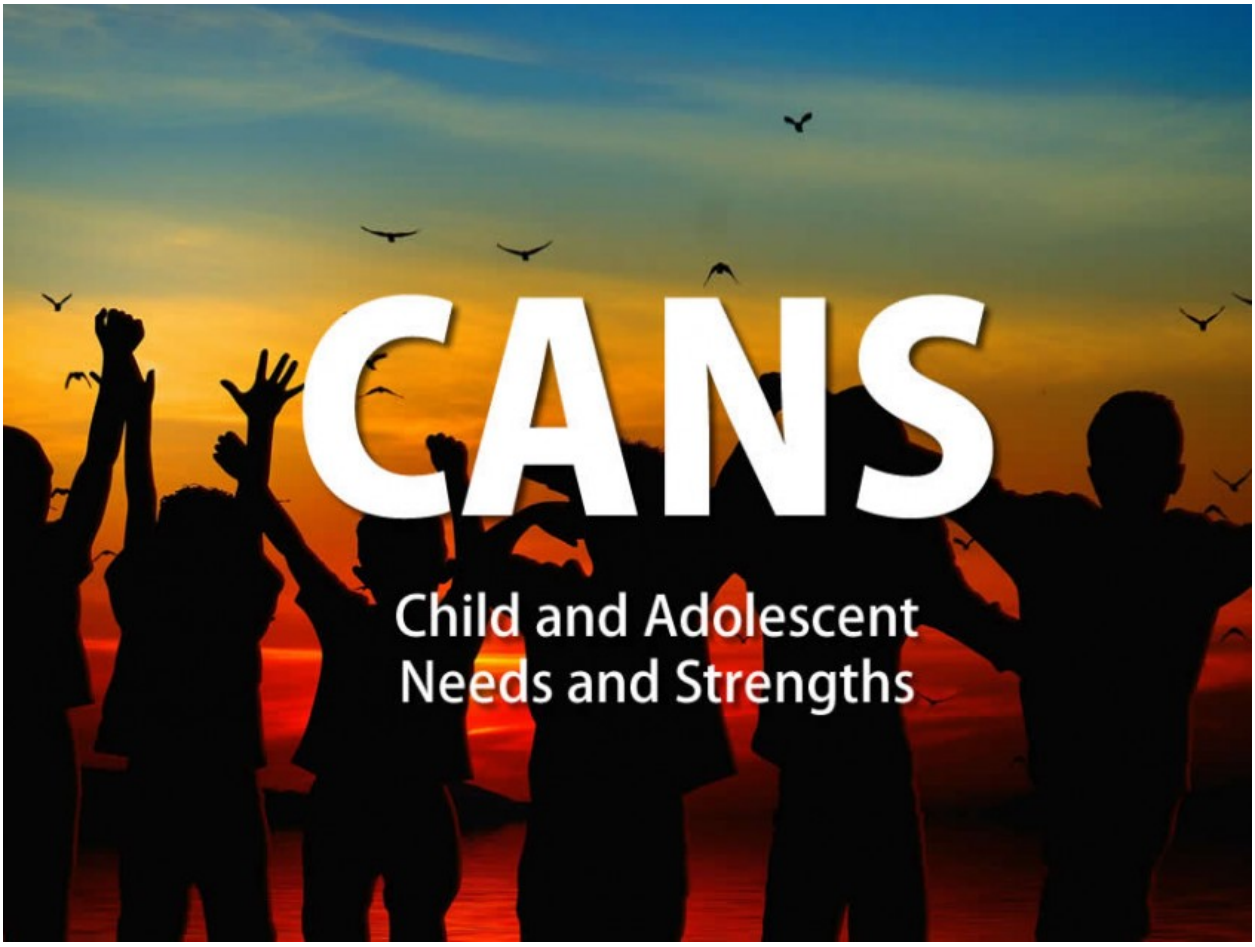

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Oregon Version

Comprehensive Screening Tool Manual

Ages 0-5

Praed Foundation

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1. INTRODUCTION

THE CANS

The Child and Adolescent Needs and Strengths (CANS) guides information gathering and team discussions, helping all team members focus on the needs and strengths of the child and family. The approach is uniquely designed to support shared visioning and effective communication. 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 design of the CANS is based on communication theory rather than the psychometric theories that have influenced most measurement development. There are six key components of a communimetric measure that apply to understanding the CANS.

SIX KEY COMPONENTS OF THE CANS

1. Items are included because they are relevant for planning and decision-making.
2. Item ratings translate into action levels. Different action levels exist for needs and strengths. For a description of these action levels please see below.
3. Focus is on the child's needs, not interventions or services that could mask a need.
4. Consider culture and development before establishing action levels. Cultural sensitivity involves considering whether cultural factors are influencing the expression of needs and strengths. Ratings should be completed considering the child's developmental and/or chronological age depending on the item.
5. It's about the "what", not the "why". Don't explain away needs with what you think might be an underlying cause.
6. Specific ratings window (30-days) can be overridden based on action levels.

HISTORY AND BACKGROUND OF THE CANS

The Child and Adolescent Needs and Strengths (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 collection of information and the design of individualized service plans including the application of evidence-based practices.

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

The CANS is made of domains that focus on various areas in a child's life, and each domain is made up of a group of specific items. There are domains that address how the child functions in everyday life, on specific emotional or behavioral concerns, on risk behaviors, on strengths and on skills needed to grow and develop. The CANS rater determines a number rating for each of these items. These ratings help everyone understand where intensive or immediate action is most needed, and also where a child has assets that could be a major part of the treatment or service

plan.

The CANS ratings, however, do not tell the whole story of a child's strengths and needs. Clinicians should also document narratives with more information about the child and family, and not rely solely on CANS ratings.

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 tool builds upon the methodological approach of the CSPI, but expands the tool to include a broader conceptualization of needs and an assessment of strengths, 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, and child- and youth-serving systems. It provides for a structured communication and critical thinking about the child and their context. It can also be used as a communication tool that provides a common language for all child- and youth-serving entities to discuss the child's or youth's needs and strengths. A review of the case record, including the CANS tool ratings, will provide information as to the appropriateness of the individualized plan and whether goals and outcomes are achieved.

MEASUREMENT PROPERTIES

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

Validity: Studies have demonstrated the CANS' validity, or its ability to measure children 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 ratings on the relevant dimensions of the CANS-Mental Health retrospectively distinguished level of care (Lyons, 2004). The CANS assessment has also been used to distinguish needs of children in urban and rural settings (Anderson & Estle, 2001). In numerous jurisdictions, the CANS has been used to predict service utilization and costs, and to evaluate outcomes of clinical interventions and programs (Lyons, 2004; Lyons & Weiner, 2009; Lyons, 2009). Five independent research groups in four states have demonstrated the reliability and validity of decision support algorithms using the CANS (Chor, et al., 2012, 2013, 2014; Cordell, et al., 2016; Epstein, et al., 2015; Israel, et al.; 2015, Lardner, 2015).

RATING NEEDS & STRENGTHS

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

Each CANS rating suggests different pathways for 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 problem that is not interfering with functioning	Watchful waiting/prevention/additional assessment
2	Problem interferes with functioning	Action/Intervention required
3	Problem is dangerous or disabling	Immediate action/Intensive action required

Basic Design for Rating Strengths

Rating	Level of Strength	Appropriate Action
0	Powerful/Centerpiece strength	Central to planning
1	Useful strength	Opportunity to further develop for use in planning
2	Identified strength	Determine appropriateness for further development. Requires intensive strength building.
3	No evidence of strength	Significant efforts are needed to identify potential strengths on which to build.

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

Ratings of 2 or 3 on Needs items necessitate further action such as intervention, assessment, or screening.

To complete the CANS, a CANS trained and certified care coordinator, case worker, clinician, practitioner, or other provider, should read the anchor descriptions for each item and then record the appropriate rating.

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

The CANS is an information integration tool, intended to include multiple sources of information (e.g., child and family, referral source, treatment providers, school, and observation by 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 and their families to discover individual and family functioning and strengths. Failure to demonstrate a child's skill should first be viewed as an opportunity to learn the skill as opposed to the problem. Focusing on a child's strengths instead of areas for growth with their families may result in enhanced motivation and improved performance. Involving the child and family in the rating process and obtaining information (evidence) from multiple sources is necessary and improves the accuracy of the rating. Meaningful use of the CANS and related information as tools (for reaching consensus, planning interventions, monitoring progress, psychoeducation, and supervision) support effective services for children and families.

As a quality improvement activity, a number of settings have utilized a fidelity model approach to look at service/treatment/action planning based on the CANS tool. 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' indicate a strength that should be the focus of strength-building activities. It is important to remember that when developing service and treatment plans for healthy child trajectories, balancing the plan to address risk behaviors/needs and protective factors/strengths is key. It has been demonstrated in the literature that strategies designed to develop child capabilities are a promising means for development and play a role in reducing risky behaviors.

Finally, the CANS can be used to monitor outcomes. This can be accomplished in two ways. First, CANS items that are initially rated a '2' or '3' are monitored over time to determine the percentage of individuals who move to a rating of '0' or '1' (resolved need, built strength). Dimension ratings can also be generated by summing items within each of the domains (Symptoms, Risk Behaviors, Functioning, etc.). These ratings can be compared over the course of treatment. CANS dimension/domain ratings 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 has demonstrated reliability and validity. With training, anyone with a bachelor's degree can learn to complete the tool reliably, although some applications require a higher degree. The average reliability of the CANS is 0.78 with vignettes, 0.84 with case records, and can be above 0.90 with live cases. The CANS is auditable, and audit reliabilities demonstrate that the CANS tool is reliable at the item level. Validity is demonstrated with the CANS relationship to level of care decisions and other similar measures of symptoms, risk behaviors, and functioning.

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 IN OREGON?

The CANS is used in many ways to impact 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.

A DISCOVERY STRATEGY

When initially meeting children, youth, and families, this guide can be helpful in ensuring that all the information 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 and practitioners have found this useful to use 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.

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 children and families, but one that we are going to attempt to work on during the course of treatment and/or planning. As such, when you write an individualized plan, you should do your best to address any CANS items rated at a 2 or higher.

FACILITATES OUTCOMES MEASUREMENT

The CANS is completed regularly to measure change and transformation. Clinicians and practitioners 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 to determine how supports are helping to alleviate suffering and restore functioning is by re-assessing needs, adjusting treatment or service plans, and tracking change.

A COMMUNICATION TOOL

The CANS facilitates communication regarding strengths and needs that should be considered, provides a shared language across systems, and creates opportunities for collaboration. CANS can describe progress, measure ongoing needs, and support continuity of care decisions by linking recommendations for future care to current needs. CANS reflects the story that needs to be heard.

A WRAPAROUND STRATEGY

The CANS can be a useful strategy to help inform the Wraparound planning process for multi-system involved children and their families. The CANS is another way for Wraparound teams to follow the Team-based and Collaborative Wraparound principles, by providing consistent language and areas of focused support in the planning process. Identifying strengths in order to utilize them to meet identified needs aligns with Wraparound’s Strengths-Based principle. Utilizing the tool to track rating changes over time allows children, families, and their Wraparound teams to determine when the formal Wraparound process is nearing Transition.

CANS: A CHILD SERVING SYSTEM STRATEGY

The CANS is a strategy to address children and youth behavioral health care needs. It can be used to compile, organize, and integrate the information gathered from clinical interviews, records reviews, and information from screening tools and other measures and share information across systems.

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 information gathering process and describe the CANS and how it will be used. The description of the CANS should include teaching the child and family about the needs and strengths rating scales, identifying the domains and items, as well as how the actionable items will be used in treatment or serving planning. When possible, share with the child and family the CANS domains and items and encourage the family to look over the items prior to meeting with them. The best time 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 child and family. Encourage families to contact you if they wish to change their answers in any area that they feel needs more or less emphasis. If the child or family sees an item differently from the rating you gave, and it's within one point, always defer to the family's preference. If there is more than a one-point difference, it would warrant an additional conversation to better understand the child's and family's perspective.

It is essential for raters to be familiar with the CANS domains and items prior to information gathering sessions/clinical interviews with children, youth, and families. This will not only help the organization of your interviews but will make the interview more conversational and natural. For example, if the family is talking about situations around the child's anger control and then shift into something like "you know, he only gets angry when he is in Mr. S's classroom", you can follow that and ask some questions about situational anger, and then explore other school related issues.

LISTENING USING THE CANS

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

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

★ **Be nonjudgmental and avoid giving 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. This process is about the child and family, not you.

★ **Be empathic.** Empathy is being warm and supportive. It is the understanding of another person from their point of reference and acknowledging feelings. You demonstrate empathetic listening when you smile, nod, 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.

★ **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; (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 FIRST PERSON FEELINGS & 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, and the child's perspective is often the most informative. Once you have the child's perspective, you can then work on organizing and coalescing the other points of view.

ACKNOWLEDGE FEELINGS

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

WRAPPING IT UP

After compiling all of information and rating the CANS, we recommend reviewing the ratings with the child and family. Take time to summarize the areas of strengths and needs to illustrate the "snapshot" of the child and family. It's important to offer the child and family the opportunity to discuss changing any ratings that they don't agree with.

It can be helpful to check with the child and family by asking the following open-ended questions:

> *"Are there any past experiences that you want to share that might be of benefit to planning for the child that we haven't yet discussed with the CANS?"*
>
> *"Is there anything you would like to add?"*

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.

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 …"

CANS BASIC STRUCTURE

The Oregon Child and Adolescent Needs and Strengths basic core items are noted below.

CORE ITEMS

Child Risk Factors/Behaviors Domain

1. Birth Weight
2. Prenatal Care
3. Substance Exposure
4. Parent or Sibling Challenges
5. Self-Harm
6. Aggressive Behavior
7. Sexual Behavior

Child Strengths Domain

8. Family Strengths
9. Interpersonal Skills
10. Adaptability
11. Persistence
12. Curiosity
13. Playfulness
14. Relationship Permanence

Exposure to Potentially Traumatic/ Adverse Childhood Experiences

15. Sexual Abuse
16. Physical Abuse
17. Emotional/Verbal Abuse
18. Neglect
19. Medical Trauma
20. Witness to Family Violence
21. Witness to Community/School Violence
22. War Affected
23. Terrorism Affected
24. Witness/Victim of Criminal Activity
25. Parental Criminal Behavior
26. Disruptions in Caregiving/Attachment Losses

Trauma Stress Symptoms Domain

27. Reaction to Traumatic Life Experiences
28. Traumatic Grief & Separation
29. Intrusions/Re-experiencing
30. Hyperarousal
31. Attempts to Avoid Stimuli
32. Numbing
33. Dissociation
34. Emotional and/or Physical Regulation

Life Functioning Domain

35. Family Functioning
36. Living Situation
37. Preschool/Daycare Behavior
38. Preschool/Daycare Achievement
39. Social Functioning
40. Recreational/Play
41. Developmental/Intellectual
42. Sensory
43. Self-Care Daily Living Skills
44. Motor
45. Communication (Receptive/Expressive)
46. Sleep
47. Medical
48. Physical

Cultural Considerations Domain

49. Language
50. Cultural Identity
51. Cultural Events and Activities
52. Cultural Stress

Behavioral/Emotional Needs Domain

53. Attachment Difficulties
54. Impulsivity/Hyperactivity
55. Temperament
56. Failure to Thrive
57. Eating/Elimination
58. Depression
59. Anxiety
60. Atypical Behaviors
61. Service Permanence

2. CHILD RISK FACTORS/ BEHAVIORS DOMAIN

This section focuses on behaviors that put the infant or child at serious risk of harm. 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: What is the developmental history of the infant or child? Do their behaviors put them at risk for serious harm?

Child Risk Behaviors Domain - use the following categories and action levels:

0 No evidence of need; no action needed.

1 History or suspicion of problem; requires monitoring, watchful waiting, or preventive activities.

2 Problem is interfering with functioning; requires action or intervention to ensure that the need is addressed.

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

1. BIRTH WEIGHT

This item describes the infant's or child's birth weight as compared to full-term infant birth weight averages.

Questions to Consider

- How did the infant's or child's birth weight compare to World Health Organization (WHO) child growth standards?

Ratings and Descriptions

0 No evidence of need; no action needed.

Infant or child was within typical weight range at birth. An infant or child weighing 2500 grams (5.5 pounds) or over at birth would be rated here.

1 History or suspicion of problem; requires monitoring, watchful waiting, or preventive activities.

Infant or child was born underweight. An infant or child weighing 1500 grams (3.3 pounds) to 2499 grams (5.4 pounds) at birth would be rated here.

2 Problem is interfering with functioning; requires action or intervention to ensure that the need is addressed.

Infant or child was born considerably underweight. An infant or child weighing 1000 grams (2.2 pounds) to 1499 grams (3.2 pounds) at birth would be rated here.

3 Problem is dangerous or disabling; requires action or intervention to ensure that the need is addressed.

Infant or child was extremely underweight at birth to the point of threatening their life. An infant or child with a birth weight of less than 1000 grams (2.2 pounds) would be rated here.

2. PRENATAL CARE

This item describes the amount of pregnancy related health care the birth parent received while carrying the infant or child, as well as pregnancy-related illness of the birth parent that impacted the infant or child in utero.

Questions to Consider

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

Ratings and Descriptions

0 No evidence of need; no action needed.

Infant's or child's birth parent had adequate prenatal care (e.g. ten or more planned visits to a physician) that began in the first trimester. Birth parent did not experience any pregnancy-related illnesses or complications.

1 History or suspicion of problem; requires monitoring, watchful waiting, or preventive activities.

Infant's or child's birth parent had some shortcomings in prenatal care, or had a mild form of a pregnancy-related illness. An infant or child whose birth parent had six or fewer planned visits to a physician would be rated here (their care must have begun in the first or early second trimester). An infant or child whose birth parent 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 Problem is interfering with functioning; requires action or intervention to ensure that the need is addressed.

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

3 Problem is dangerous or disabling; requires action or intervention to ensure that the need is addressed.

Infant's or child's birth parent had no prenatal care, or had a severe form of pregnancy-related illness. A birth parent who had toxemia/preeclampsia would be rated here.

3. SUBSTANCE EXPOSURE

This item describes the infant's or child's exposure to substance use before birth, including in utero exposure to any recreational drugs (e.g., alcohol, tobacco, marijuana, heroin, cocaine, methamphetamine, etc.), or certain prescription medications. Please consider any available information regarding genetically linked parents.

This item also includes the infant's or child's after birth exposure to recreational drug use that is occurring in their immediate environment (home, daycare, etc.).

Questions to Consider	Ratings and Descriptions
• Was the infant or child exposed to drugs, alcohol or tobacco during the pregnancy? • Is the infant or child experiencing any health problems related to substance exposure? • Was the infant or child born with symptoms of substance withdrawal at birth (e.g. crankiness, feeding problems, tremors, weak and continual crying)? • Was the birth parent receiving support or treatment for substance abuse during the pregnancy?	0 No evidence of need; no action needed. Infant or child had no in utero exposure to recreational drugs, and there is currently no exposure in their immediate environment. 1 History or suspicion of problem; requires monitoring, watchful waiting, or preventive activities. Infant or child had mild in utero exposure (e.g. birth parent drank alcohol or used tobacco fewer than four times during pregnancy). OR There is current minimal recreational drug use in the infant's or child's immediate environment. 2 Problem is interfering with functioning; requires action or intervention to ensure that the need is addressed. Infant or child was exposed to moderate recreational drugs in utero. OR There is current moderate exposure to recreational drugs in the infant's or child's immediate environment. 3 Problem is dangerous or disabling; requires action or intervention to ensure that the need is addressed. Infant or child was exposed to significant alcohol or drugs in utero and continues to be exposed in their immediate environment. Any infant or child experiencing withdrawal symptoms would be rated here.

4. PARENT OR SIBLING CHALLENGES

This item outlines the extent of any developmental disability and/or behavioral health challenges exhibited by parents or by siblings of the infant or child.

Questions to Consider

- Does the infant's or child's parent(s) have a developmental disability or behavioral health challenge?
- Does the infant's or child's sibling(s) have a developmental disability or behavioral health challenge?
- Is there Developmental Disability program involvement for the parents or siblings?
- Is there Social Security benefits eligibility for parents or siblings?
- Are parents or siblings receiving mental health services?

Ratings and Descriptions

0 No evidence of need; no action needed.

The infant's or child's parents have no known developmental disabilities or behavioral health challenges.

AND/OR

The infant or child has no siblings or siblings are not experiencing any developmental or behavioral health challenges.

1 History or suspicion of problem; requires monitoring, watchful waiting, or preventive activities.

The infant's or child's parents have no known developmental disabilities and have mild behavioral health challenges.

AND/OR

The infant or child has at least one sibling who is experiencing some mild developmental or behavioral health challenges.

2 Problem is interfering with functioning; requires action or intervention to ensure that the need is addressed.

The infant's or child's parents have no known developmental disabilities and have moderate behavioral health challenges.

AND/OR

The infant or child has at least one sibling who is experiencing significant developmental or behavioral health challenges.

3 Problem is dangerous or disabling; requires action or intervention to ensure that the need is addressed.

One or both of the infant's or child's parents have been diagnosed with a developmental disability or have significant behavioral health challenge, or the infant or child has multiple siblings who are experiencing developmental or behavioral health challenges that require ongoing intensive care.

5. SELF-HARM

This item includes repetitive, physically harmful behavior that generally serves as a self-soothing function to the infant or child (e.g., head banging, or other self-injurious behavior.)

Questions to Consider	Ratings and Descriptions	
• Does the infant or child frequently and/or repetitively bang their head? • Does the infant or child physically hurt themselves when agitated or during tantrums? • If the infant or child engages in self-harming behaviors, is caregiver able to stop the behavior by holding, comforting, or talking with them?	0	No evidence of need; no action needed. There is no evidence of self-harm behaviors.
	1	History or suspicion of problem; requires monitoring, watchful waiting, or preventive activities. History, suspicion or some evidence of self-harm behaviors. These behaviors are controllable by caregiver.
	2	Problem is interfering with functioning; requires action or intervention to ensure that the need is addressed. Infant's or child's self-harm behaviors, such as head banging, are not typically impacted by interventions from the caregiver and interfere with their functioning.
	3	Problem is dangerous or disabling; requires action or intervention to ensure that the need is addressed. Infant's or child's self-harm or reckless behaviors put their safety and well-being at risk.

Supplemental information:

Consider typical childhood development when rating this item. Children under three years generally lack the judgement to appreciate cause and effect.

6. AGGRESSIVE BEHAVIOR

This item rates the infant's or child's violent or aggressive behaviors. The intention of the behavior is to cause significant bodily harm to other people or animals. Behaviors may include hitting, biting, kicking, and pushing. Consider the caregiver when rating this item, especially when caregiver is not able to influence or control the infant's or child's violent behavior.

Questions to Consider	Ratings and Descriptions	
• Does the child lash out verbally or physically to caregivers? • Does the child frequently attempt to hurt others, throw objects, or attack? • Have childcare workers or teachers contacted the caregiver with concerns about the child's aggressive behaviors? • Is the child	0	No evidence of need; no action needed. There is no evidence of aggressive behaviors.
	1	History or suspicion of problem; requires monitoring, watchful waiting, or preventive activities. There is either a history of aggressive behavior towards people or animals or mild concerns in this area that have not yet interfered with the child's functioning.
	2	Problem is interfering with functioning; requires action or intervention to ensure that the need is addressed. There is clear evidence of aggressive behavior towards people or animals in multiple settings and situations. The behavior is persistent and a supervising adult's attempts to change the child's behavior have not been successful.

aggressive towards animals? • Does the child's aggressive behaviors show up in multiple settings and situations?	3 Problem is dangerous or disabling; requires action or intervention to ensure that the need is addressed. The child has significant challenges in this area characterized as a dangerous level of aggressive behavior involving the threat of harm towards people or animals. These behaviors are present in all settings and situations.

7. SEXUAL BEHAVIOR

This item rates age-inappropriate sexualized behaviors that may place a child at risk for victimization or risky sexual practices. Behavior may also place child at risk of being excluded from daycare, preschool, and other public spaces.

Questions to Consider	Ratings & Definitions
• Does the child initiate sexualized play with others? • Does the child's play include sexualized language? • Does the child demonstrate sexual actions? • Does the child draw sexualized pictures? • Does child stop sexualized behaviors when redirected by caregivers?	0 No evidence of need; no action needed. There is no evidence of sexualized behaviors. 1 History or suspicion of problem; requires monitoring, watchful waiting, or preventive activities. There is a history of sexualized behavior or mild concerns in this area. 2 Problem is interfering with functioning; requires action or intervention to ensure that the need is addressed. Moderate problems with sexualized behavior that place child at some risk. 3 Problem is dangerous or disabling; requires action or intervention to ensure that the need is addressed. Significant problems with sexualized behaviors. Child exhibits sexual behaviors that place the child or others at immediate risk.

3. CHILD STRENGTHS DOMAIN

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

Question to Consider for this Domain: What infant or child strengths can be used to support a need? What are the infant's or child's assets that can be used in treatment planning to support healthy development? **Please rate the highest level from the past 30 days.**

Child Strengths Domain – use the following categories and action levels:

0 Powerful/Centerpiece strength; Strength is central to planning.

1 Useful strength is evident and an opportunity to further develop for use in planning is needed. Strength might be used and built upon in planning.

2 Strengths have been identified but require intensive strength building efforts before they can be effectively utilized as part of a plan.

3 No evidence of strength; Significant efforts are needed to identify potential strengths on which to build.

8. FAMILY STRENGTHS

This item refers to connection and communication among family members and a family's contributions to the infant's or child's ability to manage difficulties. The definition of family comes from the infant's or child's perspective (i.e., who the child describes as their family). If this information is not known, then we recommend a definition of family that includes biological/adoptive relatives and their significant others with whom the infant or child is still in contact.

Questions to Consider

- Does the infant or child have positive relationships with any family member?
- Is there potential to develop positive family relationships?
- Is there a family member that the infant or child can go to in time of need for support?
- Does the presence of familial relationships help the infant or child through difficult times?
- Does the family enjoy activities together, such as mealtimes, outings, watching movies?

Ratings and Descriptions

0 Powerful/Centerpiece strength; Strength is central to planning.

The family has strong relationships and communication with the infant or child. This indicates a family with much compassion and respect for one another.

There is at least one family member who has a strong, positive relationship with the infant or child and is able to provide significant emotional or physical support. Infant or child is fully included in family activities.

1 Useful strength is evident and an opportunity to further develop for use in planning is needed. Strength might be used and built upon in planning.

The family has good relationships and good communication with the infant or child. Family members are able to enjoy each other's company. There is at least one family member who has a strong, positive relationship with the infant or child and is able to provide limited emotional or physical support.

2 Strengths have been identified but require intensive strength building efforts before they can be effectively utilized as part of a plan.

The family needs some assistance in developing relationships and communication with the child. Family members are known, but currently none are able to provide emotional or physical support to the child.

3 No evidence of strength; Significant efforts are needed to identify potential strengths on which to build.

The family needs significant assistance in developing relationships and communications with the infant or child, or the infant or child has no identified family. The infant or child is not included in typical family activities and is not receiving emotional or physical support from any family members.

9. INTERPERSONAL SKILLS

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

Questions to Consider

- Does the child have peers or friendships?
- Does the child initiate play with the same peer or peer group?
- Does the child seek interactions that often end in conflict?
- Is the infant or child pleasant and likeable?
- Can the child make friends on their own or do they need help from adults to build/foster relationships?
- Does the infant or child smile and acknowledge peers or adults they know?

Ratings and Descriptions

0 Powerful/Centerpiece strength; Strength is central to planning.

Significant interpersonal strengths. The child has well-developed interpersonal skills and has many friends. The child is well-liked by others and has significant ability to form and maintain positive relationships with peers and adults.

1 Useful strength is evident and an opportunity to further develop for use in planning is needed. Strength might be used and built upon in planning.

Infant or child has good interpersonal skills and has shown the ability to develop some positive relationships with peers and adults.

2 Strengths have been identified but require intensive strength building efforts before they can be effectively utilized as part of a plan.

Infant or child has some interpersonal skills that facilitate positive relationships with peers and adults but needs assistance in developing good social skills or healthy friendships.

3 No evidence of strength; Significant efforts are needed to identify potential strengths on which to build.

The infant or child needs significant help in developing interpersonal skills and healthy friendships. Child currently does not have any friends nor have they had any friends in the past. Child does not have positive relationships with peers or adults.

10. ADAPTABILITY

This item rates how the infant or child reacts to new situations or experiences, as well as how they respond to changes in routines. Consider how the child manages transitions between activities and schedule changes.

Questions to Consider

- Can infant or child easily and willingly transition between activities?
- Does the infant or child cry or lash out in between activities for more than 15 minutes?
- Is the infant or child difficult to soothe when plans change or a routine is shifted?
- How does the infant or child cope with changes to their routine or new situations?

Ratings and Descriptions

0 Powerful/Centerpiece strength; Strength is central to planning.

Infant or child has a strong ability to adjust to changes and transitions.

1 Useful strength is evident and an opportunity to further develop for use in planning is needed. Strength might be used and built upon in planning.

Infant or child has some ability to adjust to changes and transitions and, when challenged, the infant or child is successful with support from a supervising adult.

2 Strengths have been identified but require intensive strength building efforts before they can be effectively utilized as part of a plan.

Infant or child has difficulties much of the time adjusting to changes and transitions even with support from a supervising adult.

3 No evidence of strength. Significant efforts are needed to identify potential strengths on which to build.

Infant or child has difficulties most of the time coping with new situations, changes and transitions. Supervising adults are minimally able to impact infant's or child's difficulties in this area.

11. PERSISTENCE

This item rates the infant's or child's ability to keep trying a new task or skill, even when it is difficult.

Questions to Consider

- When attempting a new skill, such as crawling or standing, does the infant or child continue to try after falling down?
- When shown a new toy such as a puzzle, does the infant or child give up after one or two tries?
- Does infant or child respond to encouragement from caregivers to keep working on a challenging task/game?

Ratings and Descriptions

0 Powerful/Centerpiece strength; Strength is central to planning.

Infant or child has a strong ability to continue an activity when challenged or meeting obstacles.

1 Useful strength is evident and an opportunity to further develop for use in planning is needed. Strength might be used and built upon in planning.

Infant or child has some ability to continue an activity that is challenging. Infant or child will continue attempting the task or activity with adult assistance.

2 Strengths have been identified but require intensive strength building efforts before they can be effectively utilized as part of a plan.

Infant or child has limited ability to continue an activity that is challenging and adults are only sometimes able to assist them in this area.

3 No evidence of strength; Significant efforts are needed to identify potential strengths on which to build.

Infant or child has difficulties most of the time coping with challenging tasks. Support from adults minimally impacts their ability to demonstrate persistence.

12. CURIOSITY

This item describes the infant's or child's self-initiated efforts to discover their world including being interested in their surroundings and in learning and experiencing new things. This item also describes the infant's or child's eagerness and desire to know how something works, or more information.

Questions to Consider

- When a toy is placed out of their reach, does an infant make efforts to reach for it?
- Does the infant or child show interest in new food?
- Does the infant or child try new activities when they see peers or caregivers doing them?
- Does the infant or child avoid new objects by looking away or moving away?

Ratings and Descriptions

0 Powerful/Centerpiece strength; Strength is central to planning.

This level indicates an infant or child with exceptional curiosity. Infants display mouthing and banging of objects within grasp; children crawl or walk to objects of interest such as toys or food.

1 Useful strength is evident and an opportunity to further develop for use in planning is needed. Strength might be used and built upon in planning.

This level indicates an infant or child with good curiosity. An ambulatory child who does not walk to interesting objects, but who will actively explore objects such as toys or food when presented to them, would be rated here.

2 Strengths have been identified but require intensive strength building efforts before they can be effectively utilized as part of a plan.

This level indicates an infant or child with limited curiosity. They may be hesitant to seek out new information or environments, or reluctant to explore presented objects such as toys or food.

3 No evidence of strength; Significant efforts are needed to identify potential strengths on which to build.

This level indicates an infant or child with very limited or no observable curiosity. They may cry or move away when presented with new information, objects, or food and do not respond to encouragement or soothing from caregiver.

13. PLAYFULNESS

This item describes the degree to which an infant or child is given opportunities and participates in age appropriate play. Consider if they are interested in play and/or whether they need adult support while playing. Problems with either solitary or group (e.g. parallel) play could be rated here.

Questions to Consider

- Does the infant or child have opportunities to play with peers or caregivers?
- Does the infant or child initiate individual or group play?
- Does the infant or child smile or laugh during playtime?
- Does infant or child often avoid play or isolate themselves during cooperative play?
- Is an older infant frequently removed from the laying positions to engage in age appropriate play with caregivers such as "tummy time" or sitting up?

Ratings and Descriptions

0 Powerful/Centerpiece strength; Strength is central to planning.

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

1 Useful strength is evident and an opportunity to further develop for use in planning is needed. Strength might be used and built upon in planning.

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

2 Strengths have been identified but require intensive strength building efforts before they can be effectively utilized as part of a plan.

The infant or child demonstrates the ability to enjoy play and use it to support their development some of the time or with support of a caregiver.

3 No evidence of strength; Significant efforts are needed to identify potential strengths on which to build.

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

Supplemental information:

Specific information to consider regarding playfulness in infants and children:

Rating '0': Infant or child enjoys play and regularly engages in imaginative play. Infant displays changing facial expressions in response to different play objects.

Rating '1': Infant or child may enjoy play only with self or only with others. They may enjoy play with a limited selection of toys.

Rating '2': Child rarely engages in play or may exhibit unimaginative play. Child often needs prompting by others to engage in play.

Rating '3': Child does not engage in imaginative play though will handle and manipulate toys. Infant's or child's development may be negatively impacted due to no opportunities to engage in play.

14. RELATIONSHIP PERMANENCE

This item refers to the stability and consistency of significant relationships in the infant's or child's life. This likely includes family members but may also include other individuals. Here the focus is on having a lasting relationship with the infant or child.

Questions to Consider

- Does the infant or child have relationships with adults that have lasted their lifetime?
- Is the infant or child in contact with parents? Do they see them regularly?
- Are there adults in the infant's or child's life with whom they have long-lasting relationships?
- Has anyone consistently been in the infant's or child's life since birth?
- Has the infant or child been in multiple home placements?
- Does the infant or child have an adult in their life in whom they can rely?

Ratings and Descriptions

0 Powerful/Centerpiece strength; Strength is central to planning.

Infant or child has very stable relationships. Family members, friends, and community have been stable for most of their life and are likely to remain so in the foreseeable future.

1 Useful strength is evident and an opportunity to further develop for use in planning is needed. Strength might be used and built upon in planning.

Infant or child has stable relationships but there is some concern about instability in the near future due to transitions, illness, functioning, or age.

2 Strengths have been identified but require intensive strength building efforts before they can be effectively utilized as part of a plan.

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

3 No evidence of strength; Significant efforts are needed to identify potential strengths on which to build.

Infant or child does not have any stable and permanent relationships.

4. EXPOSURE TO POTENTIALLY TRAUMATIC/ADVERSE CHILDHOOD EXPERIENCES DOMAIN

These ratings are made based on exposure to trauma or adverse experiences that have occurred over the infant's or child's lifetime.

Question to Consider for this Domain: How does the infant or child and family define their experience of trauma?

Exposure to Potentially Traumatic/Adverse Childhood Experiences Domain - use the following categories and action levels:

No	No evidence of any trauma of this type.
Yes	Infant or child has had experience or there is suspicion that they have experienced this type of trauma – One incident, multiple incidents, chronic, on-going incidents.

15. SEXUAL ABUSE

This item describes the infant's or child's experience of or exposure to sexual abuse.

Questions to Consider

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

Ratings and Descriptions

No — No evidence that infant or child has experienced sexual abuse or exposure to secondary sexual abuse.

Yes — Infant or child has experienced sexual abuse, or there is a suspicion that they have experienced sexual abuse – single or multiple episodes, or chronic over an extended period of time. The abuse may have involved penetration, multiple perpetrators, and/or associated physical injury. Infant or child with exposure to secondary sexual abuse (e.g., witnessing sexual abuse, having a sibling sexually abused) should be rated here.

16. PHYSICAL ABUSE

This item describes the infant's or child's experience of physical abuse.

Questions to Consider

- Has the child or caregiver disclosed a history of physical abuse?
- What form of physical discipline used in the home?
- Has the infant or child ever received bruises, marks, or injury from discipline?

Ratings and Descriptions

No — No evidence that infant or child has experienced physical abuse.

Yes — Infant or child has experienced or there is a suspicion that they have experienced physical abuse – mild to severe, or repeated physical abuse with sufficient physical harm requiring medical treatment.

17. EMOTIONAL/VERBAL ABUSE

This item rates whether the infant or child has experienced verbal and nonverbal emotional abuse, including belittling, shaming, and humiliation, name calling, making negative comparisons to others, or verbalized degrading messages to the child. This item includes both emotional abuse, which would include psychological maltreatment such as insults or humiliation towards a child and emotional neglect, described as the denial of emotional attention and/or support from caregivers.

Questions to Consider

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

Ratings and Descriptions

No — No evidence that infant or child has experienced emotional or verbal abuse.

Yes — Infant or child has experienced emotional or verbal abuse, or there is a suspicion that they have experienced emotional or verbal abuse (mild to severe, for any length of time) including: insults or occasionally being referred to in a derogatory manner by caregivers, being denied emotional attention or completely ignored, threatened, or terrorized by others.

18. NEGLECT

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

Questions to Consider

- Is the infant or child receiving adequate supervision?
- Are the infant's or child's basic needs for food and shelter being met?
- Is the infant or child allowed access to necessary medical care?
- Do the caregivers prevent child from accessing education?

Ratings and Descriptions

No No evidence that infant or child has experienced neglect.

Yes Infant or child has experienced neglect, or there is a suspicion that they have experienced neglect. This includes occasional neglect (e.g., left home alone for a short period of time when developmentally inappropriate, or occasional failure to provide adequate supervision); multiple or prolonged absences of adults, with minimal supervision; or failure to provide basic necessities of life (adequate food, shelter, or clothing) on a regular basis.

19. MEDICAL TRAUMA

This item rates the infant's or child's experience of medically related trauma, including inpatient hospitalizations, outpatient procedures, and significant injuries. When rating this item, take into consideration if the medical event(s) were emotionally or psychologically overwhelming for the infant or child. Procedures that are uncomfortable or unpleasant but common in childhood would not be rated here.

Questions to Consider

- Has the infant or child had any broken bones, stitches or other medical procedures?
- Has the infant or child had to go to the emergency room or stay overnight in the hospital?
- Has the infant or child experienced an accident that requires on going medical attention or physical limitations?

Ratings and Descriptions

No No evidence that infant or child has experienced medical trauma.

Yes Infant or child has had a medical experience that was perceived as emotionally or mentally overwhelming. This includes events that were acute in nature and did not result in ongoing medical needs; associated distress such as minor surgery, stitches or bone setting; acute injuries and moderately invasive medical procedures such as major surgery that required only short-term hospitalization; events that may have been life threatening and may have resulted in chronic health problems that alter their physical functioning. A suspicion that an infant or child has had a medical experience that was perceived as emotionally or mentally overwhelming should be rated here.

20. WITNESS TO FAMILY VIOLENCE

This item describes exposure to family violence.

Questions to Consider

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

Ratings and Descriptions

No No evidence that infant or child has witnessed family violence.

Yes Infant or child has witnessed, or there is a suspicion that they have witnessed family violence – single, repeated, or severe episodes. This includes episodes of family violence without significant injuries (i.e. requiring emergency medical attention) and episodes in which significant injuries have occurred as a direct result of the violence.

21. WITNESS TO COMMUNITY/SCHOOL VIOLENCE

This item rates the severity and frequency of incidents of violence the infant or child has witnessed in their community. This includes witnessing violence at their school, educational, or daycare setting.

Questions to Consider

- Does the infant or child live in a neighborhood with frequent violence?
- Has the infant or child witnessed or directly experienced violence at their school?
- Are there frequent fights or other acts of violence at the child's school?
- Are weapons involved?

Ratings and Descriptions

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

22. WAR AFFECTED

This item describes exposure to war, political violence, or torture. Violence or trauma related to terrorism is NOT included here.

Questions to Consider

- Has the infant, child, or their family lived in a war-torn region?
- How close was the infant or child to war, political violence, or torture?
- Was the family displaced?
- What acts of war did the infant, child, or family witness or experience directly?

Ratings and Descriptions

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

23. TERRORISM AFFECTED

This item describes the infant's or child's exposure to terrorism. Terrorism is defined as "the calculated use of violence or the threat of violence to inculcate fear, intended to coerce or to intimidate governments or societies in the pursuit of goals that are generally political, religious, or ideological." Terrorism includes attacks by individuals acting in isolation (e.g. sniper attacks).

Questions to Consider

- Has the infant or child witnessed an act of terrorism?
- How close was the infant or child to terrorism?
- Was the infant's or child's community targeted in an act of terrorism?
- Does the child know people injured or killed in an act of terrorism?

Ratings and Descriptions

No	No evidence that infant or child has been affected by terrorism or terrorist activities.
Yes	Infant or child has experienced, or there is suspicion that they have experienced terrorism. Examples include: Infant or child may live near the area where attack occurred and be accustomed to visiting regularly in the past; infrastructure in their daily life may be disrupted due to attack (e.g. utilities or school); they may see signs of the attack in neighborhood (e.g., destroyed building); they may know people who were injured in the attack; they have witnessed the death of another person in a terrorist attack, or have had friends or family members seriously injured as a result of terrorism, or have directly been injured by terrorism leading to significant injury or lasting impact. Infant or child who did not live in a terrorism affected region, but family was affected by terrorism would be rated here.

24. WITNESS/VICTIM OF CRIMINAL ACTIVITY

This item describes exposure to criminal activity. Criminal activity includes any behavior for which an adult could be incarcerated including drug dealing, prostitution, assault, or battery.

An infant or child who has been sexually abused or witnessed others being sexually abused or physically abused to the extent that an assault charge could be filed would be rated here and on the appropriate abuse-specific items. An infant or child who has witnessed drug dealing, prostitution, assault, or battery would also be rated on this item.

Questions to Consider

- Has the infant, child, or someone in their family ever been the victim of a crime?
- Has the infant or child witnessed criminal activity in the community or home?

Ratings and Descriptions

No	No evidence that infant or child has been victimized or witnessed significant criminal activity.
Yes	Infant or child has been victimized, or there is suspicion that they have been victimized or have witnessed criminal activity. This includes a single instance, multiple instances, or chronic and severe instances of criminal activity that was life threatening or caused significant physical harm, or child has witnessed the death of a family friend or loved one due to criminal activity.

25. PARENTAL CRIMINAL BEHAVIOR

This item rates the criminal behavior of biological and stepparents, and other legal guardians, not foster parents.

Questions to Consider

- Do the infant's or child's parents engage in criminal acts?
- Are either of the parents in jail? If so, do they have contact with the infant or child?

Ratings and Descriptions

No	No evidence that infant's or child's parents have ever engaged in criminal behavior.
Yes	One or more of the infant's or child's parents or guardians have a history of criminal behavior. A suspicion that one or more of the infant's or child's parents or guardians have a history of criminal behavior would be rated here.

26. DISRUPTIONS IN CAREGIVING/ATTACHMENT LOSSES

This item describes disruptions in caregiving involving separation from primary attachment figure(s) and/or attachment losses (e.g., placement in foster care, caregiver incarceration, caregiver deployment, caregiver deportation, death of caregiver, etc.). Infants or children who have experienced placement changes including stays in residential treatment facilities or juvenile justice settings can also be rated here. Short-term hospital stays or brief juvenile detention stays, during which the infant's or child's caregiver remains the same, would not be rated on this item.

Questions to Consider

- Has the infant or child ever lived apart from their caregiver?
- Has the infant or child ever been placed in foster care?
- What happened that resulted in the infant or child living apart from their caregiver?
- Has the infant or child lost contact with or had limited access to the caregiver?

Ratings and Descriptions

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

5. TRAUMA STRESS SYMPTOMS DOMAIN

This section focuses on behaviors that can get the infant or child 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: How is the infant or child coping with their traumatic experience(s)? Are there symptoms of stress that didn't begin until after traumatic experience occurred? Could there be possible triggers that impact traumatic stress behaviors?

Trauma Stress Symptoms Domain - use the following categories and action levels:

0	No evidence of need; no action needed.
1	History or suspicion of problems; requires monitoring, watchful waiting, or preventive activities.
2	Problem is interfering with functioning; requires action or intervention to ensure that the need is addressed.
3	Problem is dangerous or disabling; requires immediate and/or intensive action.

27. REACTION TO TRAUMATIC LIFE EXPERIENCES

This item covers the infant's or child's reaction to any potentially traumatic or adverse childhood experience, not the trauma or experience itself. This item should be rated as 1 – 3 for infants or children who have ANY type of symptoms/needs that are related to their exposure to a traumatic/adverse event.

NOTE: This item allows you to rate the overall severity of the broad range of trauma-related symptoms the infant or child may be experiencing. The remaining items on the CANS will allow you to also rate each of the specific types of symptoms.

Questions to Consider	Ratings and Descriptions
• Has infant or child experienced a traumatic event? • Does infant or child have sleep disturbances that were not present before a traumatic event occurred? • Does the infant or child frequently communicate (verbally or physically) about the traumatic event? • Is the infant or child unusually afraid of being alone, or of participating in activities they use to enjoy? • Has the infant's or child's body language changed in response to being picked up or touched?	0 No evidence of need; no action needed. No evidence that infant or child has experienced a traumatic life event, OR infant or child has adjusted well to traumatic/adverse experiences. 1 History or suspicion of problems; requires monitoring, watchful waiting, or preventive activities. The infant or 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 necessary. 2 Problem is interfering with functioning; requires action or intervention to ensure that the need is addressed. Clear evidence of adjustment problems associated with traumatic life event(s). Infants may have developmental regression, or disturbances in eating or sleeping. Children may have all of the above as well as behavioral symptoms, tantrums, and withdrawn behavior. Adjustment is interfering with their functioning in at least one life domain. 3 Problem 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 infant or child to function in any life domain including symptoms such as sleep, eating, or elimination disturbances, flashbacks, nightmares, significant fearfulness, repetitive acting out, or re-experiencing trauma (consistent with Post Traumatic Stress Disorder).

28. TRAUMATIC GRIEF & SEPARATION

This item describes the level of traumatic grief the infant or child is experiencing due to death or loss/separation from significant caregivers, siblings, or other significant people. Symptoms may include depressive or overly emotionally reactive behaviors.

Questions to Consider

- Is the infant or child now acting withdrawn, depressed, or unresponsive to caregivers after a loss or separation?
- Does the infant or child become upset or irritable when current caregivers attempt to interact with them?
- Has there been a change in the infant's or child's sleeping or eating patterns?
- Does the infant or child refuse or resist being comforted or soothed?

Ratings and Descriptions

0 No evidence of need; no action needed.

There is no evidence that the infant or child is experiencing traumatic grief or separation from the loss of a significant person/people. Either the infant or child has not experienced a traumatic loss (e.g., death of a loved one) or they have adjusted well to separation.

1 History or suspicion of problems; requires monitoring, watchful waiting, or preventive activities.

Infant or child is experiencing traumatic grief due to death, loss, or separation from a significant person in a manner that is expected and/or appropriate given the recent nature of loss or separation.

History of traumatic grief symptoms would be rated here.

2 Problem is interfering with functioning; requires action or intervention to ensure that the need is addressed.

Infant or child is experiencing traumatic grief or difficulties with separation in a manner that impairs functioning in some but not all areas of their life. This could include withdrawal or isolation from others or other problems with day-to-day functioning. They may also be overly attached or clingy with strangers.

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

Infant or child is experiencing dangerous or debilitating traumatic-grief reactions that impair their functioning across several areas (e.g. interpersonal relationships, school) for a significant period of time following the loss or separation. Symptoms require immediate or intensive intervention.

29. INTRUSIONS/RE-EXPERIENCING

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

Questions to Consider

- When someone talks about the trauma, does the child attempt to leave the room or become agitated?
- Has the infant or child experienced significant changes to sleep patterns?
- Do reminders of the traumatic event, such as location, sounds, smells, or people, upset the infant or child?
- Does the child frequently talk or ask questions about the traumatic event out of context?

Ratings and Descriptions

0 No evidence of need; no action needed.

There is no history or evidence that infant or child experiences intrusive thoughts or trauma.

1 History or suspicion of problems; requires monitoring, watchful waiting, or preventive activities.

History or evidence of some intrusive thoughts of trauma but it does not affect the infant's or child's functioning. An infant or child with some problems with intrusive, or distressing memories, including occasional nightmares about traumatic events, would be rated here.

2 Problem is interfering with functioning; requires action or intervention to ensure that the need is addressed.

Infant or child has difficulties with intrusive symptoms/distressing memories, intrusive thoughts that interfere in their ability to function in some life domains. For example, the child may have recurrent frightening dreams with or without recognizable content or recurrent distressing thoughts, images, perceptions or memories of traumatic events. They may exhibit trauma-specific reenactments through repetitive play with themes of trauma or intense physiological reactions to exposure to traumatic cues.

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

Infant or child has repeated and/or severe intrusive symptoms/distressing memories that are debilitating. They may exhibit trauma-specific reenactments that include sexually or physically traumatizing other children or sexual play with adults. They may also exhibit persistent flashbacks, illusions or hallucinations that make it difficult for them to function in most life domains.

30. HYPERAROUSAL

Symptoms of hyperarousal may include difficulty falling asleep, irritability or outbursts of anger, difficulty concentrating, hyper vigilance and/or exaggerated startle response. Infant or child may also show common physical symptoms such as stomachaches and headaches that were not previously present.

Questions to Consider

- Does the infant or child seem more jumpy or irritable than is usual?
- Does the infant or child require assistance falling asleep?
- Does the infant or child have a hard time calming down?
- Does the child have frequent stomach- or headaches that were not previously present?
- Is the infant or child resistant to attempts to soothe or calm?
- Does the infant or child take cues from caregiver and/or peers when it is appropriate to be still or calm down?

Ratings and Descriptions

0 No evidence of need; no action needed.

Infant or child has no evidence of hyperarousal symptoms.

1 History or suspicion of problems; requires monitoring, watchful waiting, or preventive activities.

History or evidence of hyperarousal that does not interfere with their daily functioning. Infant or child may occasionally show distress-related physical symptoms such as stomachaches and headaches.

2 Problem is interfering with functioning; requires action or intervention to ensure that the need is addressed.

Infant or child exhibits one significant symptom or a combination or two or more of the following hyperarousal symptoms: difficulty falling or staying asleep, irritability or outbursts of anger, difficulty concentrating, hyper vigilance and/or exaggerated startle response. They may frequently show distress-related physical symptoms such as stomachaches and headaches. Symptoms are distressing for the infant or child or caregiver and negatively impact day-to-day functioning in several life domains.

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

Infant or child exhibits multiple and/or severe hyperarousal symptoms. This may include difficulty falling or staying asleep, irritability or outbursts of anger, difficulty concentrating, hyper vigilance and/or exaggerated startle response. Intensity and frequency of these symptoms are overwhelming for the infant or child or caregiver and hinder day-to-day functioning in many life areas.

31. ATTEMPTS TO AVOID STIMULI

This item describes the level of avoiding stimuli (e.g., sights, sounds, smells, conversations, places, people) associated with traumatic experiences.

Questions to Consider

- Are there places the infant or child consistently does not want to go?
- Does the infant or child seem anxious or uncomfortable around certain people and would prefer not to be around them?

Ratings and Descriptions

0 No evidence of need; no action needed.

Infant or child exhibits no avoidance symptoms.

1 History or suspicion of problems; requires monitoring, watchful waiting, or preventive activities.

Infant or child may have history or exhibits one primary avoidant symptom, including efforts to avoid thoughts, feelings or conversations associated with the trauma.

2 Problem is interfering with functioning; requires action or intervention to ensure that the need is addressed.

Infant or child exhibits avoidance symptoms that interfere with their functioning in at least one life domain. In addition to avoiding thoughts or feelings associated with the trauma, they may also avoid activities, places, or people that remind them of the trauma.

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

Infant's or child's avoidance symptoms are debilitating. Child may avoid thoughts, feelings, situations, and people associated with the trauma and is unable to recall important aspects of the trauma.

32. NUMBING

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

Questions to Consider

- Does the infant or child experience a typical range of emotions for their age group?
- Does the infant or child tend to have flat emotional responses?
- Does the infant or child react differently to daily positive and/or negative experiences?
- Is there a decreased interest in activities, toys, or food that they previously enjoyed?

Ratings and Descriptions

0 No evidence of need; no action needed.

Infant or child has no evidence of numbing responses.

1 History or suspicion of problems; requires monitoring, watchful waiting, or preventive activities.

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

2 Problem is interfering with functioning; requires action or intervention to ensure that the need is addressed.

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

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

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

33. DISSOCIATION

This item rates the level of dissociative states the infant or child may experience. Symptoms included are daydreaming, spacing or blanking out, forgetfulness, detachment, and rapid changes in personality often associated with traumatic experiences.

Questions to Consider

- Has there been a dramatic change in the infant's or child's personality?
- Does the infant or child act as if they are someone or something else in response to reminders of trauma event?
- Does the child have trouble recalling certain memories, experiences, or circumstances?
- Does the infant or child seem to lose touch with the present moment at times?
- Is the child frequently forgetful when they previously were not?

Ratings and Descriptions

0 No evidence of need; no action needed.

No evidence or history of dissociation.

1 History or suspicion of problems; requires monitoring, watchful waiting, or preventive activities.

Infant or child has history or evidence of minor dissociative problems, including some emotional numbing, avoidance or detachment, and some difficulty with forgetfulness, daydreaming, spacing/blanking out.

2 Problem is interfering with functioning; requires action or intervention to ensure that the need is addressed.

Infant or child exhibits dissociative problems that interfere with functioning in at least one life domain. This can include amnesia for traumatic experiences or inconsistent memory for trauma (e.g., remembers in one context but not another), more persistent or perplexing difficulties with forgetfulness (e.g., loses things easily, forgets basic information), frequent daydreaming or trance-like behavior. Changes in behavior present challenges when child is engaging in social and educational activities. This rating would be used for someone who meets criteria for Dissociative Disorders or another diagnosis that is specified "with dissociative features".

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

Infant or child exhibits dangerous and/or debilitating dissociative symptoms. This can include significant memory difficulties associated with trauma that also impede day-to-day functioning. Child is frequently forgetful or confused about things they should know about (e.g., no memory for activities or whereabouts of previous day or hours). Child shows rapid changes in personality or evidence of distinct personalities. Changes in behavior make it very difficult for them to engage in social or educational activities. Child who meets criteria for Dissociative Identity Disorder or a more severe level of a Dissociative Disorder would be rated here.

34. EMOTIONAL AND/OR PHYSICAL REGULATION

This item describes the level of difficulty managing or expressing emotions and energy levels. Examples might include: sudden emotional outburst or a complete lack of emotional responses, excessive and chronic silly behavior, excessive body movements, difficulties regulating sleep/wake cycle, and inability to fully engage in activities. The infant or child may demonstrate difficulties with a single type or a wide range of emotions and energy levels. This item should be rated in the context of what is normative for an infant's or child's age/developmental stage.

Questions to Consider

- Does the infant or child struggle with activity transitions, resulting at times in the inability to engage in activities?
- Does the infant or child exhibit severe reactions to changes in temperature or clothing that at times 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 infant or child have more distressing tantrums or yelling fits than other children or has a teacher/childcare worker expressed concern about intensity or frequency of tantrums?
- Does the infant or child treat efforts to engage or soothe as threatening?

Ratings and Descriptions

0 No evidence of need; no action needed.

Infant or child has no history of or current difficulties regulating emotional or physiological responses. Emotional responses and energy level are appropriate to the situation.

1 History or suspicion of problems; requires monitoring, watchful waiting, or preventive activities.

History or evidence of difficulties with affect/physiological regulation. Infants may have unpredictable emotional patterns and be difficult to console. Children may require a great deal of structure and need more support than other children in coping with frustration and difficult emotions. There is a history, suspicion of or some mild problems with regulation are present.

2 Problem is interfering with functioning; requires action or intervention to ensure that the need is addressed.

Moderate problems with regulation are present. Infants may demonstrate significant difficulties with transitions and irritability such that consistent adult intervention is necessary and disruptive to the family. Children may demonstrate reactions to sensory stimuli and emotions that interfere with their functioning and ability to progress developmentally. The family may be disrupted or distressed with infant's or child's unpredictable patterns in eating and sleeping routines.

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

Profound problems with emotional or physical regulation are present that place the infant's or child's safety, well-being or development at risk in all life domains. They are often challenging to console and are unpredictable in their needs. They demonstrate severe reactions to sensory stimuli and emotions that interfere with their functioning and ability to progress developmentally in all life domains. Family is disrupted or distressed with infant's or child's unpredictable patterns in eating and sleeping routines.

6. 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 individual, family, peer, school, and community realms. This section is rated using the needs scale and therefore will highlight any struggles the individual and family are experiencing.

Question to Consider for this Domain: How is the infant or child functioning in individual, family, peer, school, and community realms? Are there certain life domains that are particularly challenging for the infant, child, and others? In what setting(s) do most of the challenges arise for them?

Life Functioning Domain - use the following categories and action levels:

0	No evidence of need; no action needed.
1	History or suspicion of problems; requires monitoring, watchful waiting, or preventive activities.
2	Problem is interfering with functioning; requires action or intervention to ensure that the need is addressed.
3	Problem is dangerous or disabling; requires immediate and/or intensive action.

35. FAMILY FUNCTIONING

This item describes the infant's or child's relationships with those who are in their family. It is recommended that the description of family should come from the child's perspective (i.e. who the child describes as their family). In the absence of this information, consider biological and adoptive relatives and their significant others with whom the infant or child is still in contact. Foster families should only be considered for this item if they have made a significant long-term commitment to the infant or child. For infants and children involved with child welfare, family refers to the person(s) fulfilling the permanency plan e.g., relative foster family, guardianship family, biological family, pre-adoption family). When rating this item, consider the relationship the infant or child has with their family as well as the relationship of the family as a whole. Consider the severity of family conflict.

Questions to Consider

- Is there conflict in the family relationship that requires resolution?
- Is treatment required to restore or develop positive relationships in the family?
- Has there ever been any violence between the infant, child, and other family members?
- How does the family deal with challenges as they arise?

Ratings and Descriptions

0	No evidence of need; no action needed. No evidence of problems in relationships with family members, and/or infant or child is doing well in relationships with family members.
1	History or suspicion of problems; requires monitoring, watchful waiting, or preventive activities. History or suspicion of problems, or the infant or child has adequate relationships with family members, although some problems may exist. For example, occasional arguing may be common but does not result in major conflict.
2	Problem is interfering with functioning; requires action or intervention to ensure that the need is addressed. The infant or child is having conflict with parents, siblings and/or other family members that is impacting their functioning. Frequent arguing, difficulty maintaining positive relationships may be observed. The family has few supports or coping strategies to address conflict.
3	Problem is dangerous or disabling; requires immediate and/or intensive action. The infant or child is having severe conflict with parents, siblings, and/or other family members. Conflict is debilitating to the infant's or child's functioning. This would include absence of any positive family relationships, and/or presence of domestic violence (physical, emotional, and/or sexual abuse).

36. LIVING SITUATION

This item describes how infant or child is functioning in their current living situation, which could be with a relative, in a foster home, etc. This item should exclude respite care, brief detention/jail, and brief medical and psychiatric hospitalization.

Questions to Consider

- Is the infant or child causing or impacted by conflict with others in the current living situation?
- Does the infant or child seem happy or content in their living environment?
- Has the caregiver requested that the infant or child be removed from their current living situation?
- Is the caregiver able to meet the needs of the infant or child in the home?
- Do the child, caregiver, and family members express that they feel safe in the home?

Ratings and Descriptions

0 No evidence of need; no action needed.

No evidence of problem with functioning in current living environment. The child and caregivers feel comfortable dealing with issues that come up in day-to-day life.

1 History or suspicion of problems; requires monitoring, watchful waiting, or preventive activities.

The infant or child experiences mild problems with functioning in current living situation. Caregivers express some concern about the infant's or child's behavior in living situation, or the infant or child and caregiver have some difficulty dealing with issues that arise in daily life.

2 Problem is interfering with functioning; requires action or intervention to ensure that the need is addressed.

The infant or child has moderate to severe problems with functioning in current living situation. They have difficulties maintaining appropriate behavior in this setting and it is creating significant problems for others in the residence. The infant or child and caregiver(s) have difficulty interacting effectively with each other much of the time.

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

The infant or child has profound problems with functioning in current living situation. They are at immediate risk of being removed from living situation due to problematic behaviors, such as being harmed, physically harmful, or threatening physical harm.

37. PRESCHOOL/DAYCARE BEHAVIOR

This item rates the behavior of the child in daycare or preschool. If school is not in session, rate the last 30 days when school was in session. Consider the severity of any difficult behavior at school, as well as the level of disruption caused by this behavior.

Questions to Consider

- How is the child behaving at daycare or preschool?
- How does the child respond to interventions regarding their behavior?
- Is the child disruptive to others in the daycare or preschool?
- Does the child act out in ways that are dangerous or violent?
- Is the daycare provider or preschool staff able to meet the developmental and educational needs of all the children at their facility?
- Does the child require more one-on-one attention from daycare/preschool staff than the other children?

Ratings and Descriptions

0 No evidence of need; no action needed.

No evidence of behavioral problems at school or child is behaving well in preschool/daycare, or not currently enrolled.

1 History or suspicion of problems; requires monitoring, watchful waiting, or preventive activities.

Child is behaving adequately in preschool/daycare although some behavior challenges exist, or the child has a history of behavioral challenges.

2 Problem is interfering with functioning; requires action or intervention to ensure that the need is addressed.

The child's behavior challenges are interfering with their functioning in preschool/daycare. Child is disruptive and many types of interventions have been implemented.

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

Child is having severe challenges with behavior in preschool/daycare. They are frequently or severely disruptive. Preschool/daycare placement may be in jeopardy due to behavior.

38. PRESCHOOL/DAYCARE ACHIEVEMENT

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

Questions to Consider

- How is the child doing at learning new skills at daycare or preschool?
- Does the child need extra support from adults to learn and develop new skills at preschool or daycare?

Ratings and Descriptions

0 No evidence of need; no action needed.

Child is doing well and learning new skills.

1 History or suspicion of problems; requires monitoring, watchful waiting, or preventive activities.

Child is learning new skills but still experiences some challenges. Child may be able to catch up with extra adult support.

2 Problem is interfering with functioning; requires action or intervention to ensure that the need is addressed.

Child is having moderate challenges learning new skills. Child may not be able to retain concepts or meet developmental expectations even with adult support in some areas.

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

Child is having severe challenges learning new skills. Child may be completely unable to understand or participate in skill development in most or all areas.

39. SOCIAL FUNCTIONING

This item describes the difficulty an infant or child may have with relationships outside of the family, and particularly with peers. It includes age-appropriate social behavior, the ability to develop and maintain peer relationships, and evidence of adaptive peer relationships. A child with negative or little social engagement may have a need to build social skills. Consider the severity of the social problems on social relationships.

Questions to Consider

- Does the infant or child get along with others and engage in developmentally appropriate ways?
- Does the child have any close friends?
- Are the child's friendships healthy?
- Does the child tend to change friends frequently?
- Has there been an increase in peer conflicts?

Ratings and Descriptions

0 No evidence of need; no action needed.

No evidence of problems or the infant or child has developmentally-appropriate social functioning.

1 History or suspicion of problems; requires monitoring, watchful waiting, or preventive activities.

There is a history or suspicion of problems in social relationships. There are some minor problems in social relationships. Infants may be slow to respond to adults. Toddlers may need support interacting with peers and preschoolers may resist social situations.

2 Problem is interfering with functioning; requires action or intervention to ensure that the need is addressed.

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

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

Infant or child is experiencing severe 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, or aggression may be putting others at risk.

40. RECREATION/PLAY

This item rates the degree to which an infant or child is given opportunities for and participates in age-appropriate play. When rating this item, consider what is developmentally appropriate play for the infant or child, if they are interested in play, and whether they need adult support while playing. Problems with either solitary, parallel (playing separately but mirroring another child's play), or group play could be rated here.

Questions to Consider

- Does the infant or child seek out opportunities to engage in self-directed or cooperative play?
- Is anyone concerned that the infant or child is avoiding play, not showing enjoyment during play or unable to engage in developmentally-appropriate play?

Ratings and Descriptions

0 No evidence of need; no action needed.

No evidence that infant or child has problems with recreation or play. They have full access to recreation and play.

1 History or suspicion of problems; requires monitoring, watchful waiting, or preventive activities.

Infant or child is participating in recreational or play activities although some challenges may exist. Infants may not be easily engaged in play. Toddlers and preschoolers may seem uninterested and struggle to enjoy play.

2 Problem is interfering with functioning; requires action or intervention to ensure that the need is addressed.

Infant or child is having moderate challenges with recreational or play activities. They have very limited access to recreation and play. Infants resist play, toddlers and preschoolers show little enjoyment or interest in activities within or outside the home and can only be engaged in play/recreational activities with ongoing adult interaction and support.

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

Infant or child has no access to or interest in play or recreational activities. Infant spends most of time non-interactive. Toddlers and preschoolers, even with adult engagement, cannot demonstrate enjoyment or engage in recreational or play activities.

41. DEVELOPMENTAL / INTELLECTUAL

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

Questions to Consider

- Has the infant or child reached appropriate developmental milestones?
- Does the child struggle with remembering routines?
- Does the infant seem unaware of their surroundings or seem unfamiliar with their routines?
- Has the child been tested for a learning disability?
- Has the child been diagnosed with a learning disability?
- Has the child been diagnosed with an intellectual disability or delay?

Ratings and Descriptions

0 No evidence of need; no action needed.

There is no evidence of developmental delay or the infant or child has no developmental/cognitive challenges.

1 History or suspicion of problems; requires monitoring, watchful waiting, or preventive activities.

Infant or child has some indicators that cognitive development is not advancing at a rate that is appropriate for their age or are at the lower end of age for reaching developmental milestones. An infant or child who is suspected of having a mild developmental delay would be rated here.

2 Problem is interfering with functioning; requires action or intervention to ensure that the need is addressed.

Infant or child has clear indicators that their cognitive development is not advancing at the expected rate and the delay interferes with functioning much of the time.

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

Infant or child has significant delays in cognitive functioning that are seriously interfering with their functioning. They are completely reliant on caregiver to function.

42. SENSORY

This item describes the infant's or child's ability to use all senses including sight, hearing, smell, touch and taste.

Questions to Consider

- Does the infant or child have hearing or visual impairment?
- Does the infant or child become easily overwhelmed by sensory stimuli?
- Does the infant or child underreact to sensory stimuli?

Ratings and Descriptions

0 No evidence of need; no action needed.

The infant's or child's sensory functioning appears normal. There is no reason to believe that they have any problems with sensory functioning.

1 History or suspicion of problems; requires monitoring, watchful waiting, or preventive activities.

There is a history or suspicion of sensory problems. The infant or child has mild impairment on a single sense (e.g. mild hearing deficits, correctable vision problems).

2 Problem is interfering with functioning; requires action or intervention to ensure that the need is addressed.

The infant or child has moderate impairment on a single sense or mild impairment on multiple senses or moderately atypical reactions to one or more sensory stimuli (i.e., difficulties with sensory integration).

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

The infant or child has significant impairment to multiple senses (e.g., profound hearing or vision loss).

43. SELF-CARE DAILY LIVING SKILLS

This item aims to describe the infant's or child's ability to complete developmentally appropriate self-care tasks such as self-feeding, washing hands, putting away toys, toilet training, and dressing themselves. Consider the impact that their ability to complete daily living tasks has on their participation across life domains. See **Table 4 Self-Care Development Chart.**

Questions to Consider

- Does the infant or child show appropriate self-care skills for their age?
- Is the child able to groom themselves?
- Does the child's ability to complete daily self-care tasks limit their participation in daycare or school?

Ratings and Descriptions

0 No evidence of need; no action needed.

The infant's or child's self-care and daily-living skills appear developmentally appropriate. There is no reason to believe that they have any challenges with performing daily-living skills.

1 History or suspicion of problems; requires monitoring, watchful waiting, or preventive activities.

Infant or child requires some assistance with self-care tasks or daily-living skills at a greater level than would be expected for their age. Development in this area may be slow. Infants may require greater than expected level of assistance in eating and may demonstrate a lack of progression in skills.

2 Problem is interfering with functioning; requires action or intervention to ensure that the need is addressed.

Infant or child requires consistent assistance (physical prompting or doing it for the child) with developmentally appropriate self-care tasks or does not appear to be developing the needed skills in this area.

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

Infant or child is not able to function independently at all in this area.

44. MOTOR

This item describes the infant's or child's fine (e.g. hand grasping and manipulation) and gross (e.g. sitting, standing, walking) motor functioning. Consider an infant's or child's age and development when assessing if they should be crawling, scooting, or walking (mobile) when rating this item.

Questions to Consider

- Does the infant or child have difficulty grasping or holding onto objects that peers can do without difficulty?
- Does the infant or child fall frequently or have difficulty with gross motor skills such as standing, crawling, walking?
- Does the infant or child need additional assistance or accommodations to engage in tasks that requiring grasping such as holding a marker or toy?

Ratings and Descriptions

0 No evidence of need; no action needed.

Infant's or child's fine and gross motor functioning appears normal. There is no reason to believe that they have any problems with motor functioning.

1 History or suspicion of problems; requires monitoring, watchful waiting, or preventive activities.

The infant or child has mild fine (e.g., using scissors) or gross motor (e.g., rolling a ball) skill challenges. They may have previously exhibited delays in reaching developmental milestones for fine or gross motor functioning but have since reached those milestones.

2 Problem is interfering with functioning; requires action or intervention to ensure that the need is addressed.

The infant or child has moderate motor skill challenges. A child who is not walking with fine motor skills (e.g. reaching, grasping) or a mobile child with severe fine motor deficits would be rated here. A full-term newborn that does not have a sucking reflex in the first few days of life would be rated here.

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

The infant or child has severe or profound motor skill challenges. Delay causes impairment in functioning. A child who is not mobile with additional movement deficits would be rated here, as would any child older than 6 months who cannot lift their head.

45. COMMUNICATION (Receptive/Expressive)

This item rates the infant's or child's ability to communicate through any medium including all spontaneous vocalizations and articulations. This item does not refer to challenges expressing feelings.

Questions to Consider

- Does the child have difficulty understanding or using words to express themselves?
- Are there concerns that the child could have problems related with understanding others or expressing themselves?
- Is the child able to express themselves in order to be understood and have their needs met?
- Does the child seem to understand what is being communicated to them?

Ratings and Descriptions

0 No evidence of need; no action needed.

Infant's or child's receptive and expressive communication appears developmentally appropriate. There is no reason to believe that the child has any problems communicating.

1 History or suspicion of problems; requires monitoring, watchful waiting, or preventive activities.

Infant or child has a history of communication problems but currently is not experiencing problems. An infant may rarely vocalize. A toddler may have very few words and become frustrated with expressing needs. A preschooler may be difficult for others to understand.

2 Problem is interfering with functioning; requires action or intervention to ensure that the need is addressed.

Infant or child has either receptive or expressive language problems that interfere with functioning. Infants may have trouble interpreting facial gestures or initiate gestures to communicate needs. Toddlers may not follow simple 1-step directions. Preschoolers may be unable to understand simple conversation or carry out 2-3 step directions.

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

Infant or child is unable to communicate in any way, including pointing or grunting.

46. SLEEP

This item rates the infant's or 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. Bedwetting and nightmares should be considered a sleep issue. For infants and babies under two years of age, this might include a deviation from their typical sleep patterns, including daytime naps and nighttime sleep.

Questions to Consider

- Does the infant or child take naps throughout the day?
- Is the infant or child often sleepy during the day?
- How many hours does the infant or child sleep each night?
- Does the infant or child avoid or resist bedtime?
- Does the infant or child wake during the night? If so, how often?
- Do the infant's or child's sleep problems impact others in the household?
- Does the infant or child experience unusual events during sleep such as sleepwalking or nightmares?

Ratings and Descriptions

NA	Not applicable, child is younger than 12 months of age.
0	No evidence of need; no action needed. No evidence of problems with sleep.
1	History or suspicion of problems; requires monitoring, watchful waiting, or preventive activities. Infant or child has some problems with sleep. Generally, they get a full night's sleep but at least once a week problems arise. This may include occasionally awakening or bed wetting or having nightmares.
2	Problem is interfering with functioning; requires action or intervention to ensure that the need is addressed. Infant or child is having problems with sleep. Sleep is often disrupted and they seldom obtain a full night of sleep.
3	Problem is dangerous or disabling; requires immediate and/or intensive action. Infant or child is generally sleep deprived. Sleeping is almost always difficult and they are not able to get a full night's sleep.

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

Specific information to consider regarding sleep in infants and children:

Rating '1': Toddlers resist sleep and consistently need a great deal of adult support to sleep. Preschoolers may have either a history of poor sleep or continued problems 1-2 nights per week.

Rating '2': Toddlers and preschoolers may experience difficulty falling asleep, night waking, night terrors or nightmares on a regular basis.

Rating '3': Infant or child is experiencing significant sleep problems that result in sleep deprivation. Parents have exhausted numerous strategies for assisting child.

47. MEDICAL

This item rates the infant's or child's current physical health. Consider the severity of medical problems and whether they are chronic.

Questions to Consider

- Is the infant or child generally healthy?
- Does the infant or child have any medical problems?
- Does a medical problem interfere with their life?
- Does the infant or child need to see a doctor regularly to treat any problems?

Ratings and Descriptions

0 No evidence of need; no action needed.

No evidence of medical problems.

1 History or suspicion of problems; requires monitoring, watchful waiting, or preventive activities.

Infant or child has some medical problems that require medical treatment. These conditions are temporary and treatable.

2 Problem is interfering with functioning; requires action or intervention to ensure that the need is addressed.

Infant or child has chronic illness or health challenge that requires ongoing medical intervention or treatment.

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

Infant or child has life threatening illness or medical condition that requires immediate medical intervention.

48. PHYSICAL

This item is used to identify any physical limitations, including chronic conditions, limitations in vision, hearing, persistent asthma, and challenges in fine (e.g., grasping items, hand movements) and gross (e.g., standing, walking) motor skills.

Questions to Consider

- Does the infant or child have any physical limitations (such as asthma: e.g. child cannot go to gym, or needs an inhaler)?
- What activities can the infant or child not do because of a physical condition? How much does this interfere with their life?

Ratings and Descriptions

0 No evidence of need; no action needed.

Infant or child has no physical limitations.

1 History or suspicion of problems; requires monitoring, watchful waiting, or preventive activities.

There may be a history or suspicion, or the infant or child has some physical condition that places mild limitations on activities. Conditions such as impaired hearing or vision would be rated here. Treatable medical conditions that result in physical limitations (e.g. asthma) will be rated here.

2 Problem is interfering with functioning; requires action or intervention to ensure that the need is addressed.

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

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

Infant or child has severe physical limitations due to multiple physical conditions.

7. CULTURAL CONSIDERATIONS DOMAIN

Items in the Cultural Considerations Domain describe needs that infant or child may experience as a result of their membership in any cultural group or because of the relationship between members of that group and members of the dominant society. Culture in this domain is defined broadly to include cultural groups that are defined by race, ethnicity, immigration status, sexual orientation, gender identity and expression, ability, age, religion, social economic status (SES), and geography. It is it important to remember that when using the CANS, the family should be defined from the child's perspective, in addition to their identified membership to culture groups.

Question to Consider for this Domain: How does the infant's or child's membership in a particular cultural group impact their stress and wellbeing? Does the infant or child have access to cultural activities that are important to them? How do the cultural identities of providers in the infant's or child's life, as well as your own identities, align or differ from the infant's or child's[1]?

Cultural Considerations Domain - use the following categories and action levels:	
0	No evidence of need; no action needed.
1	History or suspicion of problems; requires monitoring, watchful waiting, or preventive activities.
2	Problem is interfering with functioning; requires action or intervention to ensure that the need is addressed.
3	Problem is dangerous or disabling; requires immediate and/or intensive action.

[1] In addition to considering the culture of the infant or child, it is important that raters carefully consider their own sociocultural experience, biases, beliefs, and power. The power dynamics of the relationship, the systems involved, and the referral reason and source may all influence the assessment of current needs and strengths.

49. LANGUAGE

This item describes child's or family's need for communication resources, assistance, and accommodations (e.g., interpreter, translator, ESL, ASL, Braille, or assisted technology). This item includes spoken, written, and signed communication, as well as needs related to literacy. Child should not be in the position of being expected to translate and interpret for other family members, caregivers, or providers.

Questions to Consider

- How does the family comfortably communicate with each other at home?
- Is the child interpreting for the family or providers in any situation?
- Does the child or significant family members have any special needs related to communication (e.g., interpreter, translator, ESL, ASL, Braille, or assisted technology)?

Ratings and Descriptions

0 No evidence of need; no action needed.

No evidence that there is a need or preference for accommodations and/or the child and family speak, read, and comprehend the primary language where the child or family lives.

1 History or suspicion of problems; requires monitoring, watchful waiting, or preventive activities.

Child or family communicate in the primary language where they live, but potential communication problems exist because of limited vocabulary or comprehension of the language.

2 Problem is interfering with functioning; requires action or intervention to ensure that the need is addressed.

Child or family possess limited ability to communicate in the primary language where they live. Accommodations are needed to assure adequate communication is possible for extensive work.

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

Child or family are not able to communicate in the primary language where they live. Accommodations are needed for all communication.

50. CULTURAL IDENTITY

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

Questions to Consider

- Does the child identify with any racial/ethnic/cultural group?
- Does the child find this group a source of support?
- Does the child feel pressure to join/leave/hide a particular aspect of their identity?
- Does the child ever feel conflicted about aspects of their social identity?

Ratings and Descriptions

0 No evidence of need; no action needed.

The child has a defined cultural identity and is connected to others who support their cultural identity.

1 History or suspicion of problems; requires monitoring, watchful waiting, or preventive activities.

The child is developing a cultural identity and is seeking others to support their cultural identity.

2 Problem is interfering with functioning; requires action or intervention to ensure that the need is addressed.

The child is searching for a cultural identity and has not connected with others who share an identity. Lack of identity is causing stress in child's life.

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

The child does not express a cultural identity or child is not able to safely express their cultural identity. This causes significant stress in child's life or is debilitating to their wellbeing.

51. CULTURAL EVENTS AND ACTIVITIES

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

Questions to Consider

- What holidays does the child celebrate?
- What traditions are important to the child?
- Does the child fear discrimination for practicing their traditions and rituals?
- Does the child have access to participating in important rituals and holidays?

Ratings and Descriptions

0 No evidence of need; no action needed.

Child consistently practices their chosen traditions or rituals as a part of their cultural identity.

1 History or suspicion of problems; requires monitoring, watchful waiting, or preventive activities.

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

2 Problem is interfering with functioning; requires action or intervention to ensure that the need is addressed.

Child experiences significant barriers and is sometimes prevented from practicing their chosen traditions and rituals consistent with their cultural identity.

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

Child is unable to practice their chosen traditions or rituals consistent with their cultural identity or unable to safely practice them.

52. CULTURAL STRESS

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

Questions to Consider

- How does the child describe their experience of discrimination or oppression?
- How does the caregiver support the child's identity and experiences?
- How does the community support the child's identity and experiences?

Ratings and Descriptions

0 No evidence of need; no action needed.

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

1 History or suspicion of problems; requires monitoring, watchful waiting, or preventive activities.

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

2 Problem is interfering with functioning; requires action or intervention to ensure that the need is addressed.

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

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

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

8. BEHAVIORAL/EMOTIONAL NEEDS DOMAIN

The ratings in this section identify the behavioral/emotional health needs of the infant or child. While the CANS is not a diagnostic tool, it is designed to be consistent with diagnostic communication. In the DSM-5 (Diagnostic and Statistical Manual of Mental Disorders), 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 infant or child?

Child Behavioral/Emotional Needs Domain - use the following categories and action levels:

0	No evidence of need; no action needed.
1	History or suspicion of problems; requires monitoring, watchful waiting, or preventive activities.
2	Problem is interfering with functioning; requires action or intervention to ensure that the need is addressed.
3	Problem is dangerous or disabling; requires immediate and/or intensive action.

53. ATTACHMENT DIFFICULTIES

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

Questions to Consider

- Does the infant or child struggle with separating from caregiver in an age-appropriate way?
- Does the infant or child approach or attach to unknown people/individuals in an age-appropriate way?
- Does the infant or child have the ability to make healthy attachments to appropriate adults?
- Does the infant or child have separation anxiety that interferes with ability to engage in childcare or preschool?

Ratings and Descriptions

0 No evidence of need; no action needed.

No evidence of history of attachment problems. Caregiver-child relationship is characterized by mutual satisfaction of needs and infant's or child's development of a sense of security and trust. Caregiver is able to respond to infant or child cues in a consistent, appropriate manner, and infant or child seeks age-appropriate contact with caregiver for both nurturing and safety needs.

1 History or suspicion of problems; requires monitoring, watchful waiting, or preventive activities.

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

2 Problem is interfering with functioning; requires action or intervention to ensure that the need is addressed.

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

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

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

54. IMPULSIVITY/HYPERACTIVITY

This item describes challenges with impulse control and impulsive behaviors, including motoric disruptions. Children with impulse problems tend to engage in behaviors without thinking, regardless of the consequences. Consider if a child's activity level or ability to control themselves is outside the realm of what is typical for the age and development. **If child is under 3 years old, rate NA for Not Applicable.**

Questions to Consider

- Is the child unable to sit still for any length of time?
- Is the child able to control themselves?
- Is the child's speech sometimes rapid?
- Does the child move from topic to topic quickly?

Ratings and Descriptions

NA	Not applicable, child is under 3 years old.
0	No evidence of need; no action needed. No evidence of symptoms of hyperactivity or impulsivity.
1	History or suspicion of problems; requires monitoring, watchful waiting, or preventive activities. There is a history or evidence of mild levels of impulsivity evident in action or thought that place the child at risk of future functioning difficulties. The child may exhibit limited impulse control (e.g., child may yell out answers to questions or may have difficulty waiting their turn). Some motor difficulties may be present as well, such as pushing or shoving others.
2	Problem is interfering with functioning; requires action or intervention to ensure that the need is addressed. Clear evidence of problems with impulsive, distractible, or hyperactive behavior that interferes with the child's functioning in at least one life domain. This indicates a child with impulsive behaviors that create a significant management problem for adults (e.g., caregivers, teachers, coaches). A child who often intrudes on others and often exhibits aggressive impulses would be rated here.
3	Problem is dangerous or disabling; requires immediate and/or intensive action. Clear evidence of a dangerous level of hyperactivity and/or impulsive behavior that places the child at risk of physical harm. This indicates a child with frequent and significant levels of impulsive behaviors that carry considerable safety risk (e.g., running into the street, dangerous driving, or bike riding). The child may be impulsive on a nearly continuous basis. The child endangers self or others without thinking.

55. TEMPERAMENT

This item describes the infant or child's general mood, disposition, or nature. Also rate their ability to be comforted or soothed here.

Questions to Consider

- Is infant generally considered cranky and fussy?
- Can infant or child be consoled or comforted when upset?
- Does the child tantrum in excessive ways?

Ratings and Descriptions

0 No evidence of need; no action needed.

No evidence of temperament problems. Infant or child has an easy temperament and is easily calmed or distracted when angry or upset.

1 History or suspicion of problems; requires monitoring, watchful waiting, or preventive activities.

Infant or child has some mild problems being calmed, soothed, or distracted when angry or upset. They may have occasional episodes of extended crying or tantrums.

2 Problem is interfering with functioning; requires action or intervention to ensure that the need is addressed.

Infant or child has a difficult temperament including difficulty being calmed, soothed, or distracted. Persistent episodes of crying, tantrums, or other difficult behaviors are observed.

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

Infant or child has significant difficulties being calmed, soothed, or distracted when angry or upset. Repeated and extreme persistent episodes of crying, tantrums, or other difficult behaviors are observed when the infant or child is angry or upset.

56. FAILURE TO THRIVE

Symptoms of failure to thrive focus on typical physical development such as growth and weight gain.

Questions to Consider

- Has the infant or child ever been diagnosed with failure to thrive? If so, why?
- Are there any reports indicating the infant or child has had difficulty gaining weight or growing?
- Are there current concerns about the infant's or child's lack of physical growth?
- Is the infant or child significantly under weight?

Ratings and Descriptions

0 No evidence of need; no action needed.

No evidence of failure to thrive. Infant or child does not appear to have any problems with weight gain or growth.

1 History or suspicion of problems; requires monitoring, watchful waiting, or preventive activities.

Infant or child may have experienced past problems with growth and ability to gain weight. Infant or child may presently be experiencing slow development in this area. The infant or child has mild delays in physical development (e.g., is below the 25th percentile in height or weight).

2 Problem is interfering with functioning; requires action or intervention to ensure that the need is addressed.

Infant or child had significant delays in physical development that could be described as failure to thrive (e.g., is below the 10th percentile in terms of height or weight).

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

Infant or child had severe problems with physical development that puts their life at risk (e.g., is at or under the 1st percentile in height or weight).

57. EATING/ELIMINATION

This item rates all dimensions of eating or elimination, including sensory issues related to food. Pica (habitually eating non-food items such as dirt, hair, or rocks) would be rated here if the child is above the age of exploring with their mouth (typically 12 months or older). Toilet training issues would be rated here if they interfere with participation in daycare/school or negatively impact health.

Questions to Consider

- Did the infant or child have any difficulties with breast or formula feeding?
- Did the child have any issues in the transition to solid foods?
- Does the child have issues eating certain types of food based on texture?
- Does the child eat items that are not food?
- Is child known to be a picky eater?
- Does the infant or child have any unusual difficulties with urination or bowel movements?
- Has the child regressed in toilet training?

Ratings and Descriptions

0 No evidence of need; no action needed.

There is no evidence of problems related to eating.

AND/OR

There is no evidence of elimination problems.

1 History or suspicion of problems; requires monitoring, watchful waiting, or preventive activities.

Mild problems with eating that have been present in the past or are currently present some of the time causing mild impairment in functioning.

AND/OR

May have a history of elimination difficulties.

2 Problem is interfering with functioning; requires action or intervention to ensure that the need is addressed.

Moderate problems with eating are present and impair the infant's or child's functioning. Infants may be finicky eaters, spit food or overeat. Infants may have problems with oral motor control. Children may overeat, have few food preferences, and not have a clear pattern of when they eat.

AND/OR

Demonstrates problems with elimination on a consistent basis. This is interfering with their functioning. Infants may completely lack a routine in elimination and develop constipation as a result. Issues with elimination negatively impact at least one life domain for the infant or child and family.

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

Severe problems with eating are present putting the infant or child at risk developmentally. The infant or child and family are very distressed and unable to overcome problems in this area.

AND/OR

Demonstrates significant difficulty with elimination to the extent that infant or child and parent are in significant distress or interventions have failed. Issues negatively impact multiple life domains for the infant or child and family.

58. DEPRESSION

Symptoms associated with depression may include irritability, changes in eating and sleeping, and withdrawal from playing or activities that were once of interest.

Questions to Consider	Ratings and Descriptions	
• Are the caregivers concerned that the infant or child has chronic low mood or irritability? • Has infant or child withdrawn from typical activities and play? • Does the infant or child seem lonely or not interested in others? • Is the infant or child moody, fitful, or withdrawn? • Does the infant or child cry for reasons that aren't clear?	0	No evidence of need; no action needed. No evidence of problems with depression.
	1	History or suspicion of problems; requires monitoring, watchful waiting, or preventive activities. History, suspicion, or evidence of depression associated with a recent negative life event. Brief duration of depression, irritability, or impairment of functioning that does not lead to pervasive avoidance behavior.
	2	Problem is interfering with functioning; requires action or intervention to ensure that the need is addressed. Clear evidence of depression associated with either depressed mood or significant irritability. Depression has interfered significantly in ability to function in at least one life domain.
	3	Problem is dangerous or disabling; requires immediate and/or intensive action. Clear evidence of a debilitating level of depression that significantly impacts infant's or child's ability or desire to function in any life domain. This may include a child who stays at home or in bed all day due to depression or whose emotional symptoms prevent any participation in school, friendship groups, or family life.

Supplemental information: Depression is a disorder that is thought to affect about 5% of the general population of the United States. It appears to be equally common in adolescents and adults. It might be somewhat less common among children, particularly young children. The main difference between depression in children and adolescents and depression in adults is that among children and adolescents it is thought that depression is as likely to come with an irritable mood as a depressed mood. In adults, a depressed mood is a cardinal symptom of depression.

Specific information to consider regarding depression in infants and young children:

Action Level '1': Infants may appear to be withdrawn and slow to engage or may express emotions in a muted way during the day. Older children may be irritable or do not demonstrate a range of emotions.

Action Level '2': Infants demonstrate a change from previous behavior and appear to have flat emotions with little responsiveness to interaction most of the time. Older children may have negative verbalizations, dark themes in play, and demonstrate little enjoyment in play and interactions.

Action Level '3': This would include a child who stays at home or in bed all day due to depression or one whose emotional symptoms prevent any participation in school, friendship groups, or family life. Clear evidence of disabling level of depression that makes it virtually impossible for the child to function in any life domain.

59. ANXIETY

Symptoms associated with anxiety may include excessive fear, nervousness, worry, avoidance, and panic attacks. Panic attacks can be a prominent type of fear response.

Questions to Consider

- Does the infant or child have any problems with anxiety or fearfulness?
- Is the infant or child avoiding typical activities out of fear?
- Does the infant or child act frightened or afraid?
- Does the child worry a lot?
- Is the infant or child easily startled or jumpy?
- Does the child's anxiety keep them for participating in daycare or school?

Ratings and Descriptions

0	No evidence of need; no action needed. No evidence of anxiety symptoms.
1	History or suspicion of problems; requires monitoring, watchful waiting, or preventive activities. There is a history, suspicion, or evidence of mild anxiety associated with a recent negative life event. This level is used to rate either a mild phobia or anxiety problem that is not markedly impairing functioning or causing distress.
2	Problem is interfering with functioning; requires action or intervention to ensure that the need is addressed. Clear evidence of anxiety associated with either anxious mood or significant fearfulness. Anxiety has interfered in the infant's or child's ability to function in at least one life domain.
3	Problem is dangerous or disabling; requires immediate and/or intensive action. Clear evidence of a debilitating level of anxiety that significantly impacts an infant's or child's ability and/or desire to function in any life domain.

Supplemental information: Symptoms of Generalized Anxiety Disorder include excessive worrying associated with restlessness, being easily fatigued, difficulty concentrating, irritable mood, muscle tension, sleep disturbance, worry not about other psychiatric conditions, or anxiety or worry causes significant impairment of functioning or distress.

Specific information to consider regarding depression in infants and young children:

Rating '1': An infant may appear anxious in certain situations but has the ability to be soothed. Children may appear in need of extra support to cope with some situations but are able to be calmed.

Rating '2': Infants may be irritable, over reactive to stimuli, have uncontrollable crying and significant separation anxiety. Children may have all of the above with persistent reluctance or refusal to cope with some situations.

60. ATYPICAL BEHAVIORS

This item rates whether the infant or 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 of age, head banging, smelling objects, spinning, twirling, hand flapping, finger-flicking, rocking, toe walking, staring at lights, or repetitive verbalizations.

Questions to Consider

- Does the infant or child have any unusual or odd behaviors that are concerning (especially repetitive behaviors that stand out)?
- Has anyone ever expressed concern about the infant's or child's behaviors (e.g., teacher commenting that child spins in corners or other children making fun of child for unusual actions)?
- Does the child repeat words or obsess over objects?
- Does the child spin, flick fingers, or flap their hands?

Ratings and Descriptions

0 No evidence of need; no action needed.

No evidence of atypical behaviors.

1 History or suspicion of problems; requires monitoring, watchful waiting, or preventive activities.

History or atypical behaviors reported by caregivers or familiar individuals that may have mild or occasional interference in the infant's or child's functioning.

2 Problem is interfering with functioning; requires action or intervention to ensure that the need is addressed.

Atypical behaviors generally noticed by unfamiliar individuals that have notable interference in the infant's child's functioning.

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

Atypical behaviors are consistently present and interfere with the infant's or child's functioning on a regular basis.

61. SERVICE PERMANENCE

This is intended to describe the stability of the service providers who have worked with the infant or child or family. Service providers include caseworker, mental health provider, medical provider, dental provider, substitute caregiver (does not include respite care), and daycare/preschool providers.

Questions to Consider

- Has the infant or child changed daycare providers?
- Is the infant or child seeing a new medical provider?
- Does the infant or child have a new caseworker?
- Has the infant or child had multiple foster parents?

Ratings and Descriptions

0 No evidence of need; no action needed.

No evidence of issues with service permanence. Service providers have been consistent for more than the past two years or there are no issues with service permanence. This level is also used to rate an infant or child and family who is initiating services for the first time or re-initiating services after an absence from services of at least one year.

1 History or suspicion of problems; requires monitoring, watchful waiting, or preventive activities.

History, suspicion of, or evidence of some problems with service permanence. Service providers have been consistent for at least one year, but changes occurred during the prior year.

2 Problem is interfering with functioning; requires action or intervention to ensure that the need is addressed.

At least one service provider has changed in the past year.

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

Service providers have changed multiple times during the past year.

Appendices

(1) Data Entry Guide for OR-KIDS Users

(2) Supplemental Information on Life Domain Functioning

- Table 1. Developmental Health Watch: Possible Delays; Potential Signs of Delay at Later Stages
- Table 2. Sensory Milestones; Infants
- Table 3. Motor Milestones

Data Entry Guide for OR-KIDS Users

When entering data into OR-KIDS for the *Exposure to Potentially Traumatic/Adverse Childhood Experiences Domain* please use the following scoring:

No (on CANS) = 0 (in OR-KIDS)

Yes (on CANS) = 3 (in OR-KIDS)

CANS:	**No**	**Ø**	**Ø**	**Yes**
OR-KIDS:	**0**	**1**	**2**	**3**

This applies to the *Exposure to Potentially Traumatic/Adverse Childhood Experiences Domain* items below:

15. Sexual abuse
16. Physical abuse
17. Emotional/verbal abuse
18. Neglect
19. Medical trauma
20. Witness to family violence
21. Witness to community/school violence
22. War affected
23. Terrorism affected
24. Witness/victim of criminal activity
25. Parental criminal behavior
26. Disruptions in caregiving/attachment losses

Table 1. Developmental Health Watch: Possible Delays

Age	Normative Sensory Milestones – 1st Year	Potential Signs of Delay
1 Month	• Vision focuses 8 to 12 inches away, e.g., looks at parent's face while feeding • Turns to, and looks longer at black-and-white or high-contrast patterns than other patterns • Hearing appears to be fully mature. Attends and responds to a variety of voices and sounds (loud, moderate, high pitch, low pitch), other than very quiet sounds	• Sucks poorly and feeds slowly • Doesn't blink when shown a bright light • Doesn't focus and follow a nearby object moving side to side • Rarely moves arms and legs; seems stiff
3 Months	• Watches faces intently • Follows moving objects, e.g., will track a toy that you move in front of their face • Recognizes familiar objects & people at a distance, e.g., smiles at a parent walking towards them • Starts using hands and eyes in coordination, e.g., Inspects their hands, watching their movements • Begins to imitate simple cooing sounds	• Doesn't respond to loud sounds • Doesn't notice hands (by two mos.) • Doesn't smile at the sounds of your voice (by two mos.) • Doesn't follow moving objects with their eyes by (two to three mos.)
7 Months	• Distance vision matures, so may notice a parent leaving the room • Ability to track moving objects improves, and can follow a moving toy with both eyes • Can distinguish between lumpy and smooth objects with mouth, so may respond differently to different textures of food; may show preferences	• Seems very stiff, with tight muscles • Seems very floppy, like a rag doll • Reaches with one hand only • Refuses to cuddle
12 Months	• Pays increasing attention to speech, e.g., will babble long strings in response to sentences directed to them by others; takes "turns" in conversations • Responds to simple verbal requests, e.g., "Can you give me that book?" • Finger feeds self items such as cheerios • Looks at correct picture when image is named • Imitates gestures, e.g., waving.	• Does not crawl • Cannot stand when supported • Does not search for objects that are hidden while they watch • Says no single words ("mama" or "dada")

Potential Signs of Delay at Later Stages

Age	Potential Signs of Delay
18 Months	• Cannot walk. • Does not speak at least 15 words
2 Years	• Does not use two-word sentences. • Does not follow simple instructions
3 to 4 Years	• Cannot throw a ball overhand. • Cannot jump in place. • Cannot stack four blocks. • Resists dressing, sleeping, using the toilet

Adapted from: *Caring for Your Baby and Young Child: Birth to Age 5*. 2004. American Academy of Pediatrics. 8 Jan. 2009 <http://www.aap.org/healthtopics/stages.cfm>.

Table 2. Sensory Milestones

Age Range	Sensory Milestone
Ages 8-14 Months	• Can process touch information more efficiently, e.g., will demonstrate reactions to touching different objects/surfaces in recognition of differences (touch of sandpaper and touch of plastic)
Ages 12-19 Months	• Achieves adult sensitivity to bitter tastes, e.g., will grimace when tasting something bitter
Ages 12-22 Months	• Can see about 20/60 level, gradually reaching a norm of 20/25, e.g., recognizes objects near and far, such as a speck of dust on the floor or a familiar person coming down the street

Adapted from: Sensory Development. 2003. Talaris Research Institute. 29 Jan. 2009.

Infants

Age Range	Typical Development Sensory Processing	Signs of Potential Processing Problems
1 – 12 months	• Infant molds to adult holding them	• Infant arches away from adult holding them, avoids cuddling, may prefer being held face out
	• Explores toys by putting them in their mouth	• Avoids putting toys in mouth
	• After 6 months accepts solids and textured foods	• Has difficulty with or rejects solid or textured foods
	• Plays with two hands in the mid-body, moves toys hand to hand	• Only uses one hand to play with toys (after 8 months)
12 – 18 months	• Enjoys touching textures (note: most toddlers do have a brief phase where they avoid messiness)	• Avoids touching textures, messy play, messy finger foods, etc.
	• Accepts various clothing choices	• Has difficulty with new clothes, socks with seams, tags. Won't wear shoes OR always has to wear shoes on grass, sand, etc.
	• Is not excessively frightened of loud noises	• Is very afraid of loud noises like thunder, vacuum cleaners, and sirens.
18 months – 3 years	• Adjusts to various play settings: quiet indoors, active outdoors	• Intense need for active movement: swinging, rocking jumping; OR avoids movement
	• Explores new play equipment with good balance and body control	• Has difficulty getting on and off play equipment; may be clumsy; doesn't like feet off the ground

- Tolerates loud sounds and other unusual stimulation
- Is upset by loud noises, hearing distant sounds others don't notice; has unusual reactions to light, smells, and other sensory experiences

From http://www.hceip.org/Sensory_Observation_Guide.htm

Sensory Processing Issues: Some children have difficulty with taking in information through their senses, due to neurological differences. Some children are hyper-sensitive to sound, sight, touch, or smell, or to all these senses. Not being able to "tune out" or turn down a sensory input like sound can interfere with learning, interactions, and other critical components of healthy development. For other children, the challenge is that they are hypo-sensitive, which means they don't get enough input from sight, sound, smell or touch. They may seek out brighter, louder, smellier, harder/softer stimulation, which again can interfere with learning and relationships. For other children, the challenge is with the feedback their body gets through proprioception (having to do with balance, coordination and special awareness). Here are some examples of typical sensory development and sensory processing issues for young children.

Table 3. Motor Milestones

Age Range	Typical Development Motor Processing
By Age 1 Month	• Makes jerky, quivering arm thrusts • Brings hands within range of eyes and mouth • Moves head from side to side while lying on stomach • Keeps hands in tight fists
By Age 3 Months	• Raises head and chest when lying on stomach • Opens and shuts hands • Pushes down on legs when feet are placed on firm surface • Brings hand to mouth
By Age 7 Months	• Rolls both ways (front to back, back to front) • Sits with, and then without, support of their hands • Supports their whole weight on their legs • Reaches with one hand
By Age 12 Months	• Crawls forward on belly by pulling with arms & pushing with legs • Creeps on hands and knees supporting trunk on hands and knees • Gets from sitting to crawling or prone (lying on stomach) position • Pulls self up to standing position
By Age 2 Years	• Walks alone • Pulls toys behind them while walking • Begins to run • Might use one hand more frequently than the other
By Ages 3 to 4	• Hops and stands on one foot up to five seconds • Kicks ball forward • Copies square shapes • Uses scissors

Adapted from: *Caring for Your Baby and Young Child: Birth to Age 5*. 2004. American Academy of Pediatrics. 8 Jan. 2009 <http://www.aap.org/healthtopics/stages.cfm>.

Table 4. Self-Care Development Chart

Self-Care skills are the everyday tasks undertaken to be ready to participate in life activities (including dressing, eating, cleaning teeth and more). They are often referred to as the activities of daily living (ADL's). While these are typically supported by adults in young children, it is expected that children develop independence in these as they mature.

Age Range	Developmental Milestone	Possible implications if milestones not achieved
0 – 6 months	• Tracking objects with eyes • Coordinating suck, swallow, breath sequence, (tongue is cupped, forward rhythmical movements of the tongue, and jaw consistently moves up and down in a coordinated pattern) • Sleeping for 4-10-hour intervals. • Communicating hunger, fear or discomfort through crying	• May have difficulty with breast feeding • May have difficulties settling to sleep • May cry often
6 – 12 months	• Playing for 2-3 minutes with a single toy • Reaching for nearby objects • Tracking objects with eyes • Sleeping 10-12 hours with only 1 awakening • Tolerating a range of different textured foods • Drinking from a cup • Holding bottle or cup independently • Using tongue to move food around mouth • Feeding self small crackers or other small pieces of food •	• May have difficulties settling and may wake often during the night • May have difficulties socializing with parents and joint attention • May struggle to copy and learn from others due to poor understanding and attention • May have difficulties feeding self • May have difficulties holding onto and drinking from a cup or bottle • May have difficulty tolerating different textured foods
1 – 2 years	• Distinguishing between edible and inedible objects (18 months) • Looking in the right spot for hidden objects • Playing next to children • Imitating adult behavior • Engaging in imaginative play • Has an awareness of a parent's approval or disapproval of their actions • Understanding common dangers of hot objects, stairs, glass • Regularly checking in with adults/caregivers • Tolerating nappy changes • Settling themselves to sleep at	• May have difficulties socializing with parents and joint attention • May struggle to copy and learn from others due to poor understanding and attention • May have delayed play skills (e.g. show little interest in toys) • May have difficulty learning self-care tasks such as brushing teeth and taking off shoes and socks • May have difficulty tolerating different textured foods • May have difficulties settling and may wake often during the night

	night or during the day • Attempting to brush teeth • Knowing where familiar items are kept • Removing own shoes and socks • Cooperating with dressing by extending an arm or leg	
2 – 3 years	• Using toilet with assistance and having daytime control • Having an awareness of a parent's approval or disapproval of their actions • Understanding common dangers of hot objects, stairs, glass • Settling themselves to sleep at night or during the day • Sitting to look at a book independently • Unbuttoning large buttons • Expressing emotions • Tolerating a range of different textured foods • Engaging in imaginative play • Distinguishing between urination and bowel movements, and names them correctly • Using a napkin to wipe face and hands • Feeding self simple meals using a fork or spoon • Taking socks and shoes off • Enjoying/tolerating messy play • Knowing where familiar items are kept • Attempting to brush teeth	• May struggle to copy and learn from others due to poor understanding and attention • May have difficulties following instructions at home/child care • May demonstrate delayed play skills • May demonstrate difficulties with toilet training • May have difficulty tolerating different textured foods (e.g. picky eater) • May demonstrate difficulties feeding self • May demonstrate difficulties learning to undress self. • May have difficulties getting to sleep or sleeping through the night
3 – 4 years	• Having an awareness of a parent's approval or disapproval of their actions • Understanding common dangers of hot objects, stairs, glass • Sitting to look at a book independently • Unbuttoning large buttons • Expressing emotions • Tolerating a range of different textured foods • Engaging in imaginative play • Distinguishing between urination and bowel movements, and names correctly • Using a napkin to wipe face and hands	• May have difficulties socializing with peers • May have delayed play skills • May struggle to copy and learn from others due to poor understanding and attention • May have difficulties following instructions at home, childcare, or kindergarten • May have difficulty tolerating different textured foods (e.g. picky eater) • May have difficulties maintaining attention • May have difficulties with toilet training • May have difficulties with

	• Feeding self simple meals using a fork or spoon • Taking shoes and socks off • Enjoying/tolerating messy play • Knowing where familiar items are kept • Attempting to brush teeth • Feeding self without difficulty • Tolerating different clothing textures, seams, tags etc. • Independently packing items away • Using a napkin to wipe face and hands • Toileting independently • Knowing where familiar items are kept • Dressing and undressing self (only requiring assistance with laces, buttons, and other fasteners in awkward places) • Playing with 2 or 3 children in a group • Brushing teeth independently • Taking turns • Settling themselves to sleep at night or during the day	dressing and feeding • May have difficulties getting to sleep or sleeping through the night
4 – 5 years	• Using a napkin to wipe face and hands • Settling themselves to sleep at night • Independently packing items away • Developing friendships • Expressing emotions • Following rules • Knowing where familiar items are kept • Toileting independently • Choosing weather appropriate clothes • Dressing self independently • Feeding self without difficulty • Taking turns • Playing with 4 or 5 children in a group • Tolerating different clothing textures, seams, tags etc.	• May have difficulties socializing • May have delayed play skills • May struggle to copy and learn from others due to poor understanding and attention • May have difficulties following instructions at home, kindergarten • May have difficulties expressing wants, needs, thoughts and ideas • May have difficulties sitting still • May have difficulty tolerating different textured foods (e.g. picky eater) • May have difficulties with self-care tasks such as dressing, feeding and toileting

5 – 6 years	• Dressing independently • Morning routine at school (putting bag away, swapping readers, putting drink bottle in correct spot) • Feeding self without difficulty • Expressing emotions • Opening lunch boxes, zip lock bags, food packaging • Sitting at a desk, following teacher instruction, and independently doing simple in-class assignments • Tolerating different clothing textures, seams, tags etc. • Coping in busy/noisy environments • Settling independently for sleep • Packing a bag for school or other outings with assistance	• May have difficulties socializing • May have delayed play skills • May have poor attention and concentration • May have difficulties following instructions at home, school • May have difficulties following routines • May have difficulties expressing thoughts and ideas verbally and in written form • May be easily distracted and have difficulty sitting still • May have difficulty tolerating different textured foods (e.g. picky eater) • May demonstrate poor organizational skills. • May demonstrate delayed fine motor skills • May demonstrate difficulties coping in busy environments • May have difficulties with self-care tasks such as dressing, feeding and toileting

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