MICHIGAN
Child and Adolescent Needs & Strengths

MichiCANS Screener
Birth through Age 20

2025
REFERENCE
GUIDE

Center for Innovation in Population Health • 111 Washington Avenue, Ste 201, Lexington, KY 40506 • www.iph.uky.edu

ACKNOWLEDGEMENTS

Many individuals have collaborated in the development of the Child and Adolescent Needs and Strengths. Along with the CANS, versions for developmental disabilities, juvenile justice, and child welfare, this information integration tool is designed to support individual case planning and the planning and evaluation of service systems. The CANS is an open-domain tool for use in multiple child-serving systems that address the needs and strengths of children, youth, and their families. The Praed Foundation holds the copyright 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 precisely and inclusively use individual words. As such, this reference guide uses the gender-neutral pronouns “they/them/themselves” in place of “he/him/himself” and “she/her/herself.”

This reference guide applies to a broad range of ages. To make this guide easier to use, the term “child” is being utilized in reference to “infant”, “toddler” and “preschooler” or children ages birth through 5. For ages 6 through 20, “child/youth” is being utilized in reference to “child,” “youth,” “adolescent,” or “young adult.”

For specific permission to use please contact the Praed Foundation. For more information on the CANS contact:

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INTRODUCTION

THE CANS

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

SIX KEY PRINCIPLES OF THE CANS

1. **Items were selected because they are each relevant to service/treatment planning.** An item exists because it might lead you down a different pathway in terms of planning actions.
2. **Each item uses a 4-level rating system designed to translate immediately into action levels.** Different action levels exist for needs and strengths. For a description of these action levels please see below.
3. **Rating should describe the child/youth, not the child/youth 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/ youth'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/youth's developmental age.
5. **The ratings are generally "agnostic as to etiology."** In other words this is a descriptive tool; it is about the "what" not the "why." While most items are purely descriptive, there are a few items that consider cause and effect; see individual item descriptions for details on when the "why" is considered in rating these items.
6. **A 30-day window is used for ratings in order to make sure assessments stay relevant to the child/youth'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/youth's and parents/caregivers' needs and strengths. Strengths are the child/youth's assets: areas in life where they are doing well or have an interest or ability. Needs are areas where a child/youth requires help or intervention. Care providers use an assessment process to get to know the child or youth and the families with whom they work and to understand their strengths and needs. The CANS helps care providers decide which of a child/youth'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/youth 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/youth's strengths and needs while building strong engagement.

The CANS is made up of domains that focus on various areas in a child/youth's life, and each domain is made up of a group of specific items. There are domains that address how the child/youth 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/youth and family as well as other stakeholders, gives a number rating to each of these items. These ratings help the provider, child/youth and family understand where intensive or immediate action is most needed, and also where a child/youth 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/youth'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/youth.

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/youth 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/youth-serving systems. It provides for a structured communication and critical thinking about children/youth 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/youth's progress. It can also be used as a communication tool that provides a common language for all child/youth-serving entities to discuss the child/youth'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. 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

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 case workers, probation officers, and family advocates. With approved training and certification, anyone can learn to complete the tool reliably, although some applications or more complex versions of the CANS require a higher educational degree or relevant experience. The average reliability of the CANS is 0.78 with vignettes across a sample of more than 80,000 trainees. The reliability is higher (0.84) with case records, and can be above 0.90 with live cases (Lyons, 2009). The CANS is auditable and audit reliabilities demonstrate that the CANS is reliable at the item level (Anderson et al., 2002). Training and certification with a reliability of at least 0.70 on a test case vignette is required for ethical use. In most jurisdictions, re-certification is annual. A full discussion on the reliability of the CANS assessment is found in Lyons (2009) *Communimetrics: A Communication Theory of Measurement in Human Service Settings*.

Validity

Studies have demonstrated the CANS' validity, or its ability to measure children/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/youth and family.

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

Each CANS rating suggests different pathways for 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 (separate for needs and strengths):

Basic design for rating Needs

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

Basic design for rating Strengths

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

The rating of '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/youth.

To complete the CANS, a CANS trained and certified care coordinator, case worker, clinician, or other care provider should read the anchor descriptions for each item and then record the appropriate rating on the CANS form (or electronic record). This process should be done collaboratively with the child/youth, 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/youth and family, referral source, treatment providers, school, and observation of the rater). As a strength-based approach, the CANS supports the belief that children, youth, 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/youth and their families to discover individual and family functioning and strengths. Failure to demonstrate a child/youth's skill should first be viewed as an opportunity to learn the skill as opposed to the problem. Focusing on the child/youth's strengths instead of weaknesses with their families may result in enhanced motivation and improved performance. Involving the family and child/youth in the rating process and obtaining information (evidence) from multiple sources is necessary and improves the accuracy of the rating. Meaningful use of the CANS and related information as tools (for reaching consensus, planning interventions, monitoring progress, psychoeducation, and supervision) support effective services for children, youth and families.

As a quality improvement activity, a number of settings have utilized a fidelity model approach to look at service/treatment/action planning based on the CANS 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 and youth 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 and youth 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 juvenile justice programs.

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

HOW IS THE CANS USED?

The CANS is used in many ways to transform the lives of children, youth, 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 at regular intervals to measure change and transformation. We work with children, youth, and families and their needs tend to change over time. Needs may change in response to many factors including quality clinical support provided. One way we determine how our supports are helping to alleviate suffering and restore functioning is by re-assessing needs, adjusting treatment or service plans, and tracking change.

IT IS A COMMUNICATION TOOL

When a client leaves a treatment program, a closing CANS may be completed to define progress, measure ongoing needs and help us make continuity of care decisions. Doing a closing CANS, much like a discharge summary, integrated with CANS ratings, provides a picture of how much progress has been made, and allows for recommendations for future care which ties to current needs. And finally, it allows for a shared language to talk about our child/youth 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 and youth'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/youth 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/youth 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 youth'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 and youth 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/youth 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/youth and family the CANS domains and items (see the CANS Core Item list on page 17) 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 a brief "yes," "and"—things that encourage people to continue.
- **Be non-judgmental and avoid giving personal 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 empathic listening when you smile, nod, and 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. A 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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CANS BASIC STRUCTURE

The Michigan CANS Screener core items are rated for all children and youth (see below). Individualized Assessment Modules are triggered by key core items (see italics below). Additional questions are required for the decision models to function.

CORE ITEMS

Life Functioning Domain

Ages 0-5
- Family Functioning
- Parent/Child Interaction
- Social and Emotional Functioning
- Early Care and Education
- Developmental/Intellectual
- Autism Spectrum
- Medical/Physical
- Motor (Fine/Gross)
- Sensory Responsiveness
- Communication
- Restricted Interests

Ages 6+
- Family Functioning
- Parent/Child Interaction
- Living Situation
- Social Functioning
- Developmental/Intellectual
- Autism Spectrum
- Legal (Age 11+)
- Medical/Physical
- Sleep
- School
- Job Functioning (Age 16+)
- Decision Making

Behavioral/Emotional Needs Domain

Challenges: Ages 0-5
- Impulsivity/Hyperactivity (36+ months)
- Depression
- Anxiety
- Oppositional Behavior (36+ months)
- Attachment Difficulties
- Adjustment to Trauma
- Regulatory
- Atypical Behaviors
- Sleep (12+ months)
- Aggression

Ages 6+
- Psychosis (Thought Disorder)
- Impulsivity/Hyperactivity
- Depression
- Anxiety
- Oppositional Behavior
- Conduct (Antisocial Behavior)
- Anger Control
- Eating Disturbance
- Adjustment to Trauma
- Substance Use

Risk Factors and Behaviors Domain

Risk Factors (Ages 0-5)
- Substance Exposure in Utero
- Environmental Toxin Exposure
- Prenatal Care
- Labor and Delivery
- Birth Weight
- Failure to Thrive
- Exploited

Risk Behaviors (Ages 0-5)
- Self-Harm (12+ months)
- Flight Risk/Bolting

Risk Factors (Ages 6+)
- Substance Exposure in Utero

Risk Behaviors (Ages 6+)
- Suicide Risk
- Non-Suicidal Self-Injurious Behavior
- Other Self-Harm (Recklessness)
- Danger to Others
- Problematic Sexual Behavior
- Runaway
- Victimization/Exploitation

Cultural Factors (All Ages)

Cultural Stress

Caregiver Resources & Needs (All Ages)

Adjustment to Traumatic Experiences
Mental Health
Caregiver Capacity
Supervision
Involvement with Care
Knowledge
Safety

LIFE FUNCTIONING DOMAIN

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

Question to Consider for this Domain: How is the child/youth 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 Action is required to ensure that the identified need is addressed; need is interfering with functioning.

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

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AGES 0-5

FAMILY FUNCTIONING

This item rates the child's relationships with those who are in their family. Consider biological and adoptive relatives and their significant others with whom the child is still in contact. When rating this item, consider the relationships and interactions the child has with their family as well as the relationship of the family as a whole. **Note:** For children involved with child welfare, family refers to the person(s) fulfilling the permanency plan. Foster families should only be considered if they have made a significant commitment to the child.

Questions to Consider:

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

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

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FAMILY FUNCTIONING continued

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. 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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PARENT/CHILD INTERACTION

This item rates how the caregiver and child relate to each other and the level of relationship that exists. This item assesses whether the caregiver and child have a healthy relationship, as demonstrated by good communication and care, or unhealthy, which could be demonstrated by a failure to communicate consistently, difficulty with affection or attention in the relationship, or, in the extreme, neglect and/or abuse. The caregiver who is considered in this item is the same caregiver being rated in the Caregiver Resources & Needs Domain.

Questions to Consider:

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

Ratings and Descriptions

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

No evidence of problems in the parent/child interaction.

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

There is either a history of problems or suboptimal functioning in parent/child interaction. There may be inconsistencies or indications that interaction is not optimal that has not yet resulted in problems.

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

The parent/child dyad interacts in a way that is problematic and has led to interference with the child's growth and development.

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

The parent/child dyad is having significant problems that can be characterized as abusive or neglectful.

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

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PARENT/CHILD INTERACTION

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

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

Assessing parent-child relationship in early childhood: It can be helpful to assess the following aspects of parent-child interactions:

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

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SOCIAL AND EMOTIONAL FUNCTIONING

This item rates the child's social and relationship functioning. This includes age-appropriate behavior such as showing an array of emotions, and the ability to engage and interact with others including the ability to calm oneself with help from familiar caregivers, and handling frustration.

Questions to Consider:

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

Ratings and Descriptions

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

No evidence of problems with social and emotional 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 or emotional functioning. Infants may be slow to respond to adults, toddlers may need support to interact with peers and preschoolers may resist social situations. Child may need help to calm or may have some problems in relationships due to emotional regulation, some lack of emotional responsiveness or heightened emotions.

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 and emotional functioning. Infants may be unresponsive to adults, and unaware of other infants. Toddlers may be aggressive and resist parallel play. Preschoolers may argue excessively with adults and peers and lack ability to play in groups even with adult support.

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

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

Supplemental Information: 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 give 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 some general developmental milestones for social functioning (ZTT, 2016). [continues]

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SOCIAL AND EMOTIONAL FUNCTIONING continued

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).

Social Functioning Developmental Milestones

By 3 Months	• Smiles responsively (i.e., social smile) • Imitates simple facial expressions (e.g., smiling, sticking tongue out) • Looks at caregiver's face • Coos responsively • Localizes to familiar voices and sounds • Shows interest in facial expressions • Is comforted by proximity of caregiver
By 6 Months	• Imitates some movements and facial expressions (e.g., smiling, frowning) • Engages in socially reciprocal interactions (e.g., playing simple back-and-forth games) • Seeks social engagement with vocalizations, emotional expressions, or physical contact • Watches face closely • Responds to affection with smiling, cooing, or settling • Recovers from distress when comforted by caregiver
By 9 months	• Distinguishes between familiar and unfamiliar voices • Shows some stranger wariness • Demonstrates preference for caregivers • Protests separation from caregiver • Enjoys extended play with others • Engages in back-and-forth, two-way communication using vocalizations and eye movement • Mimics other's simple gestures • Follows other's gaze and pointing

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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 [continues] • 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
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

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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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EARLY CARE AND EDUCATION

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

Questions to Consider:

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

Ratings and Descriptions

0	*No evidence of any needs; no need for action.* No evidence of problems 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 educational environment.
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: Children under 5 who are not in any congregate learning settings (EHS, HS, Preschool, Pre-K) and do not have unmet early educational needs would be rated a '0' here. Children under 5 who are not in any congregate learning settings AND have unmet early educational needs would be rated a '2,' communicating the need for connection to early educational resources.

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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EARLY CARE AND EDUCATION 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 appreciate 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
- Predictable routines
- Adults tend to the child's needs (e.g., pick up crying child, feed hungry toddler, etc.)
- Low child-adult ratios
- Safe and clean environment
- Early care/education setting provides frequent and open communication with parents

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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 or intellectual disabilities or delays. It includes Intellectual Developmental Disorder (IDD) but explicitly excludes Autism Spectrum Disorders which are described on a different item.

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 or development 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) with marked to profound deficits in adaptive functioning in one or more areas: communication, social functioning and self-care across multiple environments.

Supplemental Information – 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. [continues]

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DEVELOPMENTAL/INTELLECTUAL continued

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

By 3 Months	• Follows people and objects with eyes • Loses interest or protests if activity does not change
By 6 Months	• Tracks moving objects with eyes from side to side • Experiments with cause and effect (e.g., bangs spoon on table) • Smiles and vocalizes in response to own face in mirror image • Recognizes familiar people and things at a distance • Demonstrates anticipation of certain routine activities (e.g., shows excitement in anticipation of being fed)
By 9 Months	• Mouths or bangs objects • Tries to get objects that are out of reach • Looks for things they see others hide (e.g., toy under a blanket)
By 12 Months	• Watches the path of something as it falls • Has favorite objects (e.g., toys, blanket) • Explores objects and how they work in multiple ways (e.g., mouthing, touching, dropping) • Fills and dumps containers • Plays with two objects at the same time
By 15 Months	• Imitates complex gestures (e.g., signing) • Finds hidden objects easily • Uses objects for their intended purpose (e.g., drinks from a cup, smooths hair with a brush)
By 18 months	• Enacts play sequences with objects according to their use (e.g., pushing a dump truck and emptying its cargo) • Shows interest in a doll or stuffed animal • Points to at least one body part • Points to self when asked • Plays simple pretend games (e.g., feeding a doll) • Scribbles with crayon, marker, and so forth • Turns pages of book • Recognizes self in mirror
By 2 Years	• Finds things even when hidden under two or three covers or when hidden in one place and moved to another • Begins to sort shapes and colors

	• Completes sentences and rhymes from familiar books, stories, and songs • Plays simple make-believe games (e.g., pretend meal) • Builds towers of four or more blocks • Follows two-step instructions (e.g., "Pick up your shoes and put them in the closet")
By 3 Years	• Labels some colors correctly • Plays thematic make-believe with objects, animals, and people • Answers simple "Why" questions (e.g., "Why do we need a coat when it's cold outside?") • Shows awareness of skill limitations • Understands "bigger" and "smaller" • Understands concept of "two" • Enacts complex behavioral routines observed in daily life of caregivers, siblings, and peers [cont.] • Solves simple problems (e.g., obtains a desired object by opening a container) • Attends to a story for 5 minutes • Plays independently for 5 minutes
By 4 Years	• Names several colors and some numbers • Counts to five • Has rudimentary understanding of time • Shares past experiences • Remembers part of a story • Engages in make-believe play with capacity to build and elaborate on play themes • Connects actions and emotions • Responds to questions that require understanding of "same" and "different" • Draws a person with two to four body parts • Understands that actions can influence others' emotions (e.g., tries to make others laugh by telling a joke) • 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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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 *No evidence of any needs; no need for action*.

There is no history of Autism Spectrum symptoms.

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

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 functioning or development.

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

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

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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MEDICAL/PHYSICAL

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

Questions to Consider:

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

Ratings and Descriptions

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

No evidence that the child has any medical or physical problems, and/or child is healthy.

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

Child has mild, transient or well-managed physical or medical problems. These include well-managed chronic conditions like juvenile diabetes or asthma.

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

Child has serious medical or physical problems that require medical treatment or intervention. Or child has a chronic illness or a physical challenge that requires ongoing medical intervention.

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

Child has life-threatening illness or medical/physical condition. Immediate and/or intense action should be taken due to imminent danger to child's safety, health, and/or development.

Supplemental Information:

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.

Most transient, treatable conditions would be rated as a '1.' Most chronic conditions (e.g., diabetes, severe asthma) would be rated a '2.' The rating '3' is reserved for life-threatening medical conditions.

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MOTOR (FINE/GROSS)

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

Questions to Consider:

- How is the child's ability to move around and explore their surroundings?
- How is the child's ability to grasp and handle small objects?
- Are there any concerns that the child is lagging behind in their physical development?

Ratings and Descriptions

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

No evidence of fine or gross motor problems.

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

There is either a history of fine or gross motor problems or slow development in either or both areas.

2 *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.

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SENSORY RESPONSIVENESS

This item describes the child's responses to sensory stimuli including both hyper- or hypo-sensitivities (e.g., tactile, oral, auditory, olfactory, smell, vestibular and proprioceptive).

Questions to Consider:

- Does the child exhibit any hyper- or hypo-sensitivities to sensory stimulation?

Ratings and Descriptions

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

No evidence that the child has atypical responses to stimuli.

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

Child has some atypical reactions to one or more sensory stimuli that do not interfere with their functioning.

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

Child has atypical reactions to one or more sensory stimuli that interfere with their functioning.

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

Child's atypical reactions to one or more sensory stimuli are dangerous or disabling to them. Social, emotional and/or behavioral difficulties related to sensory integration problems are/can be extreme.

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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 delays or challenges involving expressive and/or receptive language. **This item does not refer to challenges in expressing one's feelings**.

Questions to Consider:

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

Ratings and Descriptions

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

No evidence of receptive or expressive language problems.

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

There is either a history of receptive or expressive language problems or slow development in either or both areas.

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

The child has delays in either or both receptive and expressive language development.

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

The child exhibits has significant challenges in either receptive or expressive language development.

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RESTRICTED INTERESTS

This item describes highly circumscribed or unusual/bizarre interests that are not usually seen.

Questions to Consider:

- Does the child have varied and age-appropriate interests in objects and the environment?
- Do the child's interests impact their functioning?

Ratings and Descriptions

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

Child has varied and age-appropriate interests in objects and the environment. No evidence of preoccupations in the child.

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

Child has some age-appropriate interests in objects and the environment but can also demonstrate preoccupations that have occasional interference with their functioning.

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

Child frequently demonstrates excessive preoccupations, or odd interests, but may have some age-appropriate interests in objects and the environment which interferes in a notable way with their functioning.

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

Child's interests are almost completely preoccupied with a specific focus that is disabling or dangerous.

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AGES 6+

FAMILY FUNCTIONING

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

Questions to Consider:

- Does the family identify the conflict that they would like to resolve?
- Would therapeutic intervention help to strengthen the family relationship?

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/youth 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/youth 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/youth. 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/youth 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/youth is having severe problems with parents, siblings and/or other family members. This would include problems of domestic violence, absence of any positive relationships, etc.

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

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PARENT/CHILD INTERACTION

This item rates how the caregiver and child/youth relate to each other and the level of relationship that exists. This item assesses whether the caregiver and child/youth have a healthy relationship, as demonstrated by good communication and care, or unhealthy, which could be demonstrated by a failure to communicate consistently, difficulty with affection or attention in the relationship, or, in the extreme, neglect and/or abuse. The caregiver who is considered in this item is the same caregiver being rated in the Caregiver Resources & Needs Domain.

Questions to Consider:

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

Ratings and Descriptions

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

No evidence of problems in the parent/child interaction.

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

There is either a history of problems or suboptimal functioning in parent/child interaction. There may be inconsistencies or indications that interaction is not optimal that has not yet resulted in problems.

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

The parent/child dyad interacts in a way that is problematic and has led to interference with the child/youth's growth and development.

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

The parent/child dyad is having significant problems that can be characterized as abusive or neglectful.

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LIVING SITUATION

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

Questions to Consider:

- How do current household members describe interactions with each other?

Ratings and Descriptions

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

No evidence of problems with functioning in current living environment. Child/youth 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/youth experiences some problems with functioning in current living situation. Caregivers express some concern about child/youth's behavior in living situation, and/or child/youth 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/youth has moderate to severe problems with functioning in current living situation. Child/youth's difficulties in maintaining appropriate behavior in this setting are creating significant problems for others in the residence. Child/youth 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/youth has profound problems with functioning in current living situation. Child/youth is at immediate risk of being unable to remain in present living situation due to problematic behaviors.

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SOCIAL FUNCTIONING

This item rates social skills and relationships. It includes age-appropriate behavior and the ability to make and sustain relationships. Social functioning is different from Interpersonal (Strengths) in that functioning is a description of how the child/youth is doing currently. Strengths are longer-term assets.

Questions to Consider:

- Does the child/youth or family report the child/youth having friends?
- Are the child/youth's friends in the same age group?
- Are there concerns about how the child/youth behaves in social settings?

Ratings and Descriptions

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

No evidence of problems and/or child/youth has developmentally appropriate social functioning.

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

There is a history or suspicion of problems in social relationships. Child/youth is having some difficulty interacting with others and building and/or maintaining relationships.

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

Child/youth is having some problems with their social relationships that interfere with functioning in other life domains.

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

Child/youth is experiencing significant disruptions in social relationships. Child/youth may have no friends or have constant conflict in relations with others, or have maladaptive relationships with others. The quality of the child/youth's social relationships presents imminent danger to the child/youth's safety, health, and/or development.

Supplemental Information: A child/youth who socializes with primarily younger or much older individuals would be identified as having needs on this item. A child/youth who has conflictual relationships with peers also would be described as having needs. An isolated child/youth with no same age friends would be rated '3.'

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DEVELOPMENTAL/INTELLECTUAL

This item describes the child/youth'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) but explicitly excludes Autism Spectrum Disorders which are described on a different item. 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/youth's growth and development seem healthy?
- Has the child/youth reached appropriate developmental milestones (such as walking, talking)?
- Has anyone ever mentioned that the child/youth may have developmental problems?
- Has the child/youth developed like other same age peers?

Ratings and Descriptions

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

No evidence of developmental delay and/or child/youth 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/youth 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/youth 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/youth has severe to profound intellectual disability (FSIQ, if available, less than 55) with marked to profound deficits in adaptive functioning in one or more areas: communication, social participation and independent living across multiple environments.

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

There is no history of Autism Spectrum symptoms.

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

Evidence of a low-end Autism Spectrum Disorder. The child/youth 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 functioning or development.

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

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

Child/youth 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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LEGAL (AGE 11+)

This item indicates the child/youth's level of involvement with the justice system. Family involvement with the courts is not rated here—only the identified child/youth's involvement is relevant to this rating.

Questions to Consider:

- Has the child/youth ever admitted that they have broken the law?
- Has the child/youth ever been arrested?
- Has the child/youth ever been in detention?

Ratings and Descriptions

0	*No evidence of any needs; no need for action.* Child/youth has no known legal difficulties or involvement with the court system.
1	*Identified need that requires monitoring, watchful waiting, or preventive action based on history, suspicion or disagreement.* Child/youth has a history of legal problems (e.g., status offenses such as juvenile/family conflict, in-county runaway, truancy, petty offenses) but currently is not involved with the legal system, or immediate risk of involvement with the legal system.
2	*Need is interfering with functioning. Action is required to ensure that the identified need is addressed.* Child/youth has some legal problems and is currently involved in the legal system due to moderate delinquent behaviors (misdemeanors such as offenses against persons or property, drug-related offenses, underage drinking).
3	*Need is dangerous or disabling; requires immediate and/or intensive action.* Child/youth has serious current or pending legal difficulties that place them at risk for a court-ordered out-of-home placement, or incarceration (ages 18-20) such as serious offenses against person or property (e.g., robbery, aggravated assault, possession with intent to distribute controlled substances, 1st, or 2nd degree offenses).
NA	Child/youth is younger than age 11.

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MEDICAL/PHYSICAL

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

Questions to Consider:

- Does the child/youth have anything that limits their physical activities?
- How much does this interfere with the child/youth's life?

Ratings and Descriptions

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

No evidence that the child/youth has any medical or physical problems, and/or they are healthy.

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

Child/youth has mild, transient, or well-managed physical or 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/youth has *serious* medical or physical problems that require medical treatment or intervention. Or child/youth 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/youth has *life-threatening* illness or medical/physical condition. Immediate and/or intense action should be taken due to imminent danger to child/youth's safety, health, and/or development.

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SLEEP

This item rates the child/youth'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/youth appear rested?
- Are they often sleepy during the day?
- Do they have frequent nightmares or difficulty sleeping?
- How many hours does the child/youth sleep each night?

Ratings and Descriptions

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

No evidence of problems with sleep. Child/youth gets a full night's sleep each night and feels rested.

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

Child/youth has some problems sleeping. Generally, child/youth 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. Sleep is not restful for the child/youth.

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

Child/youth is having problems with sleep. Sleep is often disrupted, and child/youth seldom obtains a full night of sleep and doesn't feel rested. 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/youth is generally sleep deprived. Sleeping is almost always difficult, and the child/youth is not able to get a full night's sleep and does not feel rested. Child/youth's sleep deprivation is dangerous and places them at risk.

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SCHOOL

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

Questions to Consider:

- What is the child/youth's experience at school?
- Does the child/youth have difficulties with attendance, learning new skills, social relationships or behavior?

Ratings and Descriptions

0	*No evidence of any needs; no need for action.* No evidence of problems 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 the school environment. Child/youth may be enrolled in a special program.
2	*Action is required to ensure that the identified need is addressed; need is interfering with functioning.* Child/youth is experiencing difficulties maintaining their behavior, attendance, and/or progress in the school setting.
3	*Need is dangerous or disabling; requires immediate and/or intensive action.* Child/youth's problems with functioning in the school environment place them at immediate risk of being removed from program due to their behaviors, lack of progress, or unmet needs.
NA	Child/youth is not in school due to age or having graduated.

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JOB FUNCTIONING (AGE 16+)

If the youth is working, this item describes their functioning in a job setting.

Questions to Consider:

- Is the youth able to meet expectations at work?
- Do they have regular conflict at work?
- Are they timely and able to complete responsibilities?

Ratings and Descriptions

0	*No evidence of any needs; no need for action.* No evidence of any problems in work environment. Youth is excelling in a job environment.
1	*Identified need that requires monitoring, watchful waiting, or preventive action based on history, suspicion, or disagreement.* Youth has a history of problems with work functioning, or youth may have some problems in the work environment that are not interfering with work functioning or other functional areas. The youth is functioning adequately in a job environment. A youth that is not currently working, but is motivated and is actively seeking work, could be rated here.
2	*Action is required to ensure that the identified need is addressed; need is interfering with functioning.* Some problems at work including disruptive behavior and/or difficulties with performing required work is indicated. Supervisors likely have warned youth about problems with their work performance. OR although not working, the youth seems interested in doing so, but may have problems with developing vocational or prevocational skills.
3	*Need is dangerous or disabling; requires immediate and/or intensive action.* Youth has problems at work in terms of attendance, performance, or relationships. Youth may have recently lost a job. Work problems are placing the youth or others in danger including aggressive behavior toward peers or superiors or severe attendance problems are evidenced. Youth may be recently fired or at very high risk of firing (e.g., on notice). OR the youth has a long history of unemployment.
NA	Youth is not currently working.

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DECISION MAKING

This item describes the child/youth's age-appropriate decision-making process and understanding of choices and consequences.

Questions to Consider:

- How is the child/youth's decision-making process and ability to make good decisions?
- Does the child/youth typically make good choices for themselves?
- How does the child/family describe the youth's decision-making ability?

Ratings and Descriptions

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

No evidence of problems with judgment or decision making that result in harm to development and/or well-being.

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

There is a history or suspicion of problems with judgment in which the child/youth makes decisions that are in some way harmful to their development and/or well-being.

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

Problems with judgment in which the child/youth makes decisions that are in some way harmful to their development and/or well-being. As a result, more supervision is required than expected for their age.

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

Child/youth makes decisions that would likely result in significant physical harm to self or others. Therefore, child/youth requires intense and constant supervision, over and above that expected for child/youth's age.

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BEHAVIORAL/EMOTIONAL NEEDS DOMAIN

This section identifies the behavioral health needs of the child/youth. 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/youth?

For the **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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CHALLENGES: AGES 0-5

IMPULSIVITY/HYPERACTIVITY (36+ months)

This item rates behavioral symptoms associated with hyperactivity and/or impulsiveness. Children with impulse problems tend to engage in behavior without thinking, regardless of the consequences. A rating of '3' on this item is reserved for those whose impulsive behavior has placed them in physical danger during the period of the rating. Rate this item a '0' if child is under 3 years of age.

Questions to Consider:

- 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?
- Does the child report feeling compelled to do something despite negative consequences?

Ratings and Descriptions

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

No evidence of hyperactivity or impulse control problems.

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

This rating is used to indicate a child with evidence of some problems with hyperactivity or impulse control that is not impacting their functioning. 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.*

Hyperactivity or impulse control problems. A child who meets DC 0-5/DSM diagnostic criteria for ADHD or an impulse control disorder would be rated here.

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

Severe impairment of impulse control. For infants and toddlers, excessive seeking of satisfaction from their sensory needs/cravings would be rated here. Frequent impulsive behavior is observed or noted that carries considerable safety risk (e.g., running into the street, dangerous bike riding). A child with profound symptoms of ADHD would be rated here.

NA Child is younger than 36 months.

Supplemental Information – Understanding attention, hyperactivity, and impulsivity in young children: 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. [continues]

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IMPULSIVITY/HYPERACTIVITY continued

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

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

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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DEPRESSION

This item rates symptoms such as irritable or depressed mood, low affect, social withdrawal, sleep disturbances, weight/eating disturbances, and loss of motivation, interest or pleasure in daily activities. These symptoms should be considered if occurring regularly for two weeks. This item can be used to rate symptoms of the depressive disorders as specified in the DC 0-5/DSM.

Questions to Consider:

- Are the child's caregivers concerned about possible depression or chronic low mood and irritability?
- Has the child withdrawn from normal activities?
- Does the child seem listless, sad, smiles infrequently, or is socially withdrawn?
- Does the child show any significant weight/eating issues?
- Does the caregiver express concern with engaging with the child socially?
- Has the infant shown a distinct change in eating or sleeping patterns that causes concern for the caregivers?

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 a 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 with significant weight/eating issues, who withdraws from activity (school, play) or interaction (with family, peers, significant adults) due to depression. Disabling forms of depressive diagnoses would be rated here. [continues]

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DEPRESSION continued

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 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 symptoms associated with DC 0-5/DSM Anxiety Disorders characterized by 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?
- Does the child show excessive difficulty with separation from familiar caregivers or in daily transitions?

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 inability 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: 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
- Difficulty separating from familiar caregivers
- Difficulty with daily transitions
- Physical symptoms such as stomachaches, headaches, excessive sweating, increased heart rate, increased blinking, or dizziness

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OPPOSITIONAL BEHAVIOR (36+ months)

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

Questions to Consider:

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

Ratings and Descriptions

0	*No evidence of any needs; no need for action.* No evidence of oppositional behaviors.
1	*Identified need that requires monitoring, watchful waiting, or preventive action based on history, suspicion, or disagreement.* History or evidence of some defiance towards authority figures that has not yet begun to cause functional impairment.
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.
NA	Child is younger than 36 months.

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ATTACHMENT DIFFICULTIES

This item should be rated within the context of the child's significant parental or caregiver relationships. Attachment relates to a child's ability to seek and receive comfort under stress and involves the degree of positive connection the child has with their parents/caregivers.

Questions to Consider:

- Does the child struggle with separating from the 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 the 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. The caregiver-child relationship is characterized by mutual satisfaction of needs and the child's development of a sense of security and trust. The child seeks age-appropriate contact with the caregiver for both nurturing and safety needs.

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

Infants appear uncomfortable with caregivers, may resist touch, or appear anxious and clingy some of the time. Caregivers feel disconnected from the infant. Older children may be overly reactive to separation or seem preoccupied with their parent. Boundaries may seem inappropriate with others.

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

Infants may fail to demonstrate stranger anxiety or have extreme reactions to separation resulting in interference with development. Older children may have ongoing problems with separation, may consistently avoid caregivers, and have inappropriate boundaries with others, putting them at risk.

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

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

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ATTACHMENT DIFFICULTIES continued

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 caregiving relationship. This ultimately leads to feelings of affection, and, by 8 months of age, an infant will typically exhibit a 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 a secure attachment with their own children when they become adults. However, it is important to note that most studies on attachment and its impacts have been done with Western, middle-class families (Keller, 2018).

Potential presenting symptoms of attachment issues in early childhood:

- Lack of preference for primary caregiver
- Indiscriminate affection with unfamiliar adults
- Lack of expectation for getting needs met
- Lack of comfort-seeking when hurt or upset
- Comfort-seeking in an odd manner
- Excessive clinginess
- Poor ability to tolerate separation
- Strange or mixed reactions to the 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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ADJUSTMENT TO TRAUMA

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

Questions to Consider:

- What was the child's trauma?
- How is it connected to the current issue(s)?
- What are the child's coping skills?
- Who is supporting the child?

Ratings and Descriptions

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

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

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

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

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

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

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

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

Supplemental Information – Understanding adjustment to trauma in early childhood: Young children are at a particularly high risk for exposure to potentially traumatic events due to their dependence on parents and caregivers, with an estimate that more than half of young children experiencing a severe stressor. Young children are especially vulnerable to adverse effects of trauma due to rapid developmental growth during this stage. Historically, a widely held misconception has been that infants and young children lack the perception, cognition, and social maturity to remember or understand traumatic events. [continues]

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ADJUSTMENT TO TRAUMA continued

Today, it is widely accepted that children have the capacity to perceive and remember traumatic events; young children may experience symptoms of mental illness immediately after a trauma, but in some cases, symptoms do not emerge until years later. PTSD, anxiety disorders, behavior disorders, substance abuse, and other physical health conditions have all been linked to traumatic events experienced during early childhood.

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

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

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

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

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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 in similar settings? Does the child have more distressing tantrums or yelling fits than other children? Does the child respond with aggression when they are upset?

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

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

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

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

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

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

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

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REGULATORY continued

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).

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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) are 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) are 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. In the past, RRBs were thought to be rare in preschoolers or toddlers with autism. This assumption has been challenged in recent studies that reported the presence of RRBs in preschoolers, toddlers, and even infants as young as 8 months later diagnosed with autism. However, at young ages, RRBs are not unique to children with autism spectrum disorders (ASD) but are also present in children with other disorders, such as intellectual disabilities and language disorders, and are present in children with typical development as well (Kim & Lord, 2010).

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SLEEP (12 months+)

This item rates the child's sleep patterns. This item is used to describe any problems with sleep, regardless of the cause, including difficulties falling asleep or staying asleep as well as sleeping too much. Both bedwetting and nightmares should be considered sleep issues. **The child must be 12 months of age (1-year-old) or older to rate this item.**

Questions to Consider:

- Does the child appear rested?
- What are the child's nap and bedtime routines?
- Does the child wake up crying and unable to handle the transition from sleeping to wake time with difficulty calming even with help from a familiar adult?
- How does the child's sleep routine impact the family?

Ratings and Descriptions

0 *No evidence of any needs; no need for action.*
The 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.*
The child has some problems sleeping. Generally, the 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 night terrors.

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 disrupted often, and the child seldom obtains a full night of sleep.

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

NA Child is younger than 12 months.

Supplemental Information – Understanding sleep behaviors in early childhood: Sleep is one of the primary reasons families seek intervention. This is often due to the impact that this has on parents/ caregivers and siblings. The bedtime 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). [continued]

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SLEEP (12 months+) 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 tend 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 move past the first year toward 18-21 months of age, they will likely lose their morning and early evening nap and nap only once a day. While toddlers need up to 14 hours a day of sleep, they typically get only about 10. Most children from about 21 to 36 months of age still need one nap a day, which may range from one to three and a half hours long.
3-6 Years	Children at this age typically get 10-12 hours of sleep a day. At age 3, most children are still napping, while at age 5, most are not. Naps gradually become shorter, as well.

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

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

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

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AGGRESSION

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?
- 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 or history of aggressive behaviors or significant verbal aggression towards others (including people and animals).

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

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 throughout 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. [continues]

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AGGRESSION continued

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 feelings or goal that may be prompting the aggressive behavior and use the moment as an opportunity for modeling or teaching emotional regulation skills (Lerner & Parlakian, 2016).

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PSYCHOSIS (THOUGHT DISORDER)

This item rates the symptoms of psychiatric disorders, including schizophrenia spectrum and other psychotic disorders. The common symptoms of these disorders include hallucinations (i.e., experiencing things others do not experience), delusions (i.e., a false belief or an incorrect inference about reality that is firmly sustained despite the fact that nearly everybody thinks the belief is false or proof exists of its inaccuracy), disorganized thinking, and bizarre/idiosyncratic behavior.

Questions to Consider:

- Does the child/youth exhibit behaviors that are unusual or difficult to understand?
- Are the unusual behaviors or repeated actions interfering with the child/youth's functioning?
- Has the child/youth engaged in magical thinking?
- Does the child/youth believe they have powers or abilities that do not align with reality?

Ratings and Descriptions

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

No evidence of psychotic symptoms. Thought processes and content are within normal range.

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

Evidence of disruption in thought processes or content. Child/youth may be somewhat tangential in speech or evidence somewhat illogical thinking (age-inappropriate). This also includes a child/youth with a history of hallucinations but none currently. Use this category for children/youth who are below the threshold for one of the DSM diagnoses listed above.

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

Evidence of disturbance in thought process or content that may be impairing the child/youth's functioning in at least one life domain. Child/youth may be somewhat delusional or have brief intermittent hallucinations. Speech may be at times quite tangential or illogical.

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

Clear evidence of dangerous hallucinations, delusions, or bizarre behavior that might be associated with some form of psychotic disorder that places the child/youth or others at risk of physical harm.

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IMPULSIVITY/HYPERACTIVITY

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

Questions to Consider:

- Is the child/youth unable to sit still for any length of time?
- Does the child/youth have trouble paying attention for more than a few minutes?
- Is the child/youth able to control their behavior, talking?

Ratings and Descriptions

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

No evidence of symptoms of loss of control of behavior.

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

This is a history or evidence of some impulsivity evident in action or thought that place the child/youth at risk of future functioning difficulties. The child/youth may exhibit limited impulse control, e.g., child/youth may yell out answers to questions or may have difficulty waiting one's turn. Some motor difficulties may be present as well, such as pushing or shoving others.

2 *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/youth's functioning in at least one life domain. This indicates a child/youth with impulsive behavior who may represent a significant management problem for adults (e.g., caregivers, teachers, coaches, etc.). A child/youth 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/youth at risk of physical harm. This indicates a child/youth with frequent and significant levels of impulsive behavior that carries considerable safety risk (e.g., running into the street, dangerous driving or bike riding). The child/youth may be impulsive on a nearly continuous basis. The child/youth endangers themselves or others without thinking.

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DEPRESSION

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

Questions to Consider:

- Does the child/youth exhibit chronic low mood and irritability?
- Has the child/youth withdrawn from normal activities?
- Does the child/youth 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, family, or academic functioning that does not lead to pervasive avoidance behavior.

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/youth'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/youth to function in any life domain. This rating is given to a child/youth with a severe level of depression. This would include a child/youth who stays at home or in bed all day due to depression or one whose emotional symptoms prevent any participation in school, friendship groups, or family life. Disabling forms of depressive diagnoses would be rated here.

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ANXIETY

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

Questions to Consider:

- Is the child/youth having any problems with excessive fear or excessive worry?
- Is the child/youth avoiding normal activities out of fear?
- Does the child/youth act frightened or afraid?
- Has the child/youth experienced panic attacks?

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.*

History, suspicion, or evidence of some anxiety. This level is used to rate either a mild phobia or anxiety problem that is not yet causing the child/youth significant distress or markedly impairing functioning in any important context.

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/youth'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 debilitating level of anxiety that makes it virtually impossible for the child/youth to function in any life domain.

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OPPOSITIONAL BEHAVIOR

This item rates the child/youth'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/youth.

Questions to Consider:

- Does the child/youth follow reasonable rules and requests from caregivers and teachers?
- Describe the child's behavior in response to rules they don't like.

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/youth 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/youth's functioning in at least one life domain. Behavior causes emotional harm to others. A child/youth whose behavior meets the criteria for Oppositional Defiant Disorder in the 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/youth has severe problems with compliance with rules or adult instruction or authority.

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CONDUCT (ANTISOCIAL BEHAVIOR)

This item rates the degree to which a child/youth engages in behavior that is consistent with the presence of a Conduct Disorder.

Questions to Consider:

- Does the child/youth admit to lying when caught?
- How frequently does the child/youth engage in age-appropriate socialization with peers?
- Has the child/youth ever shown violent or threatening behavior towards others?
- Has the child/youth ever tortured animals?
- Does the child/youth disregard or is unconcerned about the feelings of others (lack empathy)?

Ratings and Descriptions

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

No evidence of serious violations of others or laws.

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

History, suspicion or evidence of some problems associated with antisocial behavior including but not limited to lying, stealing, manipulation of others, acts of sexual aggression, or violence towards people, property or animals. The child/youth may have some difficulties in school and home behavior. Problems are recognizable but not notably deviant for age, sex, and community.

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

Clear evidence of antisocial behavior including but not limited to lying, stealing, manipulating others, sexual aggression, violence towards people, property, or animals. A child/youth rated at this level will likely meet criteria for a diagnosis of Conduct Disorder.

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

Evidence of a severe level of aggressive or antisocial behavior, as described above, that places the child/youth or community at significant risk of physical harm due to these behaviors. This could include frequent episodes of unprovoked, planned aggressive or other antisocial behavior.

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ANGER CONTROL

This item captures the child/youth's ability to identify and manage their anger when frustrated.

Questions to Consider:

- How does the child/youth control their emotions?
- Do they get upset or frustrated easily?
- Do they overreact if someone criticizes or rejects them?
- Does the child/youth seem to have dramatic mood swings?

Ratings and Descriptions

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

No evidence of any anger control problems.

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

History, suspicion of, or evidence of some problems with controlling anger. Child/youth may sometimes become verbally aggressive when frustrated. Peers and family are aware of and may attempt to avoid stimulating angry outbursts.

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

Child/youth's difficulties with controlling anger are impacting functioning in at least one life domain. Child/youth's temper has resulted in significant trouble with peers, family and/or school. Anger may be associated with physical violence. Others are likely quite aware of anger potential.

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

Child/youth's temper or anger control problem is dangerous. Child/youth frequently gets into fights that are often physical. Others likely fear the child/youth.

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EATING DISTURBANCE

This item rates problems with eating, including disturbances in body image, refusal to maintain normal body weight, recurrent episodes of binge eating, and hoarding food.

Questions to Consider:

- Does the child/youth have any challenges with eating?
- Is the child/youth an overly picky eater?
- Does the child/youth have any eating rituals?

Ratings and Descriptions

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

This rating is for a child/youth with no evidence of eating disturbances.

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

This rating is for a child/youth with some eating disturbance that is not interfering with their functioning. This could include some preoccupation with weight, calorie intake, or body size or type when of normal weight or below weight. This could also include some binge eating patterns.

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

This rating is for a child/youth with eating disturbance that interferes with their functioning. This could include preoccupation with weight gain or becoming fat when underweight, restrictive eating habits or excessive exercising to maintain below normal weight, and/or emaciated body appearance. This level could also include more notable binge eating episodes that are followed by compensatory behaviors to prevent weight gain (e.g., vomiting, use of laxatives, excessive exercising). This individual may meet criteria for a DSM Eating Disorder (Anorexia or Bulimia Nervosa).

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

This rating is for a child/youth with a more severe form of eating disturbance. This could include significantly low weight where hospitalization is required or excessive binge-purge behaviors (at least once per day).

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ADJUSTMENT TO TRAUMA

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

Questions to Consider:

- What trauma was the child/youth exposed to?
- How is it connected to the current issue(s)?
- What are the child/youth's coping skills?
- Who is supporting the child/youth?
- Do any diagnoses contribute to the behaviors being seen?

Ratings and Descriptions

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

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

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

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

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

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

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

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

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SUBSTANCE USE

This item describes problems related to the use of alcohol and illegal drugs, the misuse of prescription medications, and the inhalation of any chemical or synthetic substance by a child/youth. This rating is consistent with DSM Substance-Related and Addictive Disorders. This item does not apply to the use of tobacco or caffeine.

Questions to Consider:

- Has the child/youth used alcohol, illegal or prescription drugs for reasons other than what they are prescribed for on more than an experimental basis?
- Do you suspect that the child/youth may have an alcohol or drug use problem?
- Has the child/youth been in a recovery program for the use of alcohol or illegal drugs?

Ratings and Descriptions

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

Child/youth has no notable substance use difficulties at the present time.

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

Child/youth has substance use problems that occasionally interfere with daily life (e.g., intoxication, loss of money, reduced work/school performance, parental concern). History of substance use problems without evidence of current problems related to use is rated here.

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

Child/youth has a substance use problem that consistently interferes with the ability to function optimally but does not completely preclude functioning in an unstructured setting.

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

Child/youth has a substance use problem that represents complications to functional issues that may result in danger to self, public safety issues, or the need for detoxification of the child/youth.

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RISK FACTORS AND BEHAVIORS DOMAIN

This section focuses on behaviors that can get children and youth 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/youth's behaviors put them at risk for serious harm?

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

0 Not a developmental risk factor; no need for attention or intervention.

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

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

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

For the **Risk Behaviors Items,** 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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RISK FACTORS (AGES 0-5)

SUBSTANCE EXPOSURE IN UTERO

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

Questions to Consider:

- Was the child exposed to alcohol or drugs during the pregnancy?

Ratings and Descriptions

0 *Not a developmental risk factor; no need for attention or intervention*.

Child had no in utero exposure to alcohol or drugs.

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

Child had some in utero exposure (e.g., mother ingested alcohol or tobacco in small amounts fewer than four times during pregnancy).

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

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

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

Child was exposed to alcohol or drugs in utero. 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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ENVIRONMENTAL TOXIN EXPOSURE

This item describes the child's exposure to environmental toxins both before and after birth. **This item is rated across the lifespan**.

Questions to Consider:

- Was the child exposed to environmental toxins? What toxins?

Ratings and Descriptions

0 *Not a developmental risk factor; no need for attention or intervention*.

Child had no in utero exposure to environmental toxins and there is currently no exposure in the home or community.

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

Child had either some in utero exposure (e.g., exposure to lead at home or other toxins in the community), or there are current environmental toxins in the home or community.

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

Child was exposed to significant environmental toxins in utero. Any exposure to environmental toxins throughout the child's lifetime would be rated here.

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

Child was exposed to environmental toxins in utero and continues to be exposed in the home or community. A child who ingested lead paint and exhibited symptoms would be rated here.

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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?
- What feelings did the parents express about the birth of the baby (e.g., excitement, fear, anxiety, etc.)?
- Was the parent screened for depression during prenatal visits? What was the outcome?

Ratings and Descriptions

0 *Not a developmental risk factor; no need for attention or intervention.*

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

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

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

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

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

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

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

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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:

- Were there any unusual circumstances related to the labor and delivery of the child?
- Does the parent recall any issues with their treatment by the medical staff? Any inequities, disbelief in the parents' complaints, etc.?

Ratings and Descriptions

0 *Not a developmental risk factor; no need for attention or intervention.*

Child and mother had normal labor and delivery. A child who received an Apgar score of 7-10 at birth would be rated here.

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

Child or mother had some mild problems during delivery, but there is no history of adverse impact. An emergency C-section or a delivery-related physical injury (e.g., shoulder displacement) to the baby is rated here.

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

Child or mother had problems during delivery that resulted in temporary functional difficulties for the child or mother. Extended fetal distress, postpartum hemorrhage, or uterine rupture would be rated here. A child who received an Apgar score of 4-7 or needed some resuscitative measures at birth is rated here.

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

Child had severe problems during delivery that have long-term implications for development (e.g., extensive oxygen deprivation, brain damage). A child who received an Apgar score of 3 or lower or who needed immediate or extensive resuscitative measures at birth would be rated here.

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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 *Not a developmental risk factor; no need for attention or intervention.*

Child within normal range for weight at birth. A child with a birth weight of 2500 grams (5.5 pounds) or greater would be rated here.

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

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

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

Child considerably 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 *Evidence of dangerous or disabling impact of developmental risk factor; requires immediate or intensive action.*

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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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 *Not a developmental risk factor; no need for attention or intervention.*
No evidence of failure to thrive.

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

2 *Evidence that developmental risk factor occurred in the child's history and is impacting functioning; requires action or intervention to ensure that the need is addressed.*
The child is experiencing problems in their ability to maintain weight or growth. The child may be below the 5^{th} 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 (75^{th} to 25^{th}).

3 *Evidence of dangerous or disabling impact of developmental risk factor; requires immediate 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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EXPLOITED

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

Questions to Consider:

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

Ratings and Descriptions

0 *Not a developmental risk factor; no need for attention or intervention.*

No evidence of a history of exploitation OR no evidence of recent exploitation and no significant history of victimization within the past year. Child is not presently at risk for re-victimization.

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

Suspicion or history of exploitation, but the child has not been exploited during the past year. Child is not presently at risk for re-victimization.

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

Child has been recently exploited (within the past year) but is not at acute risk of re-exploitation. This might include experiences of physical or sexual abuse, significant psychological abuse by family or friends or violent crime.

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

Child has recently been exploited and is at acute risk of re-exploitation.

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RISK BEHAVIORS (AGES 0-5)

SELF-HARM (12 months+)

This item rates the presence of repetitive behaviors, like head-banging or biting/hitting oneself, that result in physical harm to the child. **The child must be 12 months of age (1-year old) or older to rate this item**. **If child is younger than 12 months, rate this item '0.'**

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 *Action is required to ensure that the identified need or risk behavior is addressed.*
Child's self-harm behaviors such as head banging cannot be impacted by supervising adult and interferes with their functioning.

3 *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.

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. [continued]

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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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FLIGHT RISK/BOLTING

This item refers to any planned or impulsive running or 'bolting' behavior that presents a risk to the safety of the child. Factors to consider in determining level of risk include age of the young person, frequency and duration of escape episodes, timing and context, and other risky activities while running.

Questions to Consider:

- Has the child ever bolted?
- If so, where did they go? How long did they stay away? How were they found?
- Do they ever threaten to run away?

Ratings and Descriptions

0 *No evidence of any needs; no need for action.*
Child has no history of running away or ideation of escaping from current living situation.

1 *Need or risk behavior that requires monitoring, watchful waiting, or preventive action based on history, suspicion or disagreement.*
History of escape behaviors but none in the past month, or a child who expresses ideation about escaping present living situation or has threatened to run. A child who bolts occasionally (e.g., attempts to run from caregiver) might be rated here.

2 *Need or risk behavior is interfering with functioning. Action is required to ensure that the identified need or risk behavior is addressed.*
Child has engaged in escape behaviors during the past 30 days. Repeated bolting would be rated here.

3 *Need or risk behavior is dangerous or disabling. Intensive and/or immediate action is required to address the need or risk behavior.*
Child has engaged in escape behaviors that placed the safety of the child at significant risk.

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RISK FACTORS (AGES 6+)

SUBSTANCE EXPOSURE IN UTERO

This item describes the child/youth's exposure to substance use before birth.

Questions to Consider:

- Was the child/youth exposed to alcohol or drugs during the pregnancy?

Ratings and Descriptions

0 *Not a developmental risk factor; no need for attention or intervention*.

Child/youth had no in utero exposure to alcohol or drugs.

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

Child/youth had some in utero exposure (e.g., mother ingested alcohol or tobacco in small amounts fewer than four times during pregnancy).

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

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

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

Child/youth was exposed to alcohol or drugs in utero. Any child/youth 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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RISK BEHAVIORS (AGES 6+)

SUICIDE RISK

This item describes the presence of thoughts or behaviors aimed at taking one's life. This rating describes both suicidal and significant self-injurious behavior. This item rates overt and covert thoughts and efforts on the part of a child or youth to end their life. A rating of '2' or '3' would indicate the need for a safety plan. Notice the specific time frames for each rating.

Questions to Consider:

- Has the child/youth ever talked about a wish or plan to die or to kill themselves?
- Has the child/youth ever tried to commit suicide?

Ratings and Descriptions

0	*No evidence of any needs; no need for action*. No evidence of suicidal ideation.
1	*Need or risk behavior that requires monitoring, watchful waiting, or preventive action based on history, suspicion or disagreement.* History of suicidal ideation, but no recent ideation or gesture. History of suicidal behaviors or significant ideation but none during the recent past.
2	*Need or risk behavior is interfering with functioning. Action is required to ensure that the identified need or risk behavior is addressed.* Recent, but not acute, suicidal ideation or gesture.
3	*Need or risk behavior is dangerous or disabling. Intensive and/or immediate action is required to address the need or risk behavior.* Current suicidal ideation and intent OR command hallucinations that involve self-harm.

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NON-SUICIDAL SELF-INJURIOUS BEHAVIOR

This item includes repetitive, physically harmful behavior that generally serves as a self-soothing function to the child/youth (e.g., cutting, carving, burning self, face slapping, head banging, etc.).

Questions to Consider:

- Does the child/youth ever purposely hurt themselves (e.g., cutting)?
- What kind of medical attention has the child/youth received for their self-injurious behavior? At home? ED or Urgent Care?

Ratings and Descriptions

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

No evidence of any forms of self-injury.

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

A history or suspicion of self-injurious behavior.

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

Engaged in self-injurious behavior (e.g., cutting, burns, piercing skin with sharp objects, repeated head banging) that does not require medical attention.

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

Engaged in self-injurious behavior requiring medical intervention (e.g., sutures, surgery) and that is significant enough to put the child/youth's health at risk.

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OTHER SELF-HARM (RECKLESSNESS)

This item includes reckless and dangerous behaviors that, while not intended to harm self or others, place the child/youth or others in some jeopardy. **Suicidal or self-injurious behaviors are not rated here**.

Questions to Consider:

- Has the child/youth ever acted in a way that might be dangerous to themselves?

Ratings and Descriptions

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

No evidence of behaviors (other than suicide or self-mutilation) that place the child/youth at risk of physical harm.

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

There is a history or suspicion of or mild reckless or risk-taking behavior (other than suicide or self-mutilation) that places child/youth at risk of physical harm.

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

Engaged in reckless or intentional risk-taking behavior (other than suicide or self-mutilation) that places the child/youth in danger of physical harm.

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

Engaged in reckless or intentional risk-taking behavior (other than suicide or self-mutilation) that places the child/youth at immediate risk of death.

Supplemental Information: When considering reckless behavior, include gang involvement/ affiliation, unprotected sex, multiple sexual partners, driving under the influence, or riding with drivers who are under the influence, etc.

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DANGER TO OTHERS

This item rates the child/youth's violent or aggressive behavior. The intention of this behavior is to cause significant bodily harm to others. A rating of '2' or '3' would indicate the need for a safety plan. Reckless behavior that may cause physical harm to others is not rated on this item.

Questions to Consider:

- Has the child/youth ever injured another person on purpose?
- Does the child/youth get into physical fights?
- Has the child/youth ever threatened to kill or seriously injure others?

Ratings and Descriptions

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

No evidence or history of aggressive behaviors or significant verbal threats of aggression towards others (including people and animals).

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

History of aggressive behavior or verbal threats of aggression towards others. History of fire setting would be rated here.

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

Occasional or moderate level of aggression towards others. Child/youth has made verbal threats of violence towards others.

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

Acute homicidal ideation with a plan, frequent or dangerous (significant harm) level of aggression to others. Child/youth is an immediate risk to others.

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PROBLEMATIC SEXUAL BEHAVIOR

This item describes issues around sexual behavior including age and/or developmentally-inappropriate or age-inappropriate sexual behavior.

Questions to Consider:

- Has the child/youth ever been involved in sexual activities or done anything sexually inappropriate?
- Has the child/youth ever had concerns regarding sexualized behavior or with physical/sexual boundaries?

Ratings and Descriptions

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

No evidence of challenges with sexual behavior.

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

History or evidence of challenges with sexual behavior. This includes occasional inappropriate sexual behavior, language or dress. Poor boundaries with regards to physical/sexual contact may be rated here.

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

Child/youth's sexual behaviors are impairing functioning in at least one life area. For example, frequent inappropriate sexual behavior or disinhibition, including public disrobing, multiple older sexual partners or frequent sexualized language. Age-inappropriate sexualized behavior, or lack of physical/sexual boundaries is rated here.

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

Severe sexual behavior including sexual exploitation, exhibitionism, sexually aggressive behavior or other severe sexualized or sexually reactive behavior.

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RUNAWAY

This item describes the risk of running away or actual runaway behavior.

Questions to Consider:

- Has the child/youth ever run away from home, school, or any other place?
- If so, where did the child/youth go? How long did they stay away? How was the child/youth found?
- Does the child/youth ever threaten to run away?

Ratings and Descriptions

0	*No evidence of any needs; no need for action.* Child/youth has no history of running away or ideation of escaping from current living situation.
1	*Need or risk behavior that requires monitoring, watchful waiting, or preventive action based on history, suspicion or disagreement.* Child/youth has no recent history of running away but has expressed ideation about escaping current living situation. Child/youth may have threatened running away on one or more occasions or has a history of running away but not in the recent past.
2	*Need or risk behavior is interfering with functioning. Action is required to ensure that the identified need or risk behavior is addressed.* Child/youth has run from home once or run from one treatment setting. Also rated here is a child/youth who has run home (parental or relative).
3	*Need or risk behavior is dangerous or disabling. Intensive and/or immediate action is required to address the need or risk behavior.* Child/youth has run from home and/or treatment settings in the recent past and presents an imminent flight risk. A child/youth who is currently a runaway is rated here.

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VICTIMIZATION/EXPLOITATION

This item describes a child/youth who has been victimized by others. This item is used to examine a history and pattern of being the object of abuse and/or whether the child/youth is at current risk for re-victimization. This item includes children or youth who are currently being bullied at school or in their community. It would also include individuals who are victimized in other ways (e.g., sexual abuse, sexual exploitation, inappropriate expectations based on a child's level of development, a child/youth who is forced to take on a parental level of responsibility, etc.).

Questions to Consider:

- Has the child/youth ever been bullied or the victim of a crime?
- Has the child/youth traded sexual activity for goods, money, affection, or protection?
- Has the child/youth been a victim of human trafficking?
- Is the child/youth parentified or has taken on parental responsibilities and has this impacted their functioning?

Ratings and Descriptions

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

No evidence that the child/youth has experienced victimization or exploitation. They may have been bullied, robbed, or burglarized on one or more occasions in the past, but no pattern of victimization exists. Child/youth is not presently at risk for re-victimization or exploitation.

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

Suspicion or history of victimization or exploitation, but the child/youth has not been victimized to any significant degree in the past year. Child/youth is not presently at risk for re-victimization or exploitation.

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

Child/youth has been recently victimized (within the past year) and may be at risk of re-victimization. This might include physical or sexual abuse, significant psychological abuse by family or friend, sexual exploitation, or violent crime.

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

Child/youth has been recently or is currently being victimized or exploited, including human trafficking (e.g., labor or sexual exploitation including the production of pornography, sexually explicit performance, or sexual activity) or living in an abusive relationship, or constantly taking on responsibilities of being a parent to other family members.

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CULTURAL FACTORS DOMAIN

This domain identifies 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/youth in placement can participate in cultural rituals associated with their cultural identity). Items in the Cultural Factors Domain describe difficulties that children and youth 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 individual child/youth's perspective (i.e., who the child/youth 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/youth when rating these items and creating a treatment or service plan.

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

This domain is completed for all ages.

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

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

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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CULTURAL STRESS

This item identifies circumstances in which the child/youth'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/youth 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/youth's identity and experiences if different from the caregiver's own?

Ratings and Descriptions

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

No evidence of stress between the child/youth'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/youth'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/youth is experiencing cultural stress that is causing problems of functioning in at least one life domain. The child/youth needs support to learn how to manage culture stress.

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

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

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CAREGIVER RESOURCES & NEEDS DOMAIN

This section focuses on the strengths and needs of the caregiver. Caregiver ratings should be completed by household. If the child/youth is in foster care or out-of-home placement, please rate the identified parent(s), other relative(s), or caretaker(s) planning to assume custody and/or take responsibility for the care of this child/youth (i.e., the caregiver with the permanency plan).

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/youth.

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

This domain is completed for all ages.

For the **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/ youth.

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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ADJUSTMENT TO TRAUMATIC EXPERIENCES

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

Questions to Consider:

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

Ratings and Descriptions

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

There is no evidence that the caregiver has experienced trauma, OR there is evidence that the caregiver has adjusted well to their traumatic experiences.

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

The caregiver has mild adjustment problems and exhibits some signs of distress, OR caregiver has a history of having difficulty adjusting to traumatic experiences.

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

The caregiver has marked adjustment problems and is symptomatic in response to a traumatic event (e.g., anger, depression, and anxiety).

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

The caregiver has post-traumatic stress difficulties. Symptoms may include intrusive thoughts, hyper-vigilance, constant anxiety, and other common symptoms of Post-Traumatic Stress Disorder (PTSD).

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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/youth.

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/youth.* 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/youth.

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CAREGIVER CAPACITY

This item is used to determine the caregiver's capacity to provide the parenting needed by the child/youth.

Questions to Consider:

- Are there any caregiver circumstances which make it challenging for them to meet the needs of the child/youth?
- Has there been a time in the past where the caregiver's circumstances made it challenging for them to meet the needs of the child/youth?

Ratings and Descriptions

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

No evidence of caregiver mental, physical, developmental, or substance use issues. No concerns about the family/caregiver's capacity to meet the needs of the child/youth.

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 are some concerns about the family/caregiver's abilities to fully meet the needs of the child/youth, or the family/caregivers have had difficulties in fully meeting the needs of the child/youth in the past.

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

Caregiver circumstance in which notable challenges exist for the family/caregiver to meet the needs of the child/youth.

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

Caregiver circumstance in which the family/caregiver is currently unable to meet basic needs of the child/youth.

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SUPERVISION

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

Questions to Consider:

- How does the caregiver feel about their ability to keep an eye on and set limits or redirect the child/youth?
- How does the caregiver keep the environment safe for the child/youth to explore/learn?
- 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/youth.*

No evidence caregiver needs help or assistance in monitoring or disciplining the child/youth, 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/youth. Caregiver requires immediate and continuing assistance. Child/youth is at risk of harm due to absence of supervision or monitoring.

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INVOLVEMENT WITH CARE

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

Questions to Consider:

- How involved are the caregivers in services for the child/youth?
- Is the caregiver an advocate for the child/youth?
- 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/youth.*

No evidence of problems with caregiver involvement in services or interventions, and/or caregiver can act as an effective advocate for the child/youth.

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/youth 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/youth's services and/or interventions intended to assist the child/youth.

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

Caregiver wishes for child/youth to be removed from their care.

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KNOWLEDGE

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

Questions to Consider:

- Does the caregiver understand the child/youth's current mental health diagnosis and/or symptoms?
- Does the caregiver's expectations of the child/youth reflect an understanding of the child/youth's mental or physical challenges?

Ratings and Descriptions

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

No evidence of caregiver knowledge issues. Caregiver is fully knowledgeable about the child/youth'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/youth, has some mild deficits in knowledge or understanding of the child/youth'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/youth well and significant deficits exist in the caregiver's ability to relate to the child/youth'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/youth's current condition. Caregiver's lack of knowledge about the child/youth's strengths and needs place them at risk of significant negative outcomes.

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SAFETY

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

Questions to Consider:

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

Ratings and Descriptions

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

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

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

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

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