with no adult supervision or there may be occasional failure to provide adequate supervision of the child.

2 Multiple trauma experiences or multiple incidents of trauma.

Child has experienced a moderate level of neglect. This may include occasional unintended failure to provide adequate food, shelter, or clothing with corrective action.

3 Repeated or chronic, ongoing and/or severe trauma with medical and physical consequences.

Child has experienced a severe level of neglect including prolonged absences by adults, without minimal supervision, and failure to provide basic necessities of life on a regular basis.

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EMOTIONAL ABUSE

This item rates whether the child has experienced verbal and nonverbal emotional abuse, including belittling, shaming, and humiliating a child, calling names, making negative comparisons to others, or telling a child that they are “no good.” This item includes both “emotional abuse,” which would include psychological maltreatment such as insults or humiliation towards a child and “emotional neglect,” described as the denial of emotional attention and/or support from caregivers.

Questions to Consider:

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

Ratings and Descriptions

0 No evidence of any trauma of this type.

No evidence that the child has experienced emotional abuse.

1 A single event or one incident of trauma occurred, or a suspicion exists of trauma experiences.

Child has experienced mild emotional abuse. For instance, the child may experience some insults or is occasionally referred to in a derogatory manner by caregivers.

2 Multiple trauma experiences or multiple incidents of trauma.

Child has experienced emotional abuse over an extended period of time (at least one year). For instance, the child may be consistently denied emotional attention from caregivers, insulted or humiliated on an ongoing basis, or intentionally isolated from others.

3 Repeated or chronic, ongoing and/or severe trauma with medical and physical consequences.

Child has experienced severe and repeated emotional abuse over an extended period of time (at least one year). For instance, the child is completely ignored by caregivers, or threatened/terrorized by others.

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MEDICAL TRAUMA

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

Questions to Consider:

- Has the child had any broken bones, stitches or other medical procedures?
- Has the child had to go to the emergency room, or stay overnight in the hospital?
- Did the child find this medical experience to be overwhelming and/or are they having a traumatic reaction to the experience?

Ratings and Descriptions

0 No evidence of any trauma of this type.

There is no evidence that the child has experienced any medical trauma.

1 A single event or one incident of trauma occurred, or a suspicion exists of trauma experiences.

Child has experienced mild medical trauma resulting from, for example, minor surgery (e.g. stitches, bone setting).

2 Multiple trauma experiences or multiple incidents of trauma.

Child has experienced moderate medical trauma resulting from, for example, major surgery or injuries requiring hospitalization.

3 Repeated or chronic, ongoing and/or severe trauma with medical and physical consequences.

Child has experienced life-threatening medical trauma.

Supplemental Information: This item considers 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.

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NATURAL OR MANMADE DISASTER

This item describes the individual'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 or overhear others talking about these kinds of disasters?

Ratings and Descriptions

0 No evidence of any trauma of this type.

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

1 A single event or one incident of trauma occurred, or a suspicion exists of trauma experiences.

Child has been indirectly affected by or secondhand exposure to a natural or manmade disaster (e.g., on television, hearing others discuss disasters).

2 Multiple trauma experiences or multiple incidents of trauma.

Child has experienced a natural or manmade disaster which has had a notable impact on their well-being. Child has been directly exposed to a disaster or witnessed the impact of a disaster on a family or friend. For instance, a child may observe a caregiver who has been injured in a car accident or fire or watch their neighbor's house burn down.

3 Repeated or chronic, ongoing and/or severe trauma with medical and physical consequences.

Child has experienced a life threatening natural or manmade disaster. Child has been directly exposed to a disaster that caused significant harm or death to a loved one or there is an ongoing impact or life disruption due to the disaster (e.g., house burns down, caregiver loses job).

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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

0 No evidence of any trauma of this type.

There is no evidence that the child has witnessed family violence.

1 A single event or one incident of trauma occurred, or a suspicion exists of trauma experiences.

Child has witnessed one episode of family violence.

2 Multiple trauma experiences or multiple incidents of trauma.

Child witnessed repeated episodes of family violence but no significant injuries (i.e., requiring emergency medical attention) have been witnessed.

3 Repeated or chronic, ongoing and/or severe trauma with medical and physical consequences.

Child has witnessed repeated and severe episodes of family violence. Significant injuries have occurred as a direct result of the violence.

Supplemental Information: The Family Violence item is intended to relate to violence that occurs within the home. Sometimes this violence can also be criminal activity if law enforcement is involved. If law enforcement is not involved in violence that occurs within the family, it would only be rated under the Family Violence item and not the Criminal Activity item.

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COMMUNITY VIOLENCE

This item describes the exposure to incidents of violence the child has witnessed or experienced in their community.

Questions to Consider:

- Does the child live in a neighborhood with frequent violence?
- Did the violence result in significant injury to others in the community?

Ratings and Descriptions

0 No evidence of any trauma of this type.

There is no evidence that the child has witnessed or experienced violence in the community.

1 A single event or one incident of trauma occurred, or a suspicion exists of trauma experiences.

Child has witnessed occasional fighting or other forms of violence in the community. Child has not been directly impacted by the community violence (e.g., violence not directed at self, family, or friends) and exposure has been limited.

2 Multiple trauma experiences or multiple incidents of trauma.

Child witnessed the significant injury of others in their community; has had friends/family members injured as a result of violence or criminal activity in the community; is the direct victim of violence/criminal activity that was not life threatening; or has witnessed/ experienced chronic or ongoing community violence.

3 Repeated or chronic, ongoing and/or severe trauma with medical and physical consequences.

Child has witnessed or experienced the death of another person in their community as a result of violence; is the direct victim of violence/criminal activity in the community that was life threatening; or has experienced chronic/ongoing impact as a result of community violence (e.g., family member injured and no longer able to work).

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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

0 No evidence of any trauma of this type.

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

1 A single event or one incident of trauma occurred, or a suspicion exists of trauma experiences.

Child is a witness to significant criminal activity.

2 Multiple trauma experiences or multiple incidents of trauma.

Child is a direct victim of criminal activity or witnessed the victimization of a family or friend.

3 Repeated or chronic, ongoing and/or severe trauma with medical and physical consequences.

Child is a victim of criminal activity that was life threatening or caused significant physical harm; or the child 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.

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ADJUSTMENT TO TRAUMA DOMAIN

This section identifies any dysregulated reactions or symptoms that children may exhibit to any of a variety of traumatic experiences.

Question to Consider for this Domain: Is the child exhibiting any difficulties adjusting to a trauma?

For the **Adjustment to Trauma 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 Need is interfering with functioning. Action is required to ensure that the identified need is addressed.

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

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EMOTIONAL AND/OR PHYSICAL DYSREGULATION

This item describes the child's difficulties with arousal regulation or expressing emotions and energy states.

Questions to Consider:

- Does the child have reactions that seem out of proportion (larger or smaller than is appropriate) to the situation?
- Does the child have extreme or unchecked emotional reactions to situations?

Ratings and Descriptions

0 No evidence of any needs; no need for action.
Child has no problems with emotional regulation. Emotional responses and energy level and are appropriate to the situation.

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

History or evidence of difficulties with affect/physiological regulation. The child could have some difficulty tolerating intense emotions and become somewhat jumpy or irritable in response to emotionally charged stimuli, or more watchful or hypervigilant in general or have some difficulties with regulating body functions (e.g., sleeping, eating or elimination). The child may also have some difficulty sustaining involvement in activities for any length of time or have some physical or somatic complaints.

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

Child has problems with affect/physiological regulation that are impacting their functioning in some life domains but is able to control affect at times. The child may be unable to modulate emotional responses or have more persistent difficulties in regulating bodily functions. The child may exhibit marked shifts in emotional responses (e.g., from sadness to irritability to anxiety) or have contained emotions with a tendency to lose control of emotions at various points (e.g., normally restricted affect punctuated by outbursts of anger or sadness). The child may also exhibit persistent anxiety, intense fear or helplessness, lethargy/loss of motivation, or affective or physiological over-arousal or reactivity (e.g., silly behavior, loose active limbs) or under arousal (e.g., lack of movement and facial expressions, slowed walking and talking). [continues]

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EMOTIONAL AND/OR PHYSICAL DYSREGULATION continued

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

Child is unable to regulate affect and/or physiological responses. The child may have more rapid shifts in mood and an inability to modulate emotional responses (feeling out of control of their emotions or lacking control over their movement as it relates to their emotional states). Alternately the child may be characterized by extreme lethargy, loss of motivation or drive, and no ability to concentrate or sustain engagement in activities (i.e., emotionally 'shut down'). The child may have more persistent and severe difficulties regulating sleep/wake cycle, eating patterns, or have elimination problems.

Supplemental Information: These symptoms are characterized by difficulties with arousal regulation. This can include difficulties modulating or expressing emotions and energy states such as emotional outbursts or marked shifts in emotions, overly constricted emotional responses, and intense emotional responses, and/or evidence of constricted, hyperarousal, or quickly fluctuating energy level. The child may demonstrate such difficulties with a single type or a wide range of emotions and energy states. This can also include difficulties with regulation of body functions, including disturbances in sleeping, eating, andelimination; over-reactivity or under-reactivity to touch and sounds; and physical or somatic complaints. This can also include difficulties with describing emotional or bodily states. The child's behavior likely reflects their difficulty with emotional and physiological regulation, especially for younger children. This can be demonstrated as excessive and chronic silly behavior, excessive body movements, difficulties regulating sleep/wake cycle, and inability to fully engage in activities.

Emotional dysregulation refers to difficulty regulating or "controlling" one's emotional responses and behaviors. Emotional dysregulation can be seen in both:

- the ease with which someone's mood changes, and
- the intensity of that mood change.

For example, children who have difficulties with emotional regulation will regularly have "mood swings" where they will very quickly become angry, sad, or anxious with little to no warning. These children will also have exaggerated emotional responses, so that not only do they become sad, anxious, or angry fairly suddenly, but the intensity of that emotion appears to be far in excess of what would be expected in that situation. It is important to rate this item appropriately given the child's age and developmental level. Younger children's emotional reactions may be more extreme and should not be rated unless they are out of proportion with their developmental level.

All people have occasional overreactions, but for people with dysregulation problems, these extreme emotional responses are common and cause significant difficulties in their life. Their mood swings and over-responding can lead to behavioral problems and interfere with their social interactions and relationships at home or school.

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RE-EXPERIENCING TRAUMA

This item describes intrusive memories or reminders of traumatic events, including nightmares, flashbacks, intense reliving of the events, and repetitive play with themes of specific traumatic experiences.

Questions to Consider:

- Does the child re-experience the trauma?
- If so, when and how often do they occur and in what form?

Ratings and Descriptions

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

There is no evidence that the child re-experiences the trauma.

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

The child experiences some indications that the trauma was being re-experienced in the form of sleep disruption or play after the trauma but is no longer present. Presently there may be some subtle changes in the child's functioning.

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

Child experiences consistent indications that the trauma is being re-experienced. Infants may demonstrate significant sleep disturbance, nightmares, and periods of disorganization. Older children may have the same symptoms with themes present in play.

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

Child experiences repeated and severe incidents of re-experiencing trauma that significantly interfere with functioning and cannot be mediated by caregivers.

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AVOIDANCE

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

Questions to Consider:

- Does the child make specific and concerted attempts to avoid sights, sounds, smells, etc. that are related to the trauma experience?

Ratings and Descriptions

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

No evidence of avoidant behavior.

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

Some problems with avoiding some situations either after the trauma or presently on an infrequent basis. Infants, due to limited mobility, rarely exhibit this symptom.

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

Problems with avoidant behavior that occurs consistently when the child is exposed to triggers related to the trauma. Caregiver can support the child.

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

Problems with avoidant behavior that occurs consistently but cannot be mediated by caregivers and causes significant distress.

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INCREASED AROUSAL

This item includes difficulty falling asleep, irritability or outbursts of anger, difficulty concentrating, hyper vigilance and/or exaggerated startle response. Child may also show common physical symptoms such as stomachaches and headaches. These symptoms are a part of the DSM criteria for Trauma-Related Adjustment Disorder, Posttraumatic Stress Disorder and other Trauma- and Stressor-Related Disorders.

Questions to Consider:

- Does the child seem more jumpy or irritable than is usual?
- Does the child have difficulty relaxing and/or have an exaggerated startle response?
- Does the child have stress-related physical symptoms: stomach- or headaches?
- Do these stress-related symptoms interfere with the child's ability to function?

Ratings and Descriptions

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

Child has no evidence of increased arousal symptoms.

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

History or evidence increased arousal that does not interfere with daily functioning.

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

Child demonstrates increased arousal most of the time. Infants appear wide eyed, over-reactive to stimuli, and have an exaggerated startle response. Toddlers may have all of the above with behavioral reactions such as tantrums.

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

Child demonstrates increased arousal most of the time with significant impairment in their functioning that cannot be mediated by the caregiver.

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NUMBING RESPONSE

This item describes the child's reduced capacity to feel or experience and express a range of emotions. These numbing responses were not present before the trauma.

Questions to Consider:

- Does the child experience a normal range of emotions?
- Does the child tend to have flat emotional responses?

Ratings and Descriptions

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

Child shows no evidence of numbing responses.

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

Child has a history or evidence of problems with numbing. They may have a restricted range of affect or be unable to express or experience certain emotions (e.g., anger or sadness).

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

Child exhibits numbing responses that impair their functioning in at least one life domain. Child may have a blunted or flat emotional state or have difficulty experiencing intense emotions or feel consistently detached or estranged from others following the traumatic experience.

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

Child exhibits significant numbing responses or multiple symptoms of numbing that put them at risk. The child may have a markedly diminished interest or participation in significant activities and a sense of a foreshortened future.

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LIFE FUNCTIONING DOMAIN

Life domains are the different arenas of social interaction found in the lives of children and their families. This domain rates how children 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 child 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,** 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 Need is interfering with functioning. Action is required to ensure that the identified need is addressed.

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

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FAMILY FUNCTIONING - NUCLEAR

This item evaluates and rates the child's relationships with those who are in their nuclear family. All other individuals, including those the family considers 'family' who are not legally related to them should be considered under Family Functioning – Extended.

Questions to Consider:

- Is there conflict in the family relationship that requires resolution?
- Is treatment required to restore or develop positive relationships in 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 with the child. Arguing may be common but does not result in major problems.

2 Need is interfering with functioning. Action is required to ensure that the identified need is addressed.
Child is having problems with parents, siblings and/or other family members that are impacting their functioning. Frequent arguing, difficulty maintaining positive relationships may be observed.

3 Need is dangerous or disabling; requires immediate and/or intensive action.
Child is having severe problems with parents, siblings and/or other family members. This would include problems of domestic violence, absence of any positive relationships, etc.

Supplemental Information: This item should be rated independently of the problems the child experienced or stimulated by the child currently being assessed.

Understanding family functioning in early childhood: 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. [continues]

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FAMILY FUNCTIONING – NUCLEAR continued

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

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FAMILY FUNCTIONING - EXTENDED

This item evaluates and rates the child's relationships with those who are in their extended family. This refers to all family members excluding immediate birth or adoptive parents and siblings.

Questions to Consider:

- Is there conflict in the extended family relationship that requires resolution?
- Is treatment required to restore or develop positive relationships with the extended family?

Ratings and Descriptions

0 No evidence of any needs; no need for action.
No evidence of problems in relationships with extended 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 extended family members, although some problems may exist. For example, some extended family members may have problems in their relationships with the child. Arguing may be common but does not result in major problems.

2 Need is interfering with functioning. Action is required to ensure that the identified need is addressed.
Child is having problems with extended family members that are impacting their functioning. Frequent arguing, difficulty maintaining positive relationships may be observed.

3 Need is dangerous or disabling; requires immediate and/or intensive action.
Child is having severe problems extended family members. This would include problems of domestic violence, absence of any positive relationships, etc.

Supplemental Information: This item should be rated independently of the problems the child experienced or stimulated by the child currently being assessed.

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LIVING SITUATION

This item refers to how the child is functioning in their current living arrangement, which could be with a relative, in a foster home, etc. This item should exclude respite, brief medical and psychiatric hospitalization.

Questions to Consider:

- How has the child been behaving and getting along with others in the current living situation?

Ratings and Descriptions

0 No evidence of any needs; no need for action.
No evidence of problem with functioning in current living environment. Child and caregivers feel comfortable dealing with issues that come up in day-to-day life.

1 Identified need that requires monitoring, watchful waiting, or preventive action based on history, suspicion or disagreement.
Child experiences some problems with functioning in current living situation. Caregivers express some concern about child's behavior in living situation, and/or child and caregiver have some difficulty dealing with issues that arise in daily life.

2 Need is interfering with functioning. Action is required to ensure that the identified need is addressed.
Child has moderate to severe problems with functioning in current living situation. Child's difficulties in maintaining appropriate behavior in this setting are creating significant problems for others in the residence. Child and caregivers have difficulty interacting effectively with each other much of the time.

3 Need is dangerous or disabling; requires immediate and/or intensive action.
Child has profound problems with functioning in current living situation. Child is at immediate risk of being unable to remain in present living situation due to problematic behaviors.

Supplemental Information: Understanding the living situation in early childhood: Because young children are in the beginning stages of developing self-control, challenging behaviors are common and expected in the years from birth through five. This process can lead to some difficult moments for both adults and children (ZTT, 2021). A child who engages in challenging behavior can influence family life at home and has a substantial impact on parents, siblings, and other members of the family. Studies focusing on the results of parenting a child with challenging behavior have found that families may feel increased levels of stress and isolation, as well as decreased levels of confidence. Supports that help to reduce challenging behaviors in young children are based in collaborative relationship with parents and family members (Doubet & Ostrosky, 2014).

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DEVELOPMENTAL/INTELLECTUAL*

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

Questions to Consider:

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

Ratings and Descriptions

0 No 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 are indicated.

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

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

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

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

***A rating of '1,' '2,' or '3' on this item triggers the completion of the [B] Developmental Disabilities Module.**

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Supplemental Information: All developmental disabilities occur on a continuum; a child with Autism Spectrum Disorder may be designated a '0,' '1,' '2,' or '3' depending on the significance of the disability and the impairment. Learning disability is not rated in this item. A child with suspected low IQ or developmental delays and who has not been previously diagnosed and/or assessed would be rated here and a referral for assessment would be recommended.

Understanding cognitive development in early childhood: 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).

Developmental/Cognitive Delay Milestones

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) [continues]

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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 [continues]

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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) • 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)

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[B] DEVELOPMENTAL DISABILITIES (DD) MODULE

This module is to be completed when the Developmental/Intellectual item is rated '1,' '2,' or '3.'

COGNITIVE

This item rates cognitive impairment characterized by deficits in the child's general mental abilities, such as age appropriate reasoning, problem solving, planning, and processing information.

Questions to Consider:

- Has the child been tested for or diagnosed with a learning disability?
- Does the child have an intellectual disability or delay?

Ratings and Descriptions

0	No evidence of cognitive development problems.
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.

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AUTISM SPECTRUM

This item describes the presence of Autism Spectrum Disorder.

Questions to Consider:

- Does the child have any symptoms of Autism Spectrum Disorder?
- Does the child have a previous diagnosis of Autism Spectrum Disorder?

Ratings and Descriptions

0	Child's development appears within normal range. There is no reason to believe that the child has any developmental problems associated with Autism Spectrum Disorder.
1	Evidence of a low-end Autism Spectrum Disorder. The child may have had symptoms of Autism Spectrum Disorder, but those symptoms were below the threshold for an Autism diagnosis and did not have significant effect on development.
2	Child meets criteria for a diagnosis of Autism Spectrum Disorder. Autism Spectrum symptoms are impairing child's functioning in one or more areas and requires intervention.
3	Child meets criteria for a diagnosis of Autism Spectrum Disorder and has high-end needs to treat and manage severe or disabling symptoms.

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COMMUNICATION

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

Questions to Consider:

- Do others understand the child when they are trying to communicate? Does the child understand others who are trying to communicate with them?
- Has the child ever been diagnosed with a communication disorder?

Ratings and Descriptions

0	Child's receptive and expressive communication appears developmentally appropriate. There is no reason to believe that the child has any problems communicating.
1	Child has receptive communication skills but limited expressive communication skills. Infants may rarely vocalize. A toddler may have very few words and become frustrated with expressing needs. A preschooler may be difficult for others to understand.
2	Child has both limited receptive and expressive communication skills. Infants may have trouble interpreting facial gestures or initiate gestures to communicate needs. Toddlers may not follow simple 1-step commands. Preschoolers may be unable to understand simple conversation or carry out 2-3 step commands.
3	Child is unable to communicate. Communication difficulties include inability to point and grunt.

Supplemental Information: Children with receptive language issues may have trouble understanding what other people say. They could also have difficulty following simple directions and organizing information they hear. Receptive language issues can be hard to spot in very young children.

Expressive language issues can be easier to identify early. This is because children with expressive language issues may be late to start talking and not speak until age 2. At age 3, they may be talking but hard to understand, and the problems persist into preschool. Some children, for instance, might understand the stories read to them but not be able to describe them even in a simple way.

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SELF-CARE DAILY LIVING SKILLS

This item rates the child's age-appropriate ability to participate in self-care activities, including eating, bathing, dressing and toileting and other such tasks related to keeping up with one's personal hygiene.

Questions to Consider:

- Does the child show age-appropriate self-care skills?
- Is the child able to complete all domains of self-care as is developmentally appropriate: eating, bathing, grooming, dressing, toileting, etc?

Ratings and Descriptions

0	Child's self-care and daily living skills appear age appropriate. There is no reason to believe that the child has any problems performing daily living skills.
1	Child requires excessive verbal prompting on self-care tasks or daily living skills, or the child is able to use adaptations and supports to complete self-care.
2	Child requires assistance (physical prompting) on self-care tasks or attendant care on one self-care task (e.g., eating, bathing, dressing, and toileting) and/or does not appear to be developing the needed skills in this area.
3	Child is not able to function independently at all in this area. Child requires attendant care on more than one of the self-care tasks (e.g., eating, bathing, dressing, toileting).

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End of Developmental Disabilities Module

MEDICAL*

This item rates the child's current health status. This item does not rate depression or other mental health issues. Most transient, treatable conditions would receive a rating of '1.' Most chronic conditions (e.g., diabetes, severe asthma, HIV) would receive a rating of '2.' The rating of '3' is reserved for life-threatening medical conditions or a disabling physical condition.

Questions to Consider:

- Does the child have anything that limits their physical activities?
- How much does 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 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 medical problems. These include well-managed chronic conditions like diabetes or asthma.
2	Need is interfering with functioning. Action is required to ensure that the identified need is addressed. Child has *serious* medical 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 condition. Immediate and/or intense action should be taken due to imminent danger to child's safety, health, and/or development.

Supplemental Information: Understanding medical health status in early childhood: 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.

***A rating of '1,' '2,' or '3' on this item triggers the completion of the [C] Medical Health Module.**

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[C] MEDICAL HEALTH MODULE

This module is to be completed when the Medical item is rated '1,' '2' or '3.'

LIFE THREATENING

This item refers to conditions that pose an impending danger to life or carry a high risk of death if not treated.

Questions to Consider:

- Does the child have a medical condition that poses a risk of death if not treated?

Ratings and Descriptions

0	Child's current medical condition(s) do not pose any risk to premature death.
1	Child's current medical condition(s) may shorten life but not until later in adulthood.
2	Current medical condition(s) places child at risk of premature death before reaching adulthood.
3	Child's medical condition places them at imminent risk of death.

Supplemental Information: An infant with frequent apneic episodes requiring tactile stimulation or respiratory treatment or a child has who experienced frequent, uncontrolled seizures requiring respiratory treatment within the past month would be rated a '3.'

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CHRONICITY

This item refers to a condition that is persistent or long-lasting in its effects or a disease that develops gradually over time and is expected to last a long time even with treatment. Chronic conditions are in contrast to acute conditions which have a sudden onset.

Questions to Consider:

- Is the child's medical condition acute or chronic?
- What is the expectation of recovery for the child from their medical condition?

Ratings and Descriptions

0	Child is expected to fully recover from current medical condition within the next six months to one year. Note: A child with this rating does not have a chronic condition.
1	Child's chronic condition is minor or well controlled with current medical management.
2	Child's chronic condition(s) has significant effects/exacerbations despite medical management. Child may experience more frequent medical visits, including ER visits, surgeries or hospitalizations for acute manifestation or complications of chronic condition.
3	Child's chronic condition(s) place them at risk for prolonged inpatient hospitalization or out-of-home placement (or in-home care with what would be equivalent to institutionalized care).

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DIAGNOSTIC COMPLEXITY

This item refers to the degree to which symptoms can be attributed to medical, developmental, or behavioral conditions, or there is an acknowledgement that symptoms/ behaviors may overlap and are contributing to the complexity of the child's presentation.

Questions to Consider:

- Is the diagnosis of the child's medical condition clear?
- Does the child present with symptoms that could be attributed to medical, developmental or behavioral conditions?

Ratings and Descriptions

0	The child's medical diagnoses are clear; the symptom presentation is clear.
1	Although there is some confidence in the accuracy of child's diagnoses, there also exists sufficient complexity in their symptom presentation to raise concerns that the diagnoses may not be accurate.
2	There is substantial concern about the accuracy of the child's medical diagnoses due to the complexity of symptom presentation.
3	It is currently not possible to accurately diagnose the child's medical condition(s).

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EMOTIONAL REPONSE

This item refers to how the child is managing the emotional strain of their medical condition.

Questions to Consider:

- How is the child coping with their medical condition?
- Does the child have emotional difficulties related to their medical condition that interfere with their functioning?

Ratings and Descriptions

0	Child is coping well with their medical condition.
1	Child is experiencing some emotional difficulties related to medical condition, but these difficulties do not interfere with other areas of functioning.
2	Child is having difficulties coping with medical condition. Child's emotional response is interfering with functioning in other life domains.
3	Child's emotional response to medical condition is interfering with treatment and functioning.

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IMPAIRMENT IN FUNCTIONING

This item refers to a reduction in either physical or mental capacity that is sufficient to interfere with managing day-to-day tasks of life. This limitation can range from a slight loss of function to a total impairment which is usually considered a disability. Some impairments may be short-term while others may be permanent. Assessing the impairment can help identify the best course of treatment and whether it is responding to treatment.

Questions to Consider:

- Is the child's medical condition(s) interfering with their day-to-day functioning?

Ratings and Descriptions

0	Child's medical condition is not interfering with functioning in other life domains.
1	Child's medical condition has a limited impact on functioning in at least one other life domain.
2	Child's medical condition is interfering in more than one life domain or is disabling in at least one.
3	Child's medical condition has disabled them in most other life domains.

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TREATMENT INVOLVEMENT

This item describes the degree to which the child and/or family is involved in seeking and supporting treatment to address the medical condition of the child.

Questions to Consider:

- How involved or supportive are the child and/or family in the child's treatment of the medical condition?

Ratings and Descriptions

0	Child and family are actively involved in treatment.
1	Child and/or family are generally involved in treatment but may struggle to stay consistent.
2	Child and/or family are generally uninvolved in treatment although they are sometimes compliant to treatment recommendations.
3	Child's and/or family are currently resistant to all efforts to provide medical treatment.

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INTENSITY OF TREATMENT SUPPORT

This item refers to the complexity of the child's medical treatment, including frequency of treatment, whether there is a need for special medical services or equipment, and the extent of support needed by caregivers in the management of the treatment.

Questions to Consider:

- Does the child's medical condition(s) require specialized medical equipment or services?
- Does the child have the support needed to administer their medical treatments?

Ratings and Descriptions

0	Child's medical treatment is not intrusive in the family's routine. Child and family are maintaining all necessary treatment.
1	Child's medical treatment regimen is getting in the way of the family's routine. They sometimes are unable to complete procedures, and/or require support in administering some of the treatments.
2	Child's medical treatment cannot currently be administered by the child and/or family without some support in the home.
3	Intensity of the child's treatment prevents the caregiver from managing at least one area of the family's life functioning.

Supplemental Information: In considering the intensity of treatment and supports provided, the family's circumstances and child's medical condition(s) and their risk of use of the Emergency Department, Urgent Care, and/or Hospitalization should be considered.

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ORGANIZATIONAL COMPLEXITY

This item refers to how effectively organizations and service providers caring for a child work together. The more organizations and professionals, the increased likelihood of complexity and need for ongoing communication and collaboration.

Questions to Consider:

- Is medical care for the child being provided by multiple providers? How many?
- Are the medical providers coordinated in providing care for the child?
- Does the child have a primary care provider assisting the family with coordinating care/ referrals to specialty care providers?

Ratings and Descriptions

0	All care is provided by a single provider; there are no additional service providers involved.
1	Care is provided by a single or multiple service provider(s), and while there may be some challenges, communication/collaboration among providers is generally effective.
2	Care is provided by a single or multiple services provider(s) and communication/ collaboration among providers may present some challenges for the child's care and is impacting the child's functioning.
3	Care is provided by a single or multiple services provider(s) and lack of communication/ collaboration among providers is presenting significant challenges for the child's care and places the child at risk due to their medical condition which is not improving or worsening.

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End of the Medical Health Module

PHYSICAL

This item describes the child's physical limitations.

Questions to Consider:

- Does the child have any physical limitations?
- How does the child's physical limitations impact their functioning?

Ratings and Descriptions

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

Child has no physical limitations.

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

Child has some physical condition that places mild limitations on activities. Conditions such as impaired hearing or vision would be rated here. Rate here treatable medical conditions that result in physical limitations (e.g., asthma).

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

Child has some physical condition that notably impacts activities. Sensory disorders such as blindness, deafness, or significant motor difficulties would be rated here.

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

Child has severe physical limitations due to multiple physical conditions.

Supplemental Information: Assessment of physical abilities in early childhood: If a child is experiencing any physical health limitations, obtaining information regarding both the impact to the child and the family are both needed to make the assessment of how to rate this item. A child may have a physical health limitation that is considered "disabling," but it may be managed well by the family and therefore not causing problems in their functioning. A more detailed assessment of a child's physical and motor development is available in the Motor item.

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DENTAL

This item refers to the child's need for dental health services.

Questions to Consider:

- Does the child have any dental health needs?
- When was the last time that the child had a dental exam?

Ratings and Descriptions

0	No evidence of any needs; no need for action. No evidence of any dental health needs or needs are currently being addressed appropriately.
1	Identified need that requires monitoring, watchful waiting, or preventive action based on history, suspicion or disagreement. Child has not received dental health care and requires a checkup. Child may have some dental health needs, but they are not clearly known at this time.
2	Need is interfering with functioning. Action is required to ensure that the identified need is addressed. Child has dental health needs that require attention.
3	Need is dangerous or disabling; requires immediate and/or intensive action. Child has serious dental health needs that require intensive or extended treatment/ intervention.

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DAILY FUNCTIONING

This item aims to describe the child's ability and motivation to engage in developmentally-appropriate self-care tasks such as bathing, dressing, toileting, and other such tasks related to keeping up with one's personal hygiene.

Questions to Consider:

- Does the child show age-appropriate self-care skills?
- Is the child able to complete all domains of self-care as is developmentally appropriate: eating, bathing, grooming, dressing, toileting, etc.?

Ratings and Descriptions

0	No evidence of any needs; no need for action. Child's self-care skills appear age appropriate. The child relies on other as expected for their age group.
1	Identified need that requires monitoring, watchful waiting, or preventive action based on history, suspicion or disagreement. Child shows some occasional problems in self-care skills for their age but is generally self-reliant.
2	Need is interfering with functioning. Action is required to ensure that the identified need is addressed. Child demonstrates problems in self-care skills and relies on other for help more than is expected for their age group.
3	Need is dangerous or disabling; requires immediate and/or intensive action. Child cannot complete self-care tasks without the help of others.

Supplemental Information: Understanding self-care and daily functioning in early childhood:
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). [continues]

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DAILY FUNCTIONING continued

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 Milestone 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.

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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:

- Currently, how well 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	Need is interfering with functioning. Action is required to ensure that the identified need is addressed. 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. [continues]

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SOCIAL AND EMOTIONAL FUNCTIONING continued

Supplemental Information: Understanding social development in early childhood: This item is important to assess due to how significantly it relates to all other areas of development. A child that is struggling in their capacity to relate to their parents, caregivers, and peers will also struggle in their ability to find support for the other areas of development. The importance of the parent/child relationship and the child's capacity to socialize and regulate their emotions gives a child the tools to move forward in all other areas.

Assessment of social functioning in early childhood: 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).

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 [continues]

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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]

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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)

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RECREATION/PLAY

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

Questions to Consider:

- What activities is the child involved in?
- Is the child interested in play?
- Is it easy to engage the child in play?
- Do adults need to support the child in engaging in play?

Ratings and Descriptions

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

No evidence of any problems with recreational functioning or play. Child has access to sufficient activities that they enjoy and makes full use of play activities that support their healthy development and enjoyment.

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

There is a history of or child is doing adequately with recreational or play activities although some problems may exist. Infants may not be easily engaged in play. Toddlers and preschoolers may seem uninterested and poorly able to sustain play.

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

Child may experience some problems with recreational activities. Infants resist play or do not have enough opportunities for play. Toddlers and preschoolers show little enjoyment or interest in activities and can only be engaged in play/recreational activities with ongoing adult interaction and support.

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

Child has no access to or interest in play or recreational activities. Infant spends most of time non-interactive. Toddlers and preschoolers, even with adult encouragement, cannot demonstrate enjoyment or use play to further development. [continues]

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RECREATION/PLAY continued

Supplemental Information: Understanding recreation and play in early childhood: Playtime is an important part of childhood development. During play, children are uniquely engaged and motivated, often exploring the edges of their knowledge and abilities. This makes play a unique and powerful learning tool. The first year of life typically involves sensory play. At this stage, children also develop an understanding of cause and effect and begin to grow their social skills through imitation. Play in the second year of life often involves pretend play with a toy and parallel—but not collaborative—play with other children. In the third year of life, play expands their social and motor skills. Play now often includes turn-taking and cooperative play. From three to five years of life, play becomes more complex: children coordinate many physical actions, imagination, and rules in coordinated social play with others (NCECDLT, 2017).

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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 require more adult supports to cope with frustration than other children of similar age 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 and sleep, feed on schedule, are able to make use of caregiver/ pacifier to be soothed, and are 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 Need is interfering with functioning. Action is required to ensure that the identified need is addressed.

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

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REGULATORY continued

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

Concern in two or more areas of regulation, including but not limited to: difficulties in breathing, body movements, crying, sleeping, feeding, attention, ability to self soothe, and/or sensitivity to environmental stressors. Problems with regulation are present that place the child's safety, well-being and/or development at risk.

Supplemental Information: Understanding self-regulation in young children: 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).

***A rating of '1,' '2,' or '3' on this item triggers the completion of the [D] Regulatory Module.**

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[D] REGULTORY MODULE

This module is to be completed when the Regulatory item is rated '1,' '2' or '3.'

EATING

This item refers to the process of getting food into the body by any means.

Questions to Consider:

- Does the child have any difficulties in eating?
- Is the child finicky about food?
- Is the child's eating problems impacting their growth and development?

Ratings and Descriptions

0	No evidence of problems related to eating.
1	Child has mild difficulties with eating or feeding that have been present in the past or are currently present some of the time. Child may have occasional difficulty latching on or show some fussiness around mealtime. Difficulties are well-managed by caregivers.
2	Moderate problems with eating are present. Infants may be finicky eaters, spit food or overeat. Infants may have problems with oral motor control. Older children may have few food preferences or not have a clear pattern of when they eat. Child may need help from another person or the use of adaptive equipment (e.g., adapted utensils) to feed self but manages by themself.
3	Child has difficulties with eating that are putting their development at risk. Children whose eating concerns are causing them to fall below healthy weight and those who need to be totally fed through support (e.g., parenteral nutrition or G-tube) are rated here. The child and family are very distressed and unable to overcome problems in this area.

Supplemental Information: Understanding eating behaviors in early childhood: Like sleep, eating behaviors are among the most common reasons caregivers of young children seek intervention. Some 25-40% of infants and young children are reported by their caregivers to have eating problems – mainly slow feeding, refusal to eat, picky eating, or vomiting. It can be helpful to make note of the caregiver's interaction style during feeding, which can be defined as: responsive, controlling, indulgent, or neglectful. In addition, it can also be helpful to note the ***child's interaction style,*** which may be defined as cooperative, resistant (e.g., turning the head away from food), or conflicted (e.g., throwing food) **(ZTT, 2016).**

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ELIMINATION

This item describes any needs related to urination or moving bowels.

Questions to Consider:

- Does the child have any unusual difficulties with urination or defecation?

Ratings and Descriptions

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

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SENSORY REACTIVITY

This item refers to the child's ability to organize (process) sensation (vision, hearing, smell, touch, taste, and kinesthetic) coming from the body and the environment. Difficulty in this area would impact the child's performance in one or more of their main functional areas such as play or activities of daily living. Examples include difficulty wearing certain fabrics or eating certain textures, tolerating background sounds such as florescent lights or heating systems.

Questions to Consider:

- Does the child have any unusual difficulties with their senses?
- Does the child have sensitivities to light, textures, smells etc. that impact their functioning?

Ratings and Descriptions

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

Supplemental Information: Understanding sensory reactivity in early childhood: 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). [continues]

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SENSORY REACTIVITY continued

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)

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EMOTIONAL CONTROL

This item describes the child's ability to manage emotions (positive or negative). It describes symptoms of emotional dysregulation.

Questions to Consider:

- Does the child require more adult supports to cope with frustration than other children in similar settings?

Ratings and Descriptions

0	Child has no problems with emotional control.
1	Child has some problems with emotional control that can be overcome with caregiver support.
2	Child has problems with emotional control that interferes with their functioning most of the time. Infants may be difficult to console most of the time and do not respond well to caregiver.
3	Child has emotional control problems that are interfering with their development. Caregivers are not able to mediate the effects of the emotional control problems of the child.

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End of the Regulatory Module

MOTOR

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

Questions to Consider:

- Does the child meet motor-related developmental milestones?
- Does the child show any fine or gross motor skill difficulties?

Ratings and Descriptions

0	No evidence of any needs; no need for action. The child's development of fine and gross motor functioning appears normal. There is no reason to believe that the child has any problems with motor development.
1	Identified need that requires monitoring, watchful waiting, or preventive action based on history, suspicion or disagreement. Child may have some fine (e.g., using scissors) or gross motor skill deficits. Child has exhibited delayed sitting, standing, or walking, but has since reached those milestones.
2	Need is interfering with functioning. Action is required to ensure that the identified need is addressed. The child has delays in either or both fine and gross motor development or challenges in the aspects of motor development related to strength, coordination, tone, or motor planning.
3	Need is dangerous or disabling; requires immediate and/or intensive action. The child has significant challenges in either fine or gross motor development or the related areas of strength, coordination, tone or motor planning.

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

Assessing motor development in early childhood: The following table presents a list of developmental milestones for motor development (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. [continues]

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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 Motor Development

By 3 Months	• Pushes up trunk when lying on stomach • Holds head up without support • Hands are often open (e.g., not in fists)
By 6 Months	• Swats at dangling objects • Pushes down on legs when feet are on hard surfaces • Sits without support • Rolls from tummy to back • Holds and shakes an object • Bangs two objects together • Brings hands to midline • Reaches for object with one hand
By 9 Months	• Rolls over in both directions (front to back, back to front) • Brings self to sitting position independently • Stands with support • Moves independently from one place to another (e.g., crawling, scooting) • Turns pages of a book • Reaches for and grasps objects • Passes objects from one hand to another
By 12 Months	• Takes a few steps without holding on • Walks holding onto furniture (e.g., cruises) • Moves from sitting to standing position • Stands alone • Picks up things between thumb and index finger (e.g., cereal) • Crawls forward on belly, pulling with arms, pushing with legs • Turns around while crawling • Crawls while holding an object [continues]

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By 15 Months	• Explores physical environment • Pushes objects (e.g., boxes, toy cars, push toys) • Walks independently
By 18 Months	• Stacks two blocks • Walks up steps without helping • Pulls toys while walking • Helps undress themselves (e.g., pulls off hat, socks, mittens) • Eats with a spoon • Drinks from an open cup
By 2 Years	• Participates in dressing (e.g., putting arms into sleeves, pulling pants up/down, putting on hat) • Stands on tiptoes • Kicks a ball • Runs • Climbs onto and down from furniture without help • Walks up and down stairs holding on • Draws lines • Drinks using a straw • Opens cabinets, drawers, and boxes
By 3 Years	• Manipulates some buttons, levers, and moving parts • Climbs onto high and low structures • Runs fluidly • Copies a circle • Builds towers of more than six blocks • Pedals a tricycle (three wheeled bicycle) • Catches and kicks a big ball • Walks up and down steps, alternating feet
By 4 Years	• Skips, hops, and stands on one foot for up to 2 seconds • Catches a large, bounced ball most of the time • Can copy simple symbols (e.g., the “plus” sign) • Uses toilet during the day with few accidents • Pours from one container to another, cuts with supervision, and mashes own food
By 5 Years	• Stands on one foot for 10 seconds or longer • Copies a triangle and other geometric shapes • Copies some letters or numbers • Hops on one foot • Uses utensils to eat • Uses toilet independently (wipes, flushes, and washes hands) • Swings independently on a swing

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COMMUNICATION

This item describes the child's ability to communicate through any medium including all spontaneous vocalizations and articulations. In this item, it is important to look at each piece individually and rate as such. A child may have communication problems but may comprehend well, while another child is able to comprehend well but has communication and expression issues. **This does not refer to challenges in expressing one's feelings.**

Questions to Consider:

- Is the child able to understand others' communications?
- Is the child able to communicate to others?

Ratings and Descriptions

0	No evidence of any needs; no need for action. Child's receptive and expressive communication appears developmentally appropriate. There is no reason to believe that the child has any problems communicating.
1	Identified need that requires monitoring, watchful waiting, or preventive action based on history, suspicion or disagreement. Child has a history of communication problems but currently is not experiencing problems. Infants may rarely vocalize. A toddler may have very few words and become frustrated with expressing needs. A preschooler may be difficult for others to understand.
2	Need is interfering with functioning. Action is required to ensure that the identified need is addressed. Child has either receptive or expressive language problems, comprehension or expression problems that interfere with functioning. Infants may have trouble interpreting facial gestures or initiate gestures to communicate needs. Toddlers may not follow simple 1-step commands. Preschoolers may be unable to understand simple conversation or carry out 2-3 step commands.
3	Need is dangerous or disabling; requires immediate and/or intensive action. Child has serious communication, comprehension or expression difficulties and is unable to communicate including through pointing and grunting. [continues]

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Supplemental Information: Understanding language and communication development in early childhood: 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).

Communication, Comprehension and Expression Developmental Milestones:

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 [continues]

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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
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) • Use 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" [continues]

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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
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

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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.

Questions to Consider:

- Does the child appear rested?
- Are they often sleepy during the day?
- Do they 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.

No evidence of problems with sleep. 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 Need is interfering with functioning. Action is required to ensure that the identified need is addressed.

Child is having problems with sleep. Sleep is often disrupted, and child seldom obtains a full night of sleep. Difficulties in sleep are interfering with their functioning in at least one area of their life.

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. Child's sleep deprivation is dangerous and places them at risk.

Supplemental Information: Understanding sleeping behaviors in early childhood: 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]

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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 Months	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.

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PRESCHOOL/CHILDCARE*

This item rates the child's experiences in preschool/daycare settings 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, academic achievement, support from the school staff to meet the child's needs, and the child's behavioral response to these environments.

Questions to Consider:

- What is the child's experience in school?

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	Need is interfering with functioning. Action is required to ensure that the identified need is addressed. Child is experiencing difficulties maintaining their behavior, attendance, and/or progress in this 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: Understanding the importance of early education and care in early childhood: 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. [continues]

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PRESCHOOL/CHILDCARE continued

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
- 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

***A rating of '1,' '2,' or '3' on this item triggers the completion of the [E] Preschool/Childcare Module.**

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[E] PRESCHOOL/CHILDCARE MODULE

This module is to be completed when the Preschool/Childcare item is rated '1,' '2' or '3.'

ATTENDANCE

This item rates issues of attendance. If school is not in session, rate the last 30 days when school was in session.

Questions to Consider:

- How often does the child miss school?
- Do absences interfere with their learning?

Ratings and Descriptions

0	Child attends preschool/daycare regularly.
1	Child has a history of problems attending preschool/daycare, OR child has some attendance problems but generally goes to school. They may miss up to one day per week on average or may have had moderate to severe problems during the past six months but has been attending school regularly during the past month.
2	Child's problems with preschool/daycare attendance are is impacting their educational functioning. They are missing at least two days each week on average.
3	Child is absent most of the time and this causes a significant challenge in achievement, socialization and following routine.

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COMPATABILITY

This item refers to the compatibility between the educational setting/childcare setting and the child.

Questions to Consider:

- Does the educational or childcare setting meet the child's needs?

Ratings and Descriptions

0	The school/preschool/daycare meets the needs of the child.
1	The school/preschool/daycare is marginal in its ability to meet the needs of the child. The environment may be weak in areas.
2	The school/preschool/daycare does not meet the needs of the child in most areas. The environment may not support the child's growth or promote further learning.
3	The school/preschool/daycare is contributing to problems for the child in one or more areas.

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BEHAVIOR

This item rates the behavior of the child in school or school-like settings.

Questions to Consider:

- How is the child behaving in school/preschool/daycare?
- Has the child had any suspensions?
- Has the child needed to go to an alternative educational placement?

Ratings and Descriptions

0	No evidence of behavioral problems at school, OR child is behaving well in school.
1	Child is behaving adequately in school although some behavior problems exist. Behavior problems may be related to relationship with either teachers or peers.
2	Child's behavior problems are interfering with functioning at school. The child is disruptive and may have received sanctions including suspensions.
3	Child is having severe problems with behavior in school. The child is frequently or severely disruptive. School/daycare placement may be in jeopardy due to behavior.

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ACHIEVEMENT

This item rates the child's level of academic achievement.

Questions to Consider:

- How is the child's educational progress?
- Is the child having difficulty in any educational areas?

Ratings and Descriptions

0	No evidence of issues in school achievement and/or child is doing well in school.
1	Child is doing adequately in school although some problems with achievement exist.
2	Child is having problems with school achievement. The child may be failing to learn in some areas. They may not be able to retain concepts or meet expectations even with adult support in some areas.
3	Child is having severe achievement problems. Child may be completely unable to understand or participate in skill development in most or all areas. Child might be more than one year behind same-age peers in school achievement.

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RELATIONS WITH TEACHER(S)

This item describes a child's relationships with teachers.

Questions to Consider:

- How does the child relate to teachers?
- Does the child have a strong connection with one or more teachers?
- Does the child have regular conflict with teachers?

Ratings and Descriptions

0	Child has good relations with teachers.
1	Child has occasional difficulties relating with at least one teacher. Child may have difficulties during one educational area.
2	Child has difficult relations with teachers that notably interfere with their educational progress.
3	Child has very difficult relations with all teachers (or their one teacher all the time). Relations with teachers currently prevents child from learning.

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RELATIONS WITH PEERS

This item describes a child's relationships with peers.

Questions to Consider:

- How does the child relate to peers?
- Does the child have a strong connection with one or more peers?
- Does the child have regular conflict with peers?

Ratings and Descriptions

0	Child has good relations with peers.
1	Child has occasional difficulties relating with at least one peer.
2	Child has difficult relations with peers that notably interfere with their educational progress.
3	Child has very difficult relations with all peers. Relations with peers currently prevents child from learning.

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End of the Preschool/Childcare Module

CHILD AND FAMILY CULTURAL FACTORS DOMAIN

These items identify linguistic or cultural issues for which service providers need to make accommodations (e.g., provide interpreter, find therapist who speaks family's primary language, and/or ensure that a child in an out-of-home setting can participate in cultural rituals associated with their cultural identity). Items in the Cultural Factors Domain describe difficulties that children may experience or encounter because 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 child's perspective (i.e., who the child 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 child when rating these items and creating a treatment or service plan.

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

For the **Child and Family Cultural Factors 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 Need is interfering with functioning. Action is required to ensure that the identified need is addressed.

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

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LANGUAGE

This item looks at whether the child and family need 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:

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

Ratings and Descriptions

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 they live.
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 they live, but potential communication problems exist because of limited vocabulary or comprehension of the nuances of the language.
2	Need is interfering with functioning. Action is required to ensure that the identified need is addressed. Child and/or significant family members do not speak the primary language where they live. Translator or family's native language speaker is needed for successful intervention; a qualified individual 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 they live. Translator or family's native language speaker is needed for successful intervention; no such individual is available from among natural supports.

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CULTURAL IDENTITY

Cultural identify refers to the child's view of self as belonging to a specific cultural group. This cultural group may be defined by a number of factors including race, religion, ethnicity, geography, sexual orientation, gender identity and expression (SOGIE).

Questions to Consider:

- Does the child identify with any racial/ethnic/cultural group?
- Does the child find this group a source of support?

Ratings and Descriptions

0	No evidence of any needs; no need for action. The child has defined a cultural identity and is connected to others who support their cultural identity.
1	Identified need that requires monitoring, watchful waiting, or preventive action based on history, suspicion or disagreement. The child is experiencing some confusion or concern regarding cultural identity.
2	Need is interfering with functioning. Action is required to ensure that the identified need is addressed. The child has significant struggles with their own cultural identity. Child may have cultural identity but is not connected with other who share their culture.
3	Need is dangerous or disabling; requires immediate and/or intensive action. The child does not express a cultural identity or is experiencing significant problems due to conflict regarding their cultural identity.

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TRADITIONS AND CULTURAL RITUALS

This item rates the child and/or family's access to and participation in cultural traditions, rituals and practices, including the celebration of culturally specific holidays such as Kwanza, Dia de los Muertos, Yom Kippur, Quinceañera, 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 child celebrate?
- What traditions are important to the child?
- Does the child fear discrimination for practicing their traditions and rituals?

Ratings and Descriptions

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

The child and/or family is consistently able to practice 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.

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

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

The child and/or family experiences significant barriers and is sometimes prevented from practicing traditions and rituals consistent with their cultural identity.

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

The child and/or family is unable to practice traditions and rituals consistent with their cultural identity.

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CULTURAL STRESS

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

Questions to Consider:

- Has the child experienced any problems with the reaction of others to their cultural identity?
- Has the child experienced discrimination?

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 their current environment or living situation.
2	Need is interfering with functioning. Action is required to ensure that the identified need is addressed. The child is experiencing cultural stress that is causing problems of functioning in at least one life domain. The child needs support to learn how to manage culture stress.
3	Need is dangerous or disabling; requires immediate and/or intensive action. The child is experiencing a high level of cultural stress that is making functioning in any life domain difficult under the present circumstances. The child needs immediate plan to reduce culture stress.

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KNOWLEDGE CONGRUENCE

This item refers to a family's explanation about their children's presenting issues, needs and strengths in comparison to the prevailing professional/helping culture(s) perspective.

Questions to Consider:

- How does the family describe the child's needs?
- Do members of the family disagree on how they see the needs of the child?

Ratings and Descriptions

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

There is no evidence of differences/disagreements between the family's explanation of presenting issues, needs and strengths and the prevailing professional/helping cultural view(s), i.e., the family's view of the child is congruent with the prevailing professional/ helping cultural perspective(s).

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

Small or mild differences between the family's explanation and the prevailing professional/helping cultural perspective(s), but these disagreements do not interfere with the family's ability to meet its needs.

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

Disagreement between the family's explanation and the prevailing professional/helping cultural perspective(s) creates challenges for the family and/or those who work with them.

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

Significant disagreements in terms of explanation between the family and the prevailing professional/helping cultural perspective(s) that places the family in jeopardy of significant problems or sanctions.

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HELP SEEKING CONGRUENCE

This item refers to a family's approach to help seeking behavior in comparison to the prevailing professional/helping culture(s) perspective.

Questions to Consider:

- Has the family reached out to professional or other resources to support the needs of their child?
- Are there disagreements in the family in whom to seek for support and how?

Ratings and Descriptions

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

There is no evidence of differences/disagreements between the family's approach to help seeking and the prevailing professional/helping cultural view(s), i.e., the family's approach is congruent with prevailing professional/helping cultural perspective(s) on help seeking behavior.

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

Some differences between the family's help seeking beliefs and/or behavior and the prevailing professional/helping cultural perspective(s), but these differences do not interfere with the child and/or family's ability to meet its needs.

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

Disagreement between the family's help seeking beliefs and/or behavior and the prevailing professional/helping cultural perspective(s) creates challenges for the family and/or those working with them.

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

Significant disagreements in terms of help seeking beliefs and/or behaviors between the family and the prevailing professional/helping cultural perspective(s) places the family in jeopardy of significant problems or sanctions.

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EXPRESSION OF DISTRESS

This item refers to a family's style of expressing distress in comparison to the prevailing professional/helping culture(s) perspective.

Questions to Consider:

- How does the child and/or family react to distressing situations?
- What kind of support do they have?
- What are their social resources?

Ratings and Descriptions

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

There is no evidence of differences/disagreements between the way the family expresses distress and the prevailing professional/helping cultural view(s), i.e. family's style of expressing distress is congruent with prevailing professional/helping cultural perspective(s).

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

Some differences between the way the family expresses distress and the prevailing professional/helping cultural perspective(s) but these disagreements do not interfere with the family's ability to meet its needs.

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

Disagreement between the way the family expresses distress and the prevailing professional/helping cultural perspective(s) creates challenges for the family and/or those who work with them.

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

Disagreement in terms of the way the family expresses distress and the prevailing professional/helping cultural perspective(s) places the family in jeopardy of significant problems or sanctions.

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CHILD BEHAVIORAL/EMOTIONAL NEEDS DOMAIN

This section identifies 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 needs of the child?

For the **Child Behavioral/Emotional Needs 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 Need is interfering with functioning. Action is required to ensure that the identified need is addressed.

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

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ATTACHMENT DIFFICULTIES

This item rates the level of difficulties the child has with attachment and their ability to form relationships. This item should be rated within the context of child's significant parental or caregiver relationships.

Needs on this item could include: a child who displays indiscriminate friendliness or comfort seeking; one who fails to seek comfort under stress; one who appears frightened or disoriented with their parent; one who is unable to comfortably play/explore; or one who acts punitively or controlling towards others. How a child copes with separation from a caregiver will be rated here. Note: A child can have different patterns of attachment with different caregivers, for instance, displaying a positive attachment to one parent or caregiver and not another, or showing differential preference for one parent at different stages of development. These unique patterns reflect what the child and adult bring to the process of developing the relationship.

Questions to Consider:

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

Ratings and Descriptions

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

No evidence of attachment problems. Caregiver-youth relationship is characterized by mutual satisfaction of needs and child's development of a sense of security and trust. Caregiver can respond to child cues in a consistent, appropriate manner, and 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.

Some history or evidence of insecurity in the caregiver-youth relationship. Caregiver may have difficulty accurately reading child's bids for attention and nurturance; may be inconsistent in response; or may be occasionally intrusive. Child may have some problems with separation (e.g., anxious/clingy behaviors in the absence of obvious cues of danger) or may avoid contact with caregiver in age-inappropriate way. Child may have minor difficulties with appropriate physical/emotional boundaries with others. [continues]

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ATTACHMENT DIFFICULTIES continued

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

Problems with attachment that interfere with child's functioning in at least one life domain and require intervention. Caregiver may consistently misinterpret child cues, act in an overly intrusive way, or ignore/avoid child bids for attention/nurturance. Child may have ongoing difficulties with separation, may consistently avoid contact with caregivers, and have ongoing difficulties with physical or emotional boundaries with others.

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

Child is unable to form attachment relationships with others (e.g., chronic dismissive/ avoidant/detached behavior in care giving relationships) OR child presents with diffuse emotional/physical boundaries leading to indiscriminate attachment with others. Child is considered at ongoing risk due to the nature of their attachment behaviors. Child may have experienced significant early separation from or loss of caregiver, or have experienced chronic inadequate care from early caregivers, or child may have individual vulnerabilities (e.g., mental health, developmental disabilities) that interfere with the formation of positive attachment relationships.

Supplemental Information: Understanding attachment in early childhood: 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). [continues]

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ATTACHMENT DIFFICULTIES continued

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).

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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 evidence of any needs; no need for action. No evidence of failure to thrive.
1	Identified need that requires monitoring, watchful waiting, or preventive action based on history, suspicion or disagreement. 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	Need is interfering with functioning. Action is required to ensure that the identified 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	Need is dangerous or disabling; requires immediate and/or intensive action. The child has one or more of all of the above and is currently at serious medical risk.

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DEPRESSION (WITHDRAWN)

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

Questions to Consider:

- Are caregivers concerned about possible depression or chronic low mood and irritability?
- Has the child withdrawn from normal activities? Does the child seem lonely or not interested in others?

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

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.

Supplemental Information: Understanding depression in young children: 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 [continues]

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DEPRESSION continued

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.

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ANXIETY

This item rates evidence of symptoms associated with the DSM 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 the child is able to be soothed and supported.
2	Need is interfering with functioning. Action is required to ensure that the identified need is addressed. 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 situations.
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. [continues]

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ANXIETY continued

Supplemental Information: Understanding anxiety in young children (ZTT, 2016): 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

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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	Need is interfering with functioning. Action is required to ensure that the identified need is addressed. 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: Understanding atypical or restricted and repetitive behaviors (RRB) in early childhood: Restricted and repetitive behaviors (RRBs) have long been considered one of the core characteristics of autism spectrum disorder (ASD). In the past, RRBs were thought to be rare in preschoolers or toddlers with ASD. 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 ASD. However, at young ages, RRBs are not unique to children with ASD but are also present in children with other disorders, such as intellectual disabilities and language disorders, and are present in children with typical development as well (Kim & Lord, 2010).

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IMPULSIVITY/HYPERACTIVITY

Problems with impulse control and impulsive behaviors, including motoric disruptions (e.g., tics or sudden, rapid, recurring, nonrhythmic motor movements or vocalizations) are rated here. This includes behavioral symptoms associated with Attention Deficit/Hyperactivity Disorder (ADHD) and Impulse-Control Disorders as indicated in the DSM. **Please note: Child should be 3 years old or older to rate this item.**

Questions to Consider:

- Does the child's impulsivity put them at risk?
- Is the child able to control themselves in an age-appropriate manner?
- Is the child unable to sit still for any length of time?
- Does the child have trouble paying attention for more than a few minutes?
- Is the child able to control their behavior, talking, etc.?

Ratings and Descriptions

0	No evidence of any needs; no need for action. No evidence of impulsivity/hyperactivity problems.
1	Identified need that requires monitoring, watchful waiting, or preventive action based on history, suspicion or disagreement. This is a history or evidence of some impulsivity evident in action or thought that place the child at risk of future functioning difficulties. Child may have some difficulties staying on task for an age-appropriate time period.
2	Need is interfering with functioning. Action is required to ensure that the identified need is addressed. 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). The child may be impulsive on a nearly continuous basis. The child endangers themselves or others without thinking. [continues]
NA	Child is under 3 years of age

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IMPULSIVITY/HYPERACTIVITY continued

Supplemental Information: Understanding attention, hyperactivity, and impulsivity in young children (ZTT, 2016): 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 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)

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OPPOSITIONAL BEHAVIOR

This item rates the child's relationship with authority figures. Generally oppositional behavior is displayed in response to conditions set by a parent, teacher or other authority figure with responsibility for and control over the child. **Please note: Child should be 3 years old or older to rate this item.**

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. History or evidence of mild level of defiance towards authority figures that has not yet begun to cause functional impairment. Child may occasionally talk back to teacher, parent/caregiver; there may be letters or calls from school.
2	Need is interfering with functioning. Action is required to ensure that the identified need is addressed. 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 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. [continues]
NA	Child is under 3 years of age

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OPPOSITIONAL BEHAVIOR continued

Supplemental Information: Oppositional Behavior and Conduct

The Oppositional Behavior item is intended to capture how the child relates to authority figures like parents and teachers. Conduct Disorder is when the child consistently violates the basic rights of others and/or the rules and norms of society that are antisocial in nature with no remorse. Oppositional behavior is different from conduct disorder in that the emphasis of the behavior is on the child's noncompliance to authority rather than on seriously breaking social rules, norms and laws. While children with Conduct Disorder typically exhibit aggressive and/or criminal behavior, children that are oppositional may exhibit anger and deceitfulness but without the aggressive behaviors that directly impact others. Especially in the area of rule-breaking and non-compliance, many of the features of Oppositional Behavior may also be present in Conduct Disorder, but not vice versa. In such cases, both items could be rated for the same behavior.

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CHILD RISK FACTORS DOMAIN

Risk factors are characteristics of the child prior to or at birth that are associated with a higher likelihood of negative outcomes.

Question to Consider for this Domain: Does the child have any prenatal factors or characteristics at birth that place them at risk for negative outcomes?

Please note: Some items in this domain are static indicators and the action levels have been left off the items. These items should be rated according to the guidance provided at each rating.

For the **Child Risk Factors Domain,** use the following categories and action levels:

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

1 Need or risk factor that requires monitoring, watchful waiting, or preventive action based on history, suspicion, or disagreement.

2 Need or risk factor is interfering with functioning. Action is required to ensure that the identified need or risk factor is addressed.

3 Need or risk factor is dangerous or disabling. Intensive and/or immediate action is required to address the need or risk factor.

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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	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	Child born underweight. A child with a birth weight of between 1500 grams (3.3. pounds) and 2499 grams would be rated here.
2	Child considerably underweight 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	Child extremely underweight 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.

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PICA

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

Questions to Consider:

- Does the child eat dangerous or unusual materials?

Ratings and Descriptions

0	No evidence of any needs; no need for action. No evidence that the child eats unusual or dangerous materials.
1	Need or risk factor that requires monitoring, watchful waiting, or preventive action based on history, suspicion or disagreement. Child has a history of eating unusual or dangerous materials but has not done so in the past 30 days.
2	Need or risk factor is interfering with functioning. Action is required to ensure that the identified need or risk factor is addressed. Child has eaten unusual or dangerous materials consistent with a diagnosis of Pica in the last 30 days.
3	Need or risk factor is dangerous or disabling. Intensive and/or immediate action is required to address the need or risk factor. Child has become physically ill during the past 30 days by eating dangerous materials.
NA	Child is younger than 18 months

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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	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	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	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	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.

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LENGTH OF GESTATION

This item refers to the length of time between conception and birth when the child was carried by the mother. This helps to determine whether the child was born pre-mature.

Questions to Consider:

- Was the child carried full-term?
- Was the child pre-mature? Overdue?

Ratings and Descriptions

0	Child was born full-term.
1	Child was born pre-mature or overdue, however, no significant concerns at birth.
2	Child was born pre-mature or overdue, and there were some complications at birth.
3	Child was born pre-mature or overdue and had severe problems during delivery that have resulted in long-term implications for development.

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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	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	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	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	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.

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SUBSTANCE EXPOSURE

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

Questions to Consider:

- Was the child exposed to alcohol or drugs during the pregnancy? After pregnancy? To what substances?

Ratings and Descriptions

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

Child had no in utero exposure to alcohol or drugs, and there is currently no exposure in the home.

1 Need or risk factor that requires monitoring, watchful waiting, or preventive action based on history, suspicion or disagreement.

Child had some in utero exposure (e.g., mother ingested alcohol or tobacco in small amounts fewer than four times during pregnancy), or there is current alcohol and/or drug use in the home or community.

2 Need or risk factor is interfering with functioning. Action is required to ensure that the identified need or risk factor is addressed.

Child was exposed to significant amounts of alcohol or drugs in utero. Any ingestion of illegal drugs during pregnancy (e.g., heroin, cocaine, opioids) or significant use of alcohol or tobacco would be rated here.

3 Need or risk factor is dangerous or disabling. Intensive and/or immediate action is required to address the need or risk factor.

Child was exposed to alcohol or drugs in utero and continues to be exposed in the home and 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.

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PARENT/SIBLING PROBLEMS

This item describes any developmental or behavioral problems of the child's siblings or developmental problems of the child's parents.

Questions to Consider:

- Does the child have any parents or siblings that have a behavioral or developmental problem?

Ratings and Descriptions

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

The child's parents have no developmental disabilities. The child has no siblings, or existing siblings are not experiencing any developmental or behavioral problems.

1 Need or risk factor that requires monitoring, watchful waiting, or preventive action based on history, suspicion or disagreement.

The child's parents have no developmental disabilities. The child has siblings who are experiencing some mild developmental or behavioral problems. It may be that the child has at least one healthy sibling.

2 Need or risk factor is interfering with functioning. Action is required to ensure that the identified need or risk factor is addressed.

The child's parents have no developmental disabilities. The child has a sibling who is experiencing a significant developmental or behavioral problem.

3 Need or risk factor is dangerous or disabling. Intensive and/or immediate action is required to address the need or risk factor.

One or both of the child's parents have been diagnosed with a developmental disability, or the child has multiple siblings who are experiencing significant developmental or behavioral problems.

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MATERNAL AVAILABILITY

This item addresses the primary caregiver's emotional and physical availability to the child in the weeks immediately following the birth. Rate maternal/primary caregiver availability up until 12 weeks post-partum.

Questions to Consider:

- Were there issues that prevented the mother/primary caregiver to be available to the child following their birth?

Ratings and Descriptions

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

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CHILD 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 Child **Risk Behaviors Domain,** use the following categories and action levels:

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

1 Need or risk behavior that requires monitoring, watchful waiting, or preventive action based on history, suspicion, or disagreement.

2 Need or risk behavior is interfering with functioning. Action is required to ensure that the identified need or risk behavior is addressed.

3 Need or risk behavior is dangerous or disabling. Intensive and/or immediate action is required to address the need or risk behavior.

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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. **Please note: Child must be 12 months of age or older 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 evidence of any needs; no need for action. There is no evidence of self-harm behaviors.
1	Need or risk behavior that requires monitoring, watchful waiting, or preventive action based on history, suspicion or disagreement. History, suspicion or some evidence of self-harm behaviors. These behaviors are controllable by caregiver.
2	Need or risk behavior is interfering with functioning. Action is required to ensure that the identified need or risk behavior is addressed. Child's self-harm behaviors such as head banging that cannot be impacted by supervising adult and interferes with their functioning.
3	Need or risk behavior is dangerous or disabling. Intensive and/or immediate action is required to address the need or risk behavior. Child's self-harm behavior puts their safety and well-being at risk.
NA	Child is younger than 12 months of age.

Supplemental Information: Understanding self-harm in young children: 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]

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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

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AGGRESSIVE BEHAVIOR

This item rates the child's violent or aggressive behavior. The action level descriptions consider the duration of the behaviors, the severity and significance of bodily harm to self or others, and the caregivers' ability to mediate the behavior. A rating of '2' or '3' would indicate that caregivers are unable to shape/control the child's aggressive behaviors.

Questions to Consider:

- Has the child ever tried to injure another person or animal?
- How does the child cope with emotions and frustrations? Do they hit, kick, bite, or throw things at others?

Ratings and Descriptions

0	No evidence of any needs; no need for action. No evidence of aggressive behaviors.
1	Need or risk behavior 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	Need or risk behavior is interfering with functioning. Action is required to ensure that the identified need or risk factor or behavior is addressed. 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 or risk behavior is dangerous or disabling. Intensive and/or immediate action is required to address the need or risk behavior. 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.

Supplemental Information: Understanding aggression in young children: 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]

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AGGRESSIVE BEHAVIOR 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 us the moment as an opportunity for modeling or teaching emotional regulation skills. (Lerner & Parlakian, 2016).

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INTENTIONAL MISBEHAVIOR

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

Questions to Consider:

- Does the child intentionally do or say things to upset others or get in trouble with people in positions of authority (e.g., parents or teachers)?

Ratings and Descriptions

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

Child shows no evidence of problematic social behaviors that cause adults to administer consequences.

1 Need or risk behavior that requires monitoring, watchful waiting, or preventive action based on history, suspicion or disagreement.

Some problematic social behaviors that force adults to administer consequences to the child. Provocative behavior in social settings aimed at getting a negative response from adults might be included at this level.

2 Need or risk behavior is interfering with functioning. Action is required to ensure that the identified need or risk behavior is addressed.

Child may be intentionally getting in trouble in school or at home and the consequences, or threat of consequences, is causing problems in the child's life.

3 Need or risk behavior is dangerous or disabling. Intensive and/or immediate action is required to address the need or risk behavior.

Frequent seriously inappropriate social behaviors force adults to seriously and/or repeatedly administer consequences to the child. The inappropriate social behaviors may cause harm to others and/or place the child at risk of significant consequences (e.g., expulsion from school, removal from the community). [continues]

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INTENTIONAL MISBEHAVIOR continued

Supplemental Information: The key to rating the Intentional Misbehavior item is the child's intent. This item is designed to capture behaviors in which the child is **intentionally** trying to get sanctioned. For what could be a variety of reasons, the child is trying to draw attention from parents, teachers, or other authority figures. This could be due to a true lack of attention from adults, an excessive need for attention, or the child's desire to draw the attention of authority figures away from something else. Rating should be based on the social/cultural view of the behavior. The same behavior may draw different sanctions (or none at all) in different societies. The item is based on the child's understanding of their society's sanctions. Thus, ratings should be based not only on the child's behavior, but also on society's or the parent's sanctions of the behavior. Thus, cultural societal factors may be important here. Behavior without a known intent to draw sanctions should be rated elsewhere.

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CHILD 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.

NOTE: When you have no information/evidence about a strength in this area, use a rating of '3.'

Question to Consider for this Domain: What are the child's strengths that can be used to support a need?

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

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.

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RELATIONSHIP PERMANENCE

This item refers to the stability of significant relationships in the child's life. This likely includes family members but may also include other individuals

Questions to Consider:

- Does the child have relationships with adults that have lasted their lifetime?
- Is the child in contact with their parents?
- Are there adults, including relatives, with whom the child has had long-lasting relationships?

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 the child's life and are likely to remain so in the foreseeable future.
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 a 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 the child's 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. [continues]

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RELATIONSHIP PERMANENCE continued

Supplemental Information: Understanding relationship permanence in early childhood:
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).

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FAMILY STRENGTHS - NUCLEAR

This item refers to the presence of a sense of family identity as well as love and communication among nuclear 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 nuclear family comes from the child's perspective (i.e., who the individual describes as their family). If this information is not known, then we recommend a definition of family that includes biological/adoptive relatives and their significant others with whom the child is still in contact.

Questions to Consider:

- What are the relationships like among the members of the nuclear family?
- How does the nuclear family communicate with each other?

Ratings and Descriptions

0	Well-developed, centerpiece strength; may be used as a centerpiece in an intervention/action plan. Nuclear family has strong relationships and significant family strengths.
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. Nuclear family has some good relationships and good communication.
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. Nuclear family needs some assistance in developing relationships and/or communications.
3	An area in which no current strength is identified; efforts may be recommended to develop a strength in this area. Nuclear family needs significant assistance in developing relationships and communications, or child has no identified family.

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FAMILY STRENGTHS - EXTENDED

This item refers to the presence of a sense of family identity as well as love and communication among extended 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 extended family comes from the child's perspective (i.e., who the individual describes as their family). If this information is not known, then we recommend a definition of family that includes biological/ adoptive relatives and their significant others with whom the child is still in contact.

Questions to Consider:

- What are the relationships like among the members of the extended family?
- How does the extended family communicate with each other?

Ratings and Descriptions

0	Well-developed, centerpiece strength; may be used as a centerpiece in an intervention/action plan. Extended family has strong relationships and significant family strengths.
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. Extended family has some good relationships and good communication.
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. Extended family needs some assistance in developing relationships and/or communications.
3	An area in which no current strength is identified; efforts may be recommended to develop a strength in this area. Extended family needs significant assistance in developing relationships and communications, or child has no identified extended family.

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INTERPERSONAL

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

Questions to Consider:

- Does the child have the age-appropriate social skills needed to make and maintain friendships?
- 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.

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ADAPTABILITY

Some children move smoothly from one environment or activity to another. Others struggle with any such changes. This item rates how well a child can adjust in times of transition. A toddler who cries when transitioning from one activity to another but is able to make the transition with the support of a supervising adult would be rated '1.'

Questions to Consider:

- 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. Child has a strong ability to adjust to changes and transitions.
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 the ability to adjust to changes and transitions; when challenged, the child is successful with caregiver support.
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 difficulties much of the time adjusting to changes and transitions, even with caregiver support.
3	An area in which no current strength is identified; efforts may be recommended to develop a strength in this area. Child has difficulties most of the time coping with changes and transitions. Adults are minimally able to impact child's difficulties in this area.

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PERSISTENCE

This item rates how well a child can continue an activity when feeling challenged. A child who is building a tower with blocks that continues to fall down, but the child continues to attempt to build despite this difficulty, would be rated '0.'

Questions to Consider:

- Does child show the ability to hang in there even when frustrated by a challenging task?

Ratings and Descriptions

0	Well-developed, centerpiece strength; may be used as a centerpiece in an intervention/action plan. Child has a strong ability to continue an activity when challenged or meeting obstacles.
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 some ability to continue an activity that is challenging. Adults can assist a child to continue attempting the task or activity.
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 limited ability to continue an activity that is challenging, and adults are only sometimes able to assist the child in this area.
3	An area in which no current strength is identified; efforts may be recommended to develop a strength in this area. Child has difficulties most of the time coping with challenging tasks. Support from adults minimally impacts the child's ability to demonstrate persistence.

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CURIOSITY

This item describes the child's self-initiated efforts to discover their world.

Questions to Consider:

- Does the child attempt to explore their world with all of their senses?

Ratings and Descriptions

0	Well-developed, centerpiece strength; may be used as a centerpiece in an intervention/action plan. Child with exceptional curiosity. Infants display mouthing and banging of objects within grasp; older children crawl or walk to objects of interest.
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 with good curiosity. An ambulatory child who did not walk to interesting objects, but who actively explored them when presented to them, 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 with limited curiosity. Child may have been hesitant to seek out new information or environments, or reluctant to explore even presented objects.
3	An area in which no current strength is identified; efforts may be recommended to develop a strength in this area. Child with very limited or no observable curiosity. Child may seem frightened of new information or environments.

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RESILIENCE

This item refers to the child's ability to recognize their internal strengths and use them in managing daily life.

Questions to Consider:

- What does the child do well?
- Is the child able to recognize their skills as strengths?
- Is the child able to use their strengths to problem solve and address difficulties or challenges?

Ratings and Descriptions

0	Well-developed, centerpiece strength; may be used as a centerpiece in an intervention/action plan. Child can both identify and use strengths to better themselves and successfully manage difficult challenges.
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 can identify most of their strengths and is able to partially utilize them for healthy development, problem solving, or dealing with stressful life events.
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 can identify strengths but is not able to utilize them effectively to support their healthy development, problem solving or dealing with stressful life events.
3	An area in which no current strength is identified; efforts may be recommended to develop a strength in this area. Child is not yet able to identify personal strengths for preventing or overcoming negative life events or outcomes.

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CURRENT CAREGIVER: RESOURCES & NEEDS DOMAIN

This section focuses on the strengths and needs of the child's current caregiver. In general, we recommend that you rate the unpaid caregiver or caregivers with whom the child is currently living. If the child has been placed in out-of-home care, then focus on the child's current out-of-home care provider.

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

The items in this section represent caregivers' potential areas of need while simultaneously highlighting the areas in which the caregivers can be a resource for the child.

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

For the **Current Caregiver: Resources & Needs 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.

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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 the child in their care.

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.

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PROBLEM SOLVING

This item describes the caregiver's ability to problem solve and its impact on parenting—to plan, implement, and monitor a course of action; and to judge and self-regulate behavior according to anticipated outcomes.

Questions to Consider:

- Does the caregiver have difficulties with problem solving?
- Are there particular situations that the caregiver has difficulty thinking through?
- Does the caregiver's problem-solving skills impact their ability to parent the child?

Ratings and Descriptions

0 No current need; no need for action. This may be a resource for the child.
Caregiver has good problem-solving 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 struggles with thinking through problems or situations, but this does not interfere with their functioning as a parent.

2 Need is interfering with the provision of care. Action is required to ensure that the identified need is addressed.
The caregiver has difficulty thinking through problems or situations which interferes with their ability to function as a parent.

3 Need prevents the provision of care; requires immediate and/or intensive action.
The caregiver has problems with problem solving that places the child at risk.

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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 can act as an effective advocate 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 consistently involved in the planning and/or implementation of services for the child but is not an active advocate on their behalf. 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 not actively involved in the child's services and/or interventions intended to assist the child.
3	Need prevents the provision of care; requires immediate and/or intensive action. Caregiver wishes for child to be removed from their care.

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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 needs.

Questions to Consider:

- Does the caregiver understand the child's current mental health diagnosis and/or symptoms?
- Does the caregiver's expectations of the child reflect an understanding of 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 psychological strengths and weaknesses, 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 mild deficits in knowledge or understanding of the child's psychological condition, 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 problems 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 them 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 is 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 the child. Additionally, the caregivers' understanding of the child's diagnosis and how it manifests in their behavior should be considered in rating this item.

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EMPATHY WITH 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.

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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 the 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.

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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, 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.

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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 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 currently impossible.

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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 the child.

Questions to Consider:

- Do caregivers have any mental health needs that make parenting difficult?
- Is there any evidence of transgenerational trauma that is impacting the caregiver's ability to give care effectively?

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 currently impossible to parent the child.

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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:

- Do caregivers have any substance use needs that make parenting difficult?
- Is the caregiver receiving any services for the substance use problems?

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 of, 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 abuse difficulties that interfere with their capacity to parent.
3	Need prevents the provision of care; requires immediate and/or intensive action. Caregiver has substance abuse difficulties that make it currently impossible to parent the child.

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DEVELOPMENTAL

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

Questions to Consider:

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

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 currently impossible to parent the child.

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FAMILY STRESS

This item rates 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 can 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 of 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 providing care.

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CULTURAL CONGRUENCE

This item refers to a family's child rearing practices, understanding of child development and early intervention in comparison to the prevailing professional/helping culture(s) perspective.

Questions to Consider:

- Are the family's child rearing practices, understanding of child development and early intervention aligned with the helping professional's perspectives?
- Do the differences between the family's and the helping professional's understanding of child development and early intervention or child rearing practices impacting their working relationship?

Ratings and Descriptions

0	No evidence of any needs; no need for action. This may be a resource for the child. The family does not have cultural differences related to child rearing practices, child development and early intervention that are considered by the majority culture as problematic for the child.
1	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 family has some cultural differences related to child rearing practices, child development and early intervention that are not generally accepted but not considered to put the child at risk.
2	Need is interfering with the provision of care. Action is required to ensure that the identified need is addressed. The family has cultural differences related to child rearing practices, child development and early intervention that are considered by the majority culture as problematic for the child.
3	Need prevents the provision of care; requires immediate and/or intensive action. The family has cultural differences related to child rearing practices, child development and early intervention that is considered abusive or neglectful and may result in intervention.

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IDENTIFIED PERMANENT RESOURCE: RESOURCES & NEEDS DOMAIN

This section focuses on the resources and needs of the child's permanent resource. If the child has been placed in out-of-home care, then focus on the permanency plan caregiver to whom the child will be returned. If it is a long-term foster care or pre-adoptive placement, then rate that caregiver(s), if different from the child's current caregiver.

If the child is currently in a congregate care setting, such as a hospital, shelter, group home, or residential care center then it may be more appropriate to rate the community caregivers where the child will be placed upon discharge from congregate care. If there is NO community caregiver, this section might need to be left blank with an indication that no caregiver is identified.

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

Question to Consider for this Domain: What are the resources and needs of the child's identified permanent resource?

For the **Identified Permanent Resource: Resources & Needs 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.

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RESIDENTIAL STABILITY

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

Questions to Consider:

- Is the family's current housing situation stable?
- Are there concerns that they might have to move in the near future?
- Has family lost their housing?

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.

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SELF-CARE/DAILY LIVING SKILLS

This item rates the caregiver's ability to participate in self-care activities or basic activities of daily living (including eating, bathing, dressing, and toileting) and its impact on the caregiver's ability to provide care for the child.

Questions to Consider:

- Does the caregiver have the basic activities of daily living skills needed to provide care for the child?
- What level of support with daily living skills does the caregiver need to provide care for the child?

Ratings and Descriptions

0	No current need; no need for action. This may be a resource for the child. The caregiver has the skills needed to complete the daily tasks required to care for themselves.
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 needs verbal prompting to complete the daily tasks required to care for themselves.
2	Need is interfering with the provision of care. Action is required to ensure that the identified need is addressed. Caregiver needs physical prompting to complete the daily tasks required to care for themselves. The caregiver's challenges with the basic activities of daily living interferes with their ability to care for the child.
3	Need prevents the provision of care; requires immediate and/or intensive action. Caregiver is unable to complete some or all of the daily tasks required to care for themselves which makes it impossible to care for the child. The caregiver needs immediate intervention.

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ACCESS TO CHILDCARE SERVICES

This item describes the caregiver's access to appropriate childcare for young children or older children in their care with developmental delays.

Questions to Consider:

- Does the caregiver have access to childcare services?
- What other services are needed?

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.
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. 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 has limited access to childcare services. Current services do not meet the caregiver's needs.
3	Need prevents the provision of care; requires immediate and/or intensive action. Caregiver has no access to needed childcare services.

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CULTURAL STRESS

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

Questions to Consider:

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

Ratings and Descriptions

0	No evidence of any needs; no need for action. This may be a resource for the child. No evidence of stress between the caregiver/family'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. This may be an opportunity for resource building. Some occasional stress resulting from friction between the caregiver/family's cultural identity and their current environment or living situation.
2	Need is interfering with the provision of care. Action is required to ensure that the identified need is addressed. The caregiver/family is experiencing cultural stress that is causing problems of functioning in at least one life domain. The caregiver/family needs support on managing culture stress.
3	Need prevents the provision of care; requires immediate and/or intensive action. The caregiver/family is experiencing a high level of cultural stress that is making functioning in any life domain difficult under the present circumstances. The caregiver/ family needs immediate plan to reduce culture stress.

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EMPLOYMENT/EDUCATIONAL FUNCTIONING

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

Questions to Consider:

- Does the caregiver have any problems at school or work?
- What level of support does the caregiver need to address their problems at work or school?
- Does the caregiver need support in finding employment or attending school?

Ratings and Descriptions

0 No evidence of any needs; no need for action. This may be a resource for the child.

No indication of employment or school related 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.

Some history of problems with work or school functioning, or there is some indication that future assistance will be needed for caregiver with functional challenges at work or school. Caregiver needs monitoring and further assessment.

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

Some problems with school or work functioning, or difficulties with learning. Caregiver may be recently unemployed. Caregiver needs an intervention to address employment and/or learning difficulties.

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

A severe degree of school or work problems. Caregiver is chronically unemployed and not attending any education program. Caregiver needs immediate intervention.

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EDUCATIONAL ATTAINMENT

This item rates the progress of the caregiver toward completing planned education.

Questions to Consider:

- Does the caregiver have educational goals?
- Has the caregiver achieved their educational goals?
- How does achieving (or not achieving) their educational goals impact the caregiver's vocational functioning?

Ratings and Descriptions

0	No evidence of any needs; no need for action. This may be a resource for the child. Caregiver has achieved all their identified educational goals; OR has no educational goals and educational attainment has no impact on lifetime vocational functioning.
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 set educational goals and is currently making progress towards achieving them.
2	Need is interfering with functioning. Action is required to ensure that the identified need is addressed. Caregiver has set educational goals but is currently not making progress towards achieving them.
3	Need is dangerous or disabling; requires immediate and/or intensive action. Caregiver has no educational goals and lack of educational attainment is interfering with their lifetime vocational functioning.

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FINANCIAL RESOURCES

This item describes the money and other sources of income available to caregivers that can be used in addressing the needs of the child and family.

Questions to Consider:

- Does the family have sufficient funds to raise or 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 financial issues or caregiver has financial resources necessary to meet 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. History or suspicion, or existence of difficulties. Caregiver has financial resources necessary to meet most needs; however, some limitations exist.
2	Need is interfering with the provision of care. Action is required to ensure that the identified need is addressed. Caregiver has financial difficulties that limit ability to meet significant family needs.
3	Need prevents the provision of care; requires immediate and/or intensive action. Caregiver is experiencing financial hardship or poverty.

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COMMUNITY CONNECTION

This item reflects the caregiver's connection to people, places, or institutions in their community.

Questions to Consider:

- Does the caregiver have ties with their community?
- Can the caregiver look to neighbors or other community groups for support?

Ratings and Descriptions

0	No current need; no need for action. This may be a resource for the child. Caregiver with extensive and substantial long-term ties with the community. For example, involvement in a community group for more than one year, a caregiver who is widely accepted by neighbors, or involved in other community activities or informal networks.
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 somewhat involved with their community. This level can also indicate an caregiver with significant community ties although they may be relatively short term.
2	Need is interfering with the provision of care. Action is required to ensure that the identified need is addressed. Caregiver has an identified community but has only limited, or unhealthy, ties to that community.
3	Need prevents the provision of care; requires immediate and/or intensive action. Caregiver has no known ties or supports with a community.

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LEGAL

This item rates the caregiver's level of involvement with the 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:

- 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?

Ratings and Descriptions

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.

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TRANSPORTATION

This item reflects the caregiver's ability to provide appropriate transportation for the child.

Questions to Consider:

- Does the caregiver have the means to transport the child?
- Are there any barriers to transportation?

Ratings and Descriptions

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

Caregiver has no unmet transportation needs. Caregiver can get child to appointments, school, activities, etc. consistently.

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 occasional unmet transportation needs. They have difficulty getting child to appointments, school, activities, etc. no more than weekly and do not require a special vehicle.

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

Caregiver has frequent unmet transportation needs. They have difficulty getting child to appointments, school, activities, etc. regularly (e.g., once a week). Caregiver needs assistance transporting child and access to transportation resources or may require a special vehicle.

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

Caregiver has no access to appropriate transportation and is unable to get the child to appointments, school, activities, etc. Caregiver needs immediate intervention and development of transportation resources.

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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 the child in their care.

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.

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PROBLEM SOLVING

This item describes the caregiver's ability to problem solve and its impact on parenting—to plan, implement, and monitor a course of action, to judge and self-regulate behavior according to anticipated outcomes.

Questions to Consider:

- Does the caregiver have difficulties with problem solving?
- Are there particular situations that the caregiver has difficulty thinking through?
- Does the caregiver's problem-solving skills impact their ability to parent the child?

Ratings and Descriptions

0	No current need; no need for action. This may be a resource for the child. Caregiver has good problem-solving 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 struggles with thinking through problems or situations, but this does not interfere with their functioning as a parent.
2	Need is interfering with the provision of care. Action is required to ensure that the identified need is addressed. The caregiver has difficulty thinking through problems or situations which interferes with their ability to function as a parent.
3	Need prevents the provision of care; requires immediate and/or intensive action. The caregiver has problems with problem solving that places the child at risk.

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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 can act as an effective advocate 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 consistently involved in the planning and/or implementation of services for the child but is not an active advocate on their behalf. 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 not actively involved in the child's services and/or interventions intended to assist the child.
3	Need prevents the provision of care; requires immediate and/or intensive action. Caregiver wishes for child to be removed from their care.

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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 needs.

Questions to Consider:

- Does the caregiver understand the child's current mental health diagnosis and/or symptoms?
- Does the caregiver's expectations of the child reflect an understanding of 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 psychological strengths and weaknesses, 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 psychological condition, 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 problems 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 them 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 is 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 the child. Additionally, the caregivers' understanding of the child's diagnosis and how it manifests in their behavior should be considered in rating this item.

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EMPATHY WITH 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.

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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 the 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.

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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, 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.

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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 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 currently impossible.

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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 the child.

Questions to Consider:

- Do caregivers have any mental health needs that make parenting difficult?
- Is there any evidence of transgenerational trauma that is impacting the caregiver's ability to give care effectively?

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 currently impossible to parent the child.

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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:

- Do caregivers have any substance use needs that make parenting difficult?
- Is the caregiver receiving any services for the substance use problems?

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 of, 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 abuse difficulties that interfere with their capacity to parent.
3	Need prevents the provision of care; requires immediate and/or intensive action. Caregiver has substance abuse difficulties that make it currently impossible to parent the child.

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DEVELOPMENTAL

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

Questions to Consider:

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

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 currently impossible to parent the child.

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FAMILY STRESS

This item rates 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 can 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 of 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 providing care.

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CULTURAL CONGRUENCE

This item refers to a family's child rearing practices, understanding of child development and early intervention in comparison to the prevailing professional/helping culture(s) perspective.

Questions to Consider:

- Are the family's child rearing practices, understanding of child development and early intervention aligned with the helping professional's perspectives?
- Do the differences between the family's and the helping professional's understanding of child development and early intervention or child rearing practices impacting their working relationship?

Ratings and Descriptions

0 No evidence of any needs; no need for action. This may be a resource for the child.
The family does not have cultural differences related to child rearing practices, child development and early intervention that are considered by the majority culture as problematic for the child.

1 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 family has some cultural differences related to child rearing practices, child development and early intervention that are not generally accepted but not considered to put the child at risk.

2 Need is interfering with the provision of care. Action is required to ensure that the identified need is addressed.
The family has cultural differences related to child rearing practices, child development and early intervention that are considered by the majority culture as problematic for the child.

3 Need prevents the provision of care; requires immediate and/or intensive action.
The family has cultural differences related to child rearing practices, child development and early intervention that is considered abusive or neglectful and may result in intervention.

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