Standard Comprehensive

FAMILY ADVOCACY AND SUPPORT TOOL

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ACKNOWLEDGEMENTS

A large number of individuals have collaborated in the development of The Family Advocacy and Support Tool (FAST). The FAST is a family-based version of the suite of TCOM tools that include the Child and Adolescent Needs and Strengths (CANS), the Adult Needs and Strengths Assessment (ANSA), and the Readiness Inventory for Successful Employment (RISEmploy).

The original version of the FAST, called the Multi-level Family Assessment, was developed in collaboration with Margaret Nickels, PhD, at the Juvenile Protection Agency in Chicago, Illinois. This tool was further developed into the FAST in collaboration with Susan Furrer, PsyD at Rutgers University and representatives of Family Support Organizations in New Jersey. It has been further refined in various applications in Illinois, New York, Singapore, Tennessee, and Washington. Given this history, a large number of individuals have contributed to the design, development and refinement of the FAST.

With the Standard Comprehensive FAST, we have aligned the tool's ratings scales to the ANSA and CANS. This version separates the caregiver needs items from the caregiver strengths items, and utilizes the needs and strengths scales and action levels similarly to the CANS and ANSA. Additionally, the Caregiver Advocacy & Capacity section introduces a new 5-level skills rating scale, aimed at supporting the development of particular advocacy skills towards mastery. Finally, the items in the caregiver as well as the children's sections are aligned with the ANSA Core 50, the CANS Core 50 and the CANS Early Childhood Core 46 item sets.

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

The FAST is an open domain tool, free for anyone to use. Any list of contributors would likely fall short of crediting everyone how has been involved in the evolution of this work. We recommend training and certification to ensure its proper and reliable use. For specific permission to use, please contact the Praed Foundation. For more information on the FAST contact:

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INTRODUCTION

THE FAST

The Family Advocacy and Support Tool (FAST) is the family version of the Child and Adolescent Needs and Strengths (CANS) family of planning and outcome management tools. The purpose of the FAST is to support effective interventions when the focus of those efforts is on entire families rather than single individuals. Currently, the most common use of the FAST is in efforts to address the needs of families who are at risk of child welfare involvement.

The FAST is a communimetric tool (Lyons, 2009). It is designed to maximize communication about the needs and strengths of families. The FAST includes ratings of the family together, each individual caregiver, and each individual child. Interventions in the family system can be directed at that system or to address the individual needs of family members or dyadic relationships within the family.

HISTORY AND BACKGROUND

The FAST 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 FAST was developed from a communication perspective in order to facilitate the linkage between the assessment process and the design of individualized service plans including the application of evidence-based practices.

The original version of the FAST, called the Multi-level Family Assessment, was developed in collaboration with Margaret Nickels, PhD, at the Juvenile Protection Agency in Chicago, Illinois. Following its initial use in a family therapy program to prevent child abuse and neglect, this tool was further developed into the FAST in collaboration with Susan Furrer, PsyD at Rutgers University and representatives of Family Support Organizations in New Jersey. It has been further refined in various applications in Illinois, New York, Singapore, Tennessee, and Washington. Tennessee was the first state to use the FAST as a component of its pre-custody risk assessment process in child welfare.

The FAST gathers information on the family as a system, and each caregiver and child’s needs and strengths. Strengths are the individual’s assets: areas of life where they are doing well or have an interest or ability. Needs are areas where an individual requires help or serious intervention. Care providers use an assessment process to get to know the individual and families with whom they work and to understand their strengths and needs. The FAST helps care providers decide which of the family’s needs as a whole and each family member’s needs are the most important to address in treatment or action planning. This tool also helps identify strengths, which can be the basis of a treatment plan. By working with the family and its members during the assessment process and talking together about the FAST items, care providers can develop a treatment or action plan that addresses the family and its individual member’s strengths and needs while building strong engagement.

The FAST is made up of domains that focus on various areas in the family’s life and each of its members. Each domain is made up of a group of specific sections that have items. There a section that gathers information about general family concerns. There are also domains that address how the individual family members function in everyday life, specific emotional or behavioral concerns, as well as strengths. The provider, in collaboration with the family and, when available, their treatment team, gives a number rating to each of these items. These ratings help the provider and family understand where intensive or immediate action is most needed, and also where the family and its members have assets that could be a major part of the treatment or action plan.

The FAST ratings, however, do not tell the whole story of the family’s strengths and needs. Each section in the FAST is merely the output of a comprehensive assessment process and is documented alongside narratives, developed by the care provider, family and its members that can provide more information about the family as a whole.
MEASUREMENT PROPERTIES

Note: This section is based on studies of the CANS, except where specifically noted for the FAST.

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. Of the first 426 certified FAST trainees on the Praed collaborative training website, the average reliability was 0.75. These trainees were from 30 different jurisdictions indicating consistent reliability across contexts.

With approved training, anyone with a bachelor’s degree can learn to complete the tool reliably, although some applications or more complex versions of the CANS require a higher educational degree or relevant experience. The average reliability of the CANS is 0.78 with vignettes across a sample of more than 80,000 trainees. The reliability is higher (0.84) with case records, and can be above 0.90 with live cases (Lyons, 2009). The CANS is auditable and audit reliabilities demonstrate that the CANS is reliable at the item level (Anderson et al., 2001). Training and certification with a reliability of at least 0.70 on a test case vignette is required for ethical use. In most jurisdictions, re-certification is annual. A full discussion on the reliability of the CANS assessment is found in Lyons (2009) Communimetrics: A Communication Theory of Measurement in Human Service Settings.

Validity

Studies have demonstrated the FAST’s validity (Chiua, et al, 2019). Items in the FAST have been used in a variety of research that demonstrates the validity of information collected using the communimetric theory (Lyons, 2009). In a sample of more than 1,700 cases in 15 different program types across New York State, the total scores on the relevant dimensions of the CANS-Mental Health retrospectively distinguished level of care (Lyons, 2004). 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 THE ITEMS

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

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

Each FAST rating suggests different pathways for service planning. There are four levels of rating for each item with specific anchored definitions. Like the CANS and ANSA, the majority of the items in the Standard FAST use a 4-level action-level framework with specific definitions for needs and strengths. for its items. These item level definitions, however, are designed to translate into the following action levels:

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<tr>
<td>Rating</td>
</tr>
<tr>
<td>-------</td>
</tr>
<tr>
<td>0</td>
</tr>
<tr>
<td>1</td>
</tr>
<tr>
<td>2</td>
</tr>
<tr>
<td>3</td>
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Basic Design for Rating Strengths

<table>
<thead>
<tr>
<th>Rating</th>
<th>Level of Strength</th>
<th>Appropriate Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>Centerpiece strength</td>
<td>Central to planning</td>
</tr>
<tr>
<td>1</td>
<td>Strength present</td>
<td>Useful in planning</td>
</tr>
<tr>
<td>2</td>
<td>Identified strength</td>
<td>Build or develop strength</td>
</tr>
<tr>
<td>3</td>
<td>No strength identified</td>
<td>Strength creation or identification may be indicated</td>
</tr>
</tbody>
</table>

Items rated a ‘2’ or ‘3’ are “actionable” and should be addressed in the intervention plan.

The rating levels for the Advocacy & Capacity Domain are different from the other domains both in the number of levels and the recommended actions. That is because the Advocacy & Capacity items reflect skills rather than needs or strengths. The ultimate goal of skill development is mastery, but prior to mastery, skills must be acquired and built into our routines. To capture the steps of skill development, a 5-level action rating is used in this section of the FAST.

Basic Design for Rating Advocacy & Capacity Domain Items

<table>
<thead>
<tr>
<th>Rating</th>
<th>Level of Strength</th>
<th>Appropriate Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>Mastery, could teach others.</td>
<td>Maintain mastery.</td>
</tr>
<tr>
<td>1</td>
<td>Comfortable and routine.</td>
<td>Develop mastery.</td>
</tr>
<tr>
<td>2</td>
<td>Comfortable, but not routine.</td>
<td>Build into a routine.</td>
</tr>
<tr>
<td>3</td>
<td>Tried; Not yet comfortable.</td>
<td>Develop comfort.</td>
</tr>
<tr>
<td>4</td>
<td>Have never done.</td>
<td>Try the skill.</td>
</tr>
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</table>

To complete the FAST, a FAST trained and certified care coordinator, case worker, clinician, or other care provider should read and understand the descriptions for each item and then record the appropriate rating on the FAST form (or electronic record).

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 FAST is an information integration tool, intended to include multiple sources of information (e.g., parents/caregivers, children, referral source, treatment providers, and observation of the rater). As a strength-based approach, the FAST supports the belief that 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 families to discover family and individual family members’ functioning and strengths. Failure to demonstrate an individual’s skill should first be viewed as an opportunity to learn the skill as opposed to the problem. Focusing on family’s strengths instead of weaknesses may result in enhanced motivation and improved performance. Involving the 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 FAST and related information as tools (for reaching consensus, planning interventions, monitoring progress, psychoeducation, and supervision) support effective services for families and each individual family member.

As a quality improvement activity, a number of settings have utilized a fidelity model approach to look at case/treatment/action planning based on the FAST assessment. A rating of ‘2’ or ‘3’ on a FAST need suggests that this area must be addressed in the service or treatment plan. A rating of a ‘0’ or ‘1’ identifies a strength that can be
used for strength-based planning and a ‘2’ or ‘3’ a strength that should be the focus on strength-building activities. It is important to remember that when developing service and treatment plans for healthy family 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 individual’s capabilities are a promising means for development, and play a role in reducing risky behaviors.

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

The FAST 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 FAST and share experiences, additional items, and supplementary tools.

SIX KEY PRINCIPLES OF A COMMUNIMETRIC TOOL

The FAST has six key principles that, if remembered, will make the assessment process move more smoothly.

1. **Items impact service planning.** Items were selected because they are each relevant to service/treatment planning. An item exists because it might lead you down a different pathway in terms of planning actions.

2. **Items ratings translate into Action Levels.** Each item uses a four level (’0’-’3’) rating system (five levels for the Advocacy scale). An item rated ‘2’ or ‘3’ requires action. Different action levels exist for needs and strengths (page 5 and 6).

3. **Consider culture and development.** Culture and development must be considered before establishing the action level for each item.

4. **Agnostic as to etiology.** It is descriptive tool. Rate the “what” and not the “why.” The FAST describes what is happening with the individual/family, but does not seek to assign a cause for a behavior or situation.

5. **It’s about the individual/family, not the service.** Ratings should describe the individual/family, not the individual/family in services. If an intervention is present that is masking a need but must stay in place, it is factored into the rating and would result in a rating of an actionable need (i.e., ‘2’ or ‘3’).

6. **Specific ratings window (e.g. 30 days) can be over-ridden based on action levels.** Keep the information fresh and relevant to the individual/family’s present circumstances. Don’t get stuck on 30 days – if the need is relevant and older than 30 days, still use the information. Action levels over-ride time frames – if it requires action and should be on your treatment plan, rate it higher!

HOW IS THE FAST USED?

The FAST is used in many ways to transform the lives of families and to improve the programs and systems that serve them. This guide will help you to also use the FAST as a multi-purpose tool.

IT IS AN ASSESSMENT STRATEGY

When initially meeting families, this guide can be helpful in ensuring that all the information required is gathered. Most items include “Questions to Consider” which may be useful when asking about needs and strengths. These are not questions that must be asked, but are available as suggestions. Many care providers 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.

IT GUIDES CARE AND TREATMENT/ACTION PLANNING

When an item on the FAST is rated a ‘2’ or ‘3’ (‘action needed’ or ‘immediate action needed’) it indicates not only that it is a serious need for our family, but one that we are going to attempt to work on during the course of our
treatment. As such, when you write your treatment plan, you should do your best to address any needs or impacts on functioning that you rate as a ‘2’ or ‘3’ during your assessment process.

**IT FACILITATES OUTCOMES MEASUREMENT**

Many users of the FAST and organizations complete the tool every 6 months to measure change and transformation. We work with individuals and families and their needs tend to change over time. Needs may change in response to many factors including quality clinical support provided. One way we determine how our supports are helping to alleviate suffering and restore functioning is by re-assessing needs, adjusting treatment or service plans, and tracking change.

**IT IS A COMMUNICATION TOOL**

The FAST allows for a shared language to talk with and about our families, creating opportunities for collaboration. Additionally, when a family leaves a treatment program, completing a closing FAST helps in describing progress, measuring ongoing needs and supporting continuity of care decisions by linking recommendations for future care that tie to current needs.

It is our hope that this guide will help you to make the most out of the FAST and guide you in filling it out in an accurate way that helps you make good clinical decisions.

**FAST: A STRATEGY FOR CHANGE**

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

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

Some people may “take off” on a topic. Being familiar with the FAST items can help in having more natural conversations. So, if the family is talking about situations around the father’s anger control and then shift into something like—“you know, he only gets angry when he is drinking,” you can follow that and ask some questions about situational anger, substance use and safety, and then explore other related issues.

**MAKING THE BEST USE OF THE FAST**

To increase family involvement and understanding, it is important to talk to them about the assessment process and describe the FAST and how it will be used. The description of the FAST should include teaching the family about the needs, strengths, and advocacy rating scales, identifying the domains and items, as well as how the actionable items will be used in treatment or serving planning. As a best practice, share with the family the FAST domains and items and encourage the family to look over the items prior to your meeting with them. The best time to do this is your decision—you will have a sense of the timing as you work with each family. Families often feel respected as partners when they are prepared for a meeting or a process. A copy of the completed FAST ratings should be reviewed with each family and they should be encouraged to discuss with you any changes to the ratings, and any items that they feel need more or less emphasis.

**LISTENING USING THE FAST**

Listening is the most important skill that you bring to working with the FAST. 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 a person advice. You may find yourself thinking “if I were this person, I would do X” or “that’s just like my situation, and I did X.” But since you are not that person, what you would do is not particularly relevant. Avoid making judgmental statements or telling them what you would do. It’s not really about you.

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

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

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

REDIRECT THE CONVERSATION TO CAREGIVERS’ OWN FEELINGS AND OBSERVATIONS

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

ACKNOWLEDGE FEELINGS

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

WRAPPING IT UP

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

Take time to summarize with the family those areas of strengths and of needs. Help them to get a “total picture” of the individual and family, and offer them the opportunity to change any ratings. Take a few minutes to talk about what the next steps will be. Now you have information organized into a framework that moves into the next stage—planning.

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 .. .”
REFERENCES


## FAST BASIC STRUCTURE

The Family and Advocacy Support Tool basic items are noted below.

### CORE ITEMS

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<td>Posttraumatic Reactions*</td>
<td>Persistence &amp; Adaptability</td>
</tr>
<tr>
<td>Extended Family Relations</td>
<td><strong>Caregiver Strengths</strong></td>
<td><strong>6-21 Child Functioning</strong></td>
</tr>
<tr>
<td>Natural Supports</td>
<td>Involvement with Caregiving</td>
<td>Social Functioning</td>
</tr>
<tr>
<td>Traditions and Rituals</td>
<td>Emotional Responsiveness</td>
<td>Medical/Physical</td>
</tr>
<tr>
<td><strong>Advocacy &amp; Capacity</strong></td>
<td>Organization</td>
<td>Sleep</td>
</tr>
<tr>
<td>Knowledge of Family-Child Needs</td>
<td></td>
<td>Developmental/Intellectual</td>
</tr>
<tr>
<td>Knowledge of Service Options</td>
<td></td>
<td>Sexual Development</td>
</tr>
<tr>
<td>Know. of Rights &amp; Responsibilities</td>
<td></td>
<td>School</td>
</tr>
<tr>
<td>Ability to Listen</td>
<td></td>
<td>Behavioral/Mental Health Needs*</td>
</tr>
<tr>
<td>Ability to Communicate</td>
<td></td>
<td>Risk Behaviors*</td>
</tr>
<tr>
<td><strong>Cultural Factors</strong></td>
<td></td>
<td>Adjustment to Trauma*</td>
</tr>
<tr>
<td>Language</td>
<td></td>
<td><strong>6-21 Child Strengths</strong></td>
</tr>
<tr>
<td>Cultural Stress</td>
<td></td>
<td>Family Strengths</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Community Life</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Talents and Interests</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Optimism</td>
</tr>
</tbody>
</table>

* Indicates an item that triggers a module.
FAMILY ASSESSMENT

FAMILY FUNCTIONING

This section of the FAST describes how the family is functioning as a system. The very first task of family assessment is to define family membership. In general, it is recommended that the family be allowed to define itself. If for some reason the family is unable to define itself, then for purposes of completing the FAST consider the family as a collection of individuals working together to raise one or more children.

Families typically have a ranking of authority. Generally, the parents, and others responsible for the care of the children, are given greater authority. Children are given more authority over themselves and other children as they mature. The family system is the set of inter-relationships among the family members within the context of their roles and responsibilities in that family. The items of this section should be rated within the context of the entire family as defined above.

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

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

FAMILY CONFLICT

This item refers to how much fighting and arguing occurs between family members. Domestic violence refers to physical fighting in which family members might get hurt.

Ratings and Descriptions

<table>
<thead>
<tr>
<th>Rating</th>
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<tr>
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<tr>
<td>3</td>
<td>Need is dangerous or disabling; requires immediate and/or intensive action.</td>
</tr>
</tbody>
</table>

Questions to Consider

- Does anyone in the family have conflict with one another?

**Supplemental Information:** All families have conflict. Occasional arguments are not only normal but can be healthy if resolved eventually. This level of conflict would be rated a ‘0’. Only when the conflict begins to create notable problems within the family system would a rating of ‘1’ or higher be used.
## FAMILY ROLE APPROPRIATENESS
This item refers to boundaries and hierarchies within the family. Boundaries are the ability of family members to separate themselves as individuals and maintain role-appropriate communication among family members. Hierarchies refer to the organization of decision-making authority in the family.

### Ratings and Descriptions

<table>
<thead>
<tr>
<th>Rating</th>
<th>Description</th>
</tr>
</thead>
</table>
| 0 | **No evidence of any needs; no need for action.**  
Adaptive boundaries. Family has strong appropriate boundaries among members. Clear inter-generational hierarchies are maintained. |
| 1 | **Identified need that requires monitoring, watchful waiting, or preventive action based on history, suspicion or disagreement.**  
Mostly adaptive boundaries. Family has generally appropriate boundaries and hierarchies. May experience some minor blurring of roles. |
| 2 | **Action is required to ensure that the identified need is addressed; need is interfering with functioning.**  
Limited adaptive boundaries. Family has difficulty maintaining appropriate boundaries and/or hierarchies. Some significant role problems exist. |
| 3 | **Need is dangerous or disabling; requires immediate and/or intensive action.**  
Significant difficulties with boundaries. Family has significant problems with establishing and maintaining reasonable boundaries and hierarchies. Significant role confusion or reversals may exist. |

### Questions to Consider
- What are the boundaries like within the family?
- What is the nature of the family hierarchy?

### Supplemental Information:
This item is used to describe when family roles get out of line with healthy development. For example, in some single parent families, particularly when parental mental health or substance use needs are evident, older children step into developmentally-inappropriate parent roles (i.e., the parentified child). This role can place an enormous stress on the development of that child. Sometimes lonely parents will seek friendship and companionship from their children. This can be healthy to a point, but since parents have to maintain their role as supervisor and disciplinarian, too much of a friendship model can be unhealthy, particularly for younger children.
### FAMILY SAFETY
This item refers to the degree to which family members are safe from being injured in the home. This item describes whether individuals in the home present a danger to the child. This item does not describe situations in which caregivers are unable to prevent a child from hurting themselves despite well-intentioned efforts.

<table>
<thead>
<tr>
<th>Rating</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>No evidence of any needs; no need for action. Family provides a safe home environment and the child is not at risk from others.</td>
</tr>
<tr>
<td>1</td>
<td>Identified need that requires monitoring, watchful waiting, or preventive action based on history, suspicion or disagreement. Family home environment is safe, but concerns exist about the safety of the child due to family history or others in the household who present safety concerns.</td>
</tr>
<tr>
<td>2</td>
<td>Action is required to ensure that the identified need is addressed; need is interfering with functioning. Family home environment presents some danger from one or more individuals with access to the household.</td>
</tr>
<tr>
<td>3</td>
<td>Need is dangerous or disabling; requires immediate and/or intensive action. Family home environment presents a clear and immediate risk of harm to the child from one or more individuals.</td>
</tr>
</tbody>
</table>

**Questions to Consider**
- Is the family able to protect the family members from harm in the home?
- Are there individuals living in the home or visiting the home that may be pose risks to the family?

**Supplemental Information:** A family living in a shelter is less safe than a family living in an apartment. A family living in an apartment in which gang members or drug abusers routinely come and go is less safe than a family living in an apartment which no such intrusions. In most cases, risks of domestic violence indicate an immediate/intensive level of need (i.e. ‘3’) on this item.

### FINANCIAL RESOURCES
This item refers to the income and other sources of money available to family members (particularly caregivers) that can be used to address family needs.

<table>
<thead>
<tr>
<th>Rating</th>
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</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>No evidence of any needs; no need for action. Family has financial resources necessary to meet needs.</td>
</tr>
<tr>
<td>1</td>
<td>Identified need that requires monitoring, watchful waiting, or preventive action based on history, suspicion or disagreement. Family has financial resources necessary to meet most needs, but the family has a history of financial hardship or there is reason to believe that mild difficulties might exist.</td>
</tr>
<tr>
<td>2</td>
<td>Action is required to ensure that the identified need is addressed; need is interfering with functioning. Family has moderate financial difficulties that limit their ability to meet significant family needs.</td>
</tr>
<tr>
<td>3</td>
<td>Need is dangerous or disabling; requires immediate and/or intensive action. Family is experiencing significant financial hardship or poverty.</td>
</tr>
</tbody>
</table>

**Questions to Consider**
- Does the family have sufficient funds necessary to meet the family’s needs?

**Supplemental Information:** Similar to the issue described with Family Conflict, few families have as many financial resources as they would like. Fewer still consider themselves as having sufficient resources. So, the ‘0’ level is used to indicate a ‘good enough’ level of financial resources. The family may not be rich, but that have enough money to take care of basic needs.
RESIDENTIAL STABILITY
This item refers to the stability of the family’s housing. This does not refer to the risk of placement outside of the family home for any member of the family.

Ratings and Descriptions

0  No evidence of any needs; no need for action.
   Family has stable housing for the foreseeable future.

1  Identified need that requires monitoring, watchful waiting, or preventive action based on history, suspicion or disagreement.
   Family currently has stable housing; however, the family has a history of housing instability or there is reason to believe that there may be mild difficulties maintaining housing due to things such as difficulty paying rent or utilities or conflict with a landlord.

2  Action is required to ensure that the identified need is addressed; need is interfering with functioning.
   Family has had to move in the past year or will have to move in the near future due to housing difficulties.

3  Need is dangerous or disabling; requires immediate and/or intensive action.
   Family has experienced homelessness in the past six months.

Questions to Consider
- Is the family’s current housing situation stable?
- Are there concerns that they might have to move in the near future?

Supplemental Information: A ‘3’ indicates problems of recent homelessness. A ‘1’ indicates concerns about instability in the immediate future. A family having difficulty paying utilities, rent or a mortgage might be rated as a ‘1’. This item refers exclusively to the housing stability of the caregiver and should not reflect whether the child might be placed outside of the home.
FAMILY STRENGTHS

This section of the FAST describes the assets and resources that can be accessed by the family system. The very first task of family assessment is to define family membership. In general, it is recommended that the family be allowed to define itself.

In addition to the family system’s internal capacity, the assessment can be used to organize information about the family’s external support network (Extended Family Relations, Natural Supports). The focus is on people and institutions that can help to support the family during difficult times and/or strengthen the family system and their ability to manage adversity. The items of this section should be rated within the context of what assets and resources can be utilized, strengthened or developed in relation to the overall goals for the family system.

For the Family Strengths Domain, the following categories and action levels are used:

- **0** Well-developed, centerpiece strength; may be used as a focus of an intervention/action plan.
- **1** Identified and useful strength. Strength will be used, maintained or built upon as part of the plan. May require some effort to develop strength into a centerpiece strength.
- **2** Strengths have been identified but require strength-building efforts before they can be effectively utilized as part of a plan. Identified but not useful.
- **3** An area in which no current strength is identified; efforts may be recommended to develop a strength in this area.

FAMILY SOCIAL IDENTITY

This item describes a central, shared and guiding worldview that is inclusive of family cultural and/or ethnic identity. Signs of family social identity include a shared feeling of belonging and pride in ethnic group(s), a strong shared family narrative that includes knowledge of family history (how we got through, etc.) and a shared guiding narrative about values and expectations that is reflected in how families talk about their history. Families members share positive belief systems associated with their ability to band together to overcome adversity.

Ratings and Descriptions

- **0** Well-developed, centerpiece strength; may be used as a centerpiece in an intervention/action plan.
  
  Family has a strong social identity. The family’s consistent and coherent view of itself as a family is a powerful organizing factor for the family. There is unanimity in the family of the importance of the family in all family member’s lives.

- **1** Identified and useful strength. Strength will be used, maintained or built upon as part of the plan. May require some effort to develop strength into a centerpiece strength.
  
  Family has a social identity. There is a consistent feeling among all family members that the family has a unique identity. There is a consistent recognition that the family is relevant in all family member’s lives.

- **2** Strengths have been identified but require strength-building efforts before they can be effectively utilized as part of a plan. Identified but not useful.
  
  At least one member of the family has a sense of a family social identity. However, this sense is not consistent across family members.

- **3** An area in which no current strength is identified; efforts may be recommended to develop a strength in this area.
  
  No evidence that family has a family social identity. There does not appear to be a coherent and consistent view of itself as a family unit among any members of the family.
**PARENTAL/CAREGIVER COLLABORATION**

This item refers to the relationship between parents (or other primary caregivers) and the skills related to working together in child-rearing activities.

### Ratings and Descriptions

<table>
<thead>
<tr>
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<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td><strong>Well-developed, centerpiece strength; may be used as a centerpiece in an intervention/action plan.</strong> Adaptive collaboration. Parents can work together regarding family issues and issues of the development and well-being of the child(ren). They are able to negotiate disagreements and work on challenges together.</td>
</tr>
<tr>
<td>1</td>
<td><strong>Identified and useful strength. Strength will be used, maintained or built upon as part of the plan. May require some effort to develop strength into a centerpiece strength.</strong> Mostly adaptive collaboration. Generally good parental collaboration. While there may be occasional difficulties negotiating, or miscommunications and misunderstandings, the caregivers are able to resolve these issues and remain focused on the well-being of the child(ren).</td>
</tr>
<tr>
<td>2</td>
<td><strong>Strengths have been identified but require strength-building efforts before they can be effectively utilized as part of a plan. Identified but not useful.</strong> Caregivers need supports to strengthen the communication and collaboration skills of the caregiving system.</td>
</tr>
<tr>
<td>3</td>
<td><strong>An area in which no current strength is identified; efforts may be recommended to develop a strength in this area.</strong> Caregivers cannot currently manage family disagreements, effectively communicate about supporting the child(ren)’s well-being and develop shared approaches to parenting.</td>
</tr>
</tbody>
</table>

### Questions to Consider

- How do caregivers handle disagreements between each other as they relate to parenting?
- How well do caregivers communicate?

### Supplemental Information

Families that do not have two parents can also have caregiving alliances. Anytime more than one caregiver is involved in a family, the degree to which the caregivers work together in support of each other is an important family characteristic. Divorced parents can maintain good collaborations in their efforts to parent their shared children despite living separate adult lives.
## RELATIONS AMONG SIBLINGS
This item refers to how the children in the family (brothers and sisters as well as step-siblings, half-siblings and foster siblings) get along with each other.

<table>
<thead>
<tr>
<th>Questions to Consider</th>
<th>Ratings and Descriptions</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Describe the relationship among the siblings.</td>
<td>0  <strong>Well-developed, centerpiece strength; may be used as a centerpiece in an intervention/ action plan. Adaptive relationships. Siblings generally get along well and have a supportive relationship. They can identify their siblings’ emotional needs and are responsive to those needs.</strong></td>
</tr>
<tr>
<td>• How do the siblings currently handle disagreements?</td>
<td>1  <strong>Identified and useful strength. Strength will be used, maintained or built upon as part of the plan. May require some effort to develop strength into a centerpiece strength.</strong> Mostly adaptive relationships. Siblings generally get along and there is a healthy and supportive relationship among siblings. Siblings will have the occasional disagreement or fight that they are able to resolve.</td>
</tr>
<tr>
<td>• How does the sibling respond if they recognize their sibling is facing a challenge?</td>
<td>2  <strong>Strengths have been identified but require strength-building efforts before they can be effectively utilized as part of a plan. Identified but not useful.</strong> Siblings need support to further develop a healthy and supportive sibling relationship. Siblings generally attempt to resolve any disagreements or fights but often rely on supports to do so.</td>
</tr>
<tr>
<td></td>
<td>3  <strong>An area in which no current strength is identified; efforts may be recommended to develop a strength in this area.</strong> No evidence that siblings currently have a healthy and supportive relationship.</td>
</tr>
</tbody>
</table>

**Supplemental Information:** This item is rated based on whether any problems exist that require intervention. Thus a ‘2’ could be used even in circumstances where the sibling problems just involve a relationship between two children in a much larger sibling group.
EXTENDED FAMILY RELATIONS
This item refers to the family’s relationship with other relatives who do not currently live with the family but do live in the same geographic area. This can include relatives who are not blood relatives (e.g., related by marriage).

Questions to Consider
• Does extended family play a role with the family?
• What are the relationships like between the family members and the extended family?

Ratings and Descriptions

0  Well-developed, centerpiece strength; may be used as a centerpiece in an intervention/action plan.
Extended family members play a central role in the functioning and well-being of the family. They have predominately positive relationships with members of the extended family and conflicts are resolved quickly.

1  Identified and useful strength. Strength will be used, maintained or built upon as part of the plan. May require some effort to develop strength into a centerpiece strength.
Extended family members play a supportive role in family functioning. They generally have positive relationships with members of the extended family. Conflicts may linger but eventually are resolved.

2  Strengths have been identified but require strength-building efforts before they can be effectively utilized as part of a plan. Identified but not useful.
Extended family members can be identified but are currently marginally involved in the functioning and well-being of the family.

3  An area in which no current strength is identified; efforts may be recommended to develop a strength in this area.
Family either does not have extended family or current relationships are not positive and/or supportive.

Supplemental Information: A family who has recently immigrated to the United States may be estranged from their extended family simply because of geographic distance. This estrangement can be stressful and would be rated in this item.
NATURAL SUPPORTS
This item rates the level of support that the family can access from unpaid others. This item generally excludes immediate and extended family as well as professionals who provide support as a part of their role.

Ratings and Descriptions

0   Well-developed, centerpiece strength; may be used as a centerpiece in an intervention/action plan.
    Family has substantial natural supports to assist in addressing most family and child needs.

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

2   Strengths have been identified but require strength-building efforts before they can be effectively utilized as part of a plan. Identified but not useful.
    Family has limited natural supports. Natural supports can be identified but they are not currently supportive.

3   An area in which no current strength is identified; efforts may be recommended to develop a strength in this area.
    No evidence of natural supports or family has no natural supports.

Questions to Consider

- Does the family have friends, connections from community groups (e.g., church, volunteer group, book club, mothers’ group), or others who provide support?
- Can the family call on this support network to help in times of need?

Supplemental Information: The existing body of research in system of care indicates that this is the single hardest aspect of wraparound philosophy to develop. However, it is also one of the most powerful aspects of intensive community-based intervention. The concept of natural supports comes from the African parable that ‘it takes a village’ to raise a child. Paid individuals only count as natural supports if it is someone who would remain involved with the family even if they were not receiving a check.
### TRADITIONS AND RITUALS

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

<table>
<thead>
<tr>
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</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td><strong>Well-developed, centerpiece strength; may be used as a centerpiece in an intervention/action plan.</strong> Family consistently practices their chosen traditions and rituals consistent with their cultural identity.</td>
</tr>
<tr>
<td>1</td>
<td><strong>Identified and useful strength. Strength will be used, maintained or built upon as part of the plan. May require some effort to develop strength into a centerpiece strength.</strong> Family generally practices their chosen traditions and rituals consistent with their cultural identity; however, they sometimes experience some obstacles to the performance of these practices.</td>
</tr>
<tr>
<td>2</td>
<td><strong>Strengths have been identified but require strength-building efforts before they can be effectively utilized as part of a plan. Identified but not useful.</strong> Family experiences significant barriers and are sometimes prevented from practicing their chosen traditions and rituals consistent with their cultural identity.</td>
</tr>
<tr>
<td>3</td>
<td><strong>An area in which no current strength is identified; efforts may be recommended to develop a strength in this area.</strong> Family is unable to practice their chosen traditions and rituals consistent with their cultural identity.</td>
</tr>
</tbody>
</table>

#### Questions to Consider
- What holidays does the family celebrate?
- What traditions are important to the family?
- Does the family fear discrimination for practicing their traditions and rituals?
ADVOCACY & CAPACITY

In Transformational Collaborative Outcomes Management (TCOM), access to care is not an outcome. In fact, we have not been successful helping people until we are able to say goodbye and people are able to help themselves. Therefore, developing the family’s capacity to successfully advocate for themselves is an important part of our work. This section describes the family’s advocacy skills along with their level of satisfaction with the level of services/interventions they are receiving. The indicated advocacy skills may be characteristic of one person in the family rather than of all family members or even of all caregivers. For example, if any family member is knowledgeable about service options, then that is an identified area of skill. Likewise, a lack of knowledge about service options by a family member responsible for finding services/supports would be an area of skill development.

**Please Note:** The rating levels for these items are different from the other items both in the number of levels and the recommended actions. That is because these items reflect skills rather than needs or strengths. The ultimate goal of skill development is mastery, but prior to mastery, skills must be acquired and built into our routines. To capture the steps of skill development, a 5-level action rating is used in this section of the FAST.

<table>
<thead>
<tr>
<th>Skill Rating</th>
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</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>Mastery, could teach others. Maintain mastery.</td>
</tr>
<tr>
<td>1</td>
<td>Comfortable and routine. Develop mastery.</td>
</tr>
<tr>
<td>2</td>
<td>Comfortable, but not routine. Build into a routine.</td>
</tr>
<tr>
<td>3</td>
<td>Tried; Not yet comfortable. Develop comfort.</td>
</tr>
<tr>
<td>4</td>
<td>Have never done. Try skill.</td>
</tr>
</tbody>
</table>

For the **Advocacy & Capacity Domain**, use the following skill ratings:

For the items in this section, rate the highest level of skill.

**KNOWLEDGE OF FAMILY AND CHILD NEEDS**

This item refers to the caregiver’s ability to recognize the needs of the family and individual family members.

**Questions to Consider**

- Does the caregiver understand what types of service options are available to their family?
- Is the caregiver able to identify the needs of the family? Of the individual family members?
- Is the caregiver’s lack of understanding of the family’s needs interfering with the family’s functioning?

**Ratings and Descriptions**

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</tbody>
</table>

**Supplemental Information:** A family who is pushing for the residential placement of a child when that child’s needs are not sufficiently complex to warrant out-of-community treatment would be rated a ‘3’ on this item.
KNOWLEDGE OF SERVICE OPTIONS
This item refers to the choices the family might have for specific treatments, interventions or other services that might help the family address their needs or the needs of one of the family’s members.

Ratings and Descriptions

0  Mastery, could teach others. Maintain mastery.
   The caregiver has a strong understanding of service options.

1  Comfortable and routine. Develop mastery.
   The caregiver has an understanding of service options, but may require some help in learning about certain aspects of these services or there is a history of caregiver lack of understanding of service options.

2  Comfortable, but not routine. Build into a routine.
   The caregiver sometimes understands service options, but occasionally still needs assistance to understand available service options.

3  Tried; Not yet comfortable. Develop comfort.
   The caregiver requires some assistance in identifying and understanding service options.

4  Have never done. Try skill.
   The caregiver requires substantial assistance in identifying and understanding service options.

Supplemental Information: A family who is pushing for the residential placement of a child when that child’s needs are not sufficiently complex to warrant out of community treatment would be described on this item.

KNOWLEDGE OF RIGHTS & RESPONSIBILITIES
This item refers to the caregiver’s ability to understand and acknowledge the legal and societal expectations and responsibilities of their caregiver roles.

Ratings and Descriptions

0  Mastery, could teach others. Maintain mastery.
   The caregiver has a strong understanding of rights and responsibilities.

1  Comfortable and routine. Develop mastery.
   The caregiver has an understanding of rights and responsibilities, but may require some help in learning about certain aspects of these rights and responsibilities or there is a history of caregiver lack of understanding of rights and responsibilities.

2  Comfortable, but not routine. Build into a routine.
   The caregiver sometimes understands rights and responsibilities, but occasionally still needs assistance to understand some rights and responsibilities.

3  Tried; Not yet comfortable. Develop comfort.
   The caregiver requires some assistance in identifying and understanding rights and responsibilities.

4  Have never done. Try skill.
   The caregiver requires substantial assistance in identifying and understanding rights and responsibilities.

Supplemental Information: Lack of mastery, or action at any level, should be addressed primarily using educational resources.
**ABILITY TO LISTEN**
This item refers to the caregiver’s ability to hear both positive and negative feedback about themselves and family members. This item would include the caregiver asking clarifying questions.

<table>
<thead>
<tr>
<th>Questions to Consider</th>
<th>Ratings and Descriptions</th>
</tr>
</thead>
</table>
| **Is the caregiver able to listen and understand news regarding their family?** | 0  *Mastery, could teach others. Maintain mastery.*  
The caregiver is able to listen carefully and understand both good and bad news regarding family and child issues. |
| 1  *Comfortable and routine. Develop mastery.*  
The caregiver has generally effective listening skills but sometimes struggles to hear either good or bad news regarding family and child issues. |
| 2  *Comfortable, but not routine. Build into a routine.*  
The caregiver sometimes listens effectively, but occasionally still needs help to listen effectively. |
| 3  *Tried; Not yet comfortable. Develop comfort.*  
The caregiver requires some help to learn to listen effectively. |
| 4  *Have never done. Try skill.*  
The caregiver requires substantial help to learn to listen effectively. |

**Supplemental Information:** Listening can be extremely difficult when you are hearing your child described in a negative light. However, it is an important skill to sit and listen even when the news is hard to take and even when you are convinced that the person speaking is absolutely wrong. Talking over people or not letting people finish their thoughts becomes problematic when it comes your turn to speak.
ABILITY TO COMMUNICATE
This item refers to the caregiver’s ability to effectively describe their needs and the needs of other family members in a manner that others can understand.

Ratings and Descriptions

0  **Mastery, could teach others. Maintain mastery.**
   The caregiver is able to express feelings and thoughts effectively with regard to family and child issues. Others hear, understand, and respond.

1  **Comfortable and routine. Develop mastery.**
   The caregiver is generally able to express feelings and thoughts effectively but sometimes struggles to express them in a way that others can listen and/or understand.

2  **Comfortable, but not routine. Build into a routine.**
   The caregiver sometimes expresses feelings and thoughts effectively with regard to family and child issues, but occasionally still needs help to learn to express feelings and thoughts effectively.

3  **Tried; Not yet comfortable. Develop comfort.**
   The caregiver requires some help to learn to express feelings and thoughts effectively with regard to family and child issues.

4  **Have never done. Try skill.**
   The caregiver requires substantial help to learn to express feelings and thoughts effectively with regard to family and child issues.

**Supplemental Information:** The FAST can be seen as a strategy to help develop exactly what family leadership needs to communicate to the system so that their family’s needs are effectively addressed. Teaching parents and family leaders to be able to communicate effectively with professionals is an important goal in advocacy development.
CULTURAL FACTORS

These items identify linguistic or cultural issues for which service providers need to make accommodations (e.g., provide interpreter, finding therapist who speaks family’s primary language, and/or ensure that a family has the opportunity to participate in cultural rituals associated with their cultural identity). Items in the Cultural Factors Domain describe difficulties that families may experience or encounter as a result of their membership in any cultural group, and/or because of the relationship between members of that group and members of the dominant society. The cultural issues in this domain should be considered in relation to the impact they are having on the life of the individuals within the family.

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

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

LANGUAGE

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

Questions to Consider

- What language does the family speak at home?
- Is there a child interpreting for the family in situations that may compromise the child or family’s care?
- Does the child or significant family members have any special needs related to communication (e.g., ESL, ASL, Braille, or assisted technology)?

Ratings and Descriptions

0  No evidence of any needs; no need for action.
   No evidence that there is a need or preference for an interpreter and/or the family speaks and reads the primary language where they live.

1  Identified need that requires monitoring, watchful waiting, or preventive action based on history, suspicion or disagreement.
   Family speaks or reads the primary language where they live, but potential communication problems exist because of limited vocabulary or comprehension of the nuances of the language.

2  Action is required to ensure that the identified need is addressed; need is interfering with functioning.
   Significant family members do not speak the primary language where the family lives. Translator or family’s native language speaker is needed for successful intervention; a qualified individual(s) can be identified within natural supports.

3  Need is dangerous or disabling; requires immediate and/or intensive action.
   Significant family members do not speak the primary language where the family lives. Translator or family’s native language speaker is needed for successful intervention; no such individual is available from among natural supports.
CULTURAL STRESS
This item identifies circumstances in which the family’s cultural identity is met with hostility or other problems within their environment due to differences in attitudes, behavior, or beliefs of others (this includes cultural differences that are causing stress between the child and their family). Racism, negativity toward sexual orientation, gender identity and expression (SOGIE) and other forms of discrimination would be rated here.

Ratings and Descriptions

Questions to Consider

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

0  **No evidence of any needs; no need for action.**
   No evidence of stress between the family’s cultural identity and current environment or living situation.

1  **Identified need that requires monitoring, watchful waiting, or preventive action based on history, suspicion or disagreement.**
   Some mild or occasional stress resulting from friction between the family’s cultural identity and current environment or living situation.

2  **Action is required to ensure that the identified need is addressed; need is interfering with functioning.**
   Family is experiencing cultural stress that is causing problems of functioning in at least one life domain. Family needs support to learn how to manage culture stress.

3  **Need is dangerous or disabling; requires immediate and/or intensive action.**
   Family is experiencing a high level of cultural stress that is making functioning in any life domain difficult under the present circumstances. Family needs immediate plan to reduce culture stress.
CAREGIVER ASSESSMENT

This section describes the individual strengths and needs of each of the parents and/or caregivers in the family. These are the adults in the family who have been identified as having some responsibility for helping raise the children in the family. A single parent household with no other adults would have one caregiver. However, if two single parent households (e.g. divorced parents) share custody or caregiving responsibilities, then two caregivers would be rated (i.e. one in each household). Adults in the family with no caregiving responsibilities are not rated here. For example, if the elderly mother of one of the parents lives with them but has no role in taking care of the children, she would not be included. Alternatively, in a multigenerational family in which the grandmother is an active caregiver, the grandmother would be included in the ratings of caregivers.

CAREGIVER NEEDS

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

<table>
<thead>
<tr>
<th>Rating</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>No evidence of any needs; no need for action.</td>
</tr>
<tr>
<td>1</td>
<td>Identified need that requires monitoring, watchful waiting, or preventive action based on history, suspicion or disagreement.</td>
</tr>
<tr>
<td>2</td>
<td>Need is interfering with the provision of care; action is required to ensure that the identified need is addressed.</td>
</tr>
<tr>
<td>3</td>
<td>Need prevents the provision of care; requires immediate and/or intensive action.</td>
</tr>
</tbody>
</table>

MONITORING
This item refers to the success with which the caregiver is able to monitor children in their care. This item should be rated consistent with the developmental needs of the child.

Questions to Consider

- Does the caregiver provide consistent supervision to the children?
- Does the caregiver think they need some help with these issues?

Ratings and Descriptions

0  
No evidence of any needs; no need for action. 
There is no evidence that the caregiver has difficulties monitoring the children in their care. The caregiver demonstrates consistent ability to monitor children in their care according to their developmental needs.

1  
Identified need that requires monitoring, watchful waiting, or preventive action based on history, suspicion or disagreement. 
The caregiver demonstrates generally good ability to monitor children in their care but some problems may occur occasionally or there is a history of inadequate monitoring.

2  
Need is interfering with the provision of care; action is required to ensure that the identified need is addressed. 
The caregiver has difficulty maintaining an appropriate level of monitoring of children in their care.

3  
Need prevents the provision of care; requires immediate and/or intensive action. 
The caregiver has significant problems maintaining any monitoring of children in their care.
**KNOWLEDGE**

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

**Questions to Consider**

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

**Ratings and Descriptions**

0  **No evidence of any needs; no need for action.**
   No evidence of caregiver knowledge issues. Caregiver is fully knowledgeable about the child’s psychological strengths and weaknesses, talents and limitations.

1  **Identified need that requires monitoring, watchful waiting, or preventive action based on history, suspicion or disagreement.**
   Caregiver, while being generally knowledgeable about the child, has some mild deficits in knowledge or understanding of the child’s psychological condition, talents, skills and assets.

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

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

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**BOUNDARIES**

This item refers to the caregiver’s ability to maintain appropriate boundaries. This item may include physical separation, respecting privacy, and preventing children from being exposed to developmentally-inappropriate information.

**Questions to Consider**

- What is the nature of the caregiver’s boundaries in relation to others?
- Does the caregiver have any difficulties in maintaining their boundaries? Or are the caregiver’s boundaries overly rigid?

**Ratings and Descriptions**

0  **No evidence of any needs; no need for action.**
   Adaptive boundaries. Caregiver has strong, appropriate boundaries between themselves and their children.

1  **Identified need that requires monitoring, watchful waiting, or preventive action based on history, suspicion or disagreement.**
   Mostly adaptive boundaries. Caregiver has generally appropriate boundaries between themselves and their children. Mild boundary violations may occur at times. Minor problems of rigidity of boundaries may occur.

2  **Need is interfering with the provision of care; action is required to ensure that the identified need is addressed.**
   Limited adaptive boundaries. Caregiver has problems maintaining appropriate boundaries between themselves and their children. Mild boundary violations may be routine or significant boundary violations may be occasional. Boundaries may be rigid.

3  **Need prevents the provision of care; requires immediate and/or intensive action.**
   Significant difficulties with boundaries. Caregiver has significant and consistent problems maintaining appropriate boundaries between themselves and their children or is excessively rigid in their boundaries.

**Supplemental Information:** A parent who confides their secrets to the children is violating boundaries. A parent who tells the children about how badly the other parent treats them (e.g. infidelity) is violating boundaries. A parent who cannot stop a child from entering the bathroom on them is experiencing problems with boundaries.
DISCIPLINE
Discipline refers to the caregiver’s ability to encourage positive behaviors by children in their care through the use of a variety of different techniques including, but not limited to, praise, redirection, and punishment.

Questions to Consider
- Is the caregiver able to provide appropriate limits to the children?
- Does the caregiver provide appropriate support to the child to meet the caregiver’s expectations?
- Does the caregiver think they need some help with these issues?

Ratings and Descriptions
0  No evidence of any needs; no need for action.
   There is no evidence that the caregiver has difficulty with discipline. The caregiver generally demonstrates the ability to discipline children in their care in a consistent and benevolent manner. They usually are able to set age-appropriate limits and to enforce them.

1  Identified need that requires monitoring, watchful waiting, or preventive action based on history, suspicion or disagreement.
   The caregiver is often able to set age-appropriate limits and to enforce them. On occasion their interventions may be either too harsh or too lenient but at other times their expectations of children in their care may be too high or too low, or there is a history of inappropriate discipline.

2  Need is interfering with the provision of care; action is required to ensure that the identified need is addressed.
   The caregiver demonstrates limited ability to discipline children in their care in a consistent and benevolent manner. They are rarely able to set age-appropriate limits and to enforce them. Their interventions may be erratic and overly harsh but not physically harmful. Their expectations of children in their care are frequently unrealistic.

3  Need prevents the provision of care; requires immediate and/or intensive action.
   The caregiver disciplines children in their care in an unpredictable fashion. There is either an absence of limit setting and disciplinary interventions or the limit setting and disciplinary interventions are rigid, extreme, or physically harmful.

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

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

Ratings and Descriptions
0  No evidence of any needs; no need for action.
   No evidence of medical or physical health problems. Caregiver is generally healthy.

1  Identified need that requires monitoring, watchful waiting, or preventive action based on history, suspicion or disagreement.
   There is a history or suspicion of, and/or caregiver is in recovery from medical/physical problems.

2  Need is interfering with the provision of care; action is required to ensure that the identified need is addressed.
   Caregiver has medical/physical problems that interfere with the capacity to provide care for the child.

3  Need prevents the provision of care; requires immediate and/or intensive action.
   Caregiver has medical/physical problems that make providing care for the child impossible at this time.
MENTAL HEALTH*
This item refers to any serious mental health issues (not including substance abuse) among caregivers that might limit their capacity for parenting/caregiving to the child.

Ratings and Descriptions

<table>
<thead>
<tr>
<th>Rating</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>No evidence of any needs; no need for action. No evidence of caregiver mental health difficulties.</td>
</tr>
<tr>
<td>1</td>
<td>Identified need that requires monitoring, watchful waiting, or preventive action based on history, suspicion or disagreement. There is a history or suspicion of mental health difficulties, and/or caregiver is in recovery from mental health difficulties.</td>
</tr>
<tr>
<td>2</td>
<td>Need is interfering with the provision of care; action is required to ensure that the identified need is addressed. Caregiver’s mental health difficulties interfere with their capacity to parent.</td>
</tr>
<tr>
<td>3</td>
<td>Need prevents the provision of care; requires immediate and/or intensive action. Caregiver has mental health difficulties that make it impossible to parent the child at this time.</td>
</tr>
</tbody>
</table>

Questions to Consider
- Does the caregiver have any mental health needs?
- Are the caregiver’s mental health needs interfering with their functioning?

*A rating of ‘1,’ ‘2,’ or ‘3’ on this item triggers the completion of the [A] Mental Health Module.

[A] MENTAL HEALTH MODULE
The items in this module focus on identifying mental health needs. This module is to be completed when the Mental Health item is rated ‘1,’ ‘2’ or ‘3.’

MH1. PSYCHOSIS (THOUGHT DISORDER)
This item rates the symptoms of psychiatric disorders with a known neurological base, including schizophrenia spectrum and other psychotic disorders.

Ratings and Descriptions

<table>
<thead>
<tr>
<th>Rating</th>
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</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>No evidence of psychotic symptoms. Both thought processes and content are within normal range.</td>
</tr>
<tr>
<td>1</td>
<td>Evidence of disruption in thought processes or content. Individual may be somewhat tangential in speech or evidence somewhat illogical thinking (age-inappropriate). This also includes an individual with a history of hallucinations but none currently. Use this category for an individual who is below the threshold for one of the DSM diagnoses listed above.</td>
</tr>
<tr>
<td>2</td>
<td>Evidence of disturbance in thought process or content that may be impairing the individual’s functioning in at least one life domain. Individual may be somewhat delusional or have brief intermittent hallucinations. Speech may be at times quite tangential or illogical.</td>
</tr>
<tr>
<td>3</td>
<td>Clear evidence of dangerous hallucinations, delusions, or bizarre behavior that might be associated with some form of psychotic disorder that places the individual or others at risk of physical harm.</td>
</tr>
</tbody>
</table>

Supplemental Information: The common symptoms of these disorders include hallucinations (i.e. experiencing things others do not experience), delusions (i.e. a false belief or an incorrect inference about reality that is firmly sustained despite the fact that nearly everybody thinks the belief is false or proof exists of its inaccuracy), disorganized thinking, and bizarre/idiosyncratic behavior.
### MH2. MOOD DISTURBANCE
This item captures problems related to mood, including symptoms of depressed mood, hypomania, or mania.

<table>
<thead>
<tr>
<th>Questions to Consider</th>
<th>Ratings and Descriptions</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Does the individual have periods of feeling super happy/excited for hours or days?</td>
<td>0 Individual with no prolonged emotional/mood problems. No evidence of depression, hypomania, or mania.</td>
</tr>
<tr>
<td>Periods of feeling very angry/cranky for hours or days at a time?</td>
<td>1 Individual with prolonged emotional/mood problems. Evidence of depression, irritability, or other issues of mood, including mood swings with some evidence of hypomania. These problems are not yet impacting the individual’s functioning.</td>
</tr>
<tr>
<td>• Does the individual have periods of time where they feel they don’t need to sleep or eat?</td>
<td>2 Individual with mood disturbance problems that interfere with their functioning. This would include episodes of mania, depression, social withdrawal, school avoidance, or inability to experience happiness.</td>
</tr>
<tr>
<td></td>
<td>3 Individual with mood disturbance problems that are dangerous or disabling. This would include an individual whose emotional symptoms prevent appropriate participation in school, friendship groups, or family life.</td>
</tr>
</tbody>
</table>

### MH3. DEPRESSION
This item rates symptoms such as irritable or depressed mood, social withdrawal, sleep disturbances, weight/eating disturbances, and loss of motivation, interest or pleasure in daily activities.

<table>
<thead>
<tr>
<th>Questions to Consider</th>
<th>Ratings and Descriptions</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Does the individual display any symptoms of depression?</td>
<td>0 No evidence of problems with depression.</td>
</tr>
<tr>
<td>• Does the individual have a diagnosis of depression?</td>
<td>1 History or suspicion of depression or evidence of depression associated with a recent negative life event with minimal impact on life domain functioning. Brief duration of depression, irritability, or impairment of peer, family, or academic functioning that does not lead to pervasive avoidance behavior.</td>
</tr>
<tr>
<td></td>
<td>2 Clear evidence of depression associated with either depressed mood or significant irritability. Depression has interfered significantly in individual’s ability to function in at least one life domain.</td>
</tr>
<tr>
<td></td>
<td>3 Clear evidence of disabling level of depression that makes it virtually impossible for the individual to function in any life domain. This rating is given to an individual with a severe level of depression. This would include an individual who stays at home or in bed all day due to depression or one whose emotional symptoms prevent any participation in school, friendship groups, or family life. Disabling forms of depressive diagnoses would be rated here.</td>
</tr>
</tbody>
</table>
MH4. IMPULSE CONTROL
Problems with impulse control and impulsive behaviors, including motoric disruptions, are rated here.

Ratings and Descriptions

0  No evidence of symptoms of loss of control of behavior.
1  There is a history or evidence of mild levels of impulsivity evident in action or thought that place the individual at risk of future functioning difficulties. The individual may exhibit limited impulse control, e.g., individual may yell out answers to questions or may have difficulty waiting one’s turn. Some motor difficulties may be present as well, such as pushing or shoving others.
2  Clear evidence of problems with impulsive, distractible, or hyperactive behavior that interferes with the individual’s functioning in at least one life domain. An individual who often intrudes on others and often exhibits aggressive impulses would be rated here.
3  Clear evidence of a dangerous level of hyperactivity and/or impulsive behavior that places the individual at risk of physical harm. This indicates an individual with frequent and significant levels of impulsive behavior that carries considerable safety risk (e.g., running into the street, dangerous driving or bike riding). The individual may be impulsive on a nearly continuous basis. The individual endangers self or others without thinking.

Supplemental Information: This item includes behavioral symptoms associated with Attention-Deficit Hyperactivity Disorder (ADHD), Impulse-Control Disorders and mania as indicated in the DSM-5. Individuals with impulse problems tend to engage in behavior without thinking, regardless of the consequences. This can include compulsions to engage in gambling, violent behavior (e.g., road rage), and sexual behavior, fire-starting or stealing. Manic behavior is also rated here.

MH5. ANXIETY
This item rates symptoms associated with DSM-5 anxiety disorders characterized by excessive fear and anxiety and related behavioral disturbances (including avoidance behaviors).

Ratings and Descriptions

0  No evidence of anxiety symptoms.
1  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 yet causing the individual significant distress or markedly impairing functioning in any important context.
2  Clear evidence of anxiety associated with either anxious mood or significant fearfulness. Anxiety has interfered in the individual’s ability to function in at least one life domain.
3  Clear evidence of debilitating level of anxiety that makes it virtually impossible for the individual to function in any life domain.

Supplemental Information: Panic attacks can be a prominent type of fear response.
### MH6. INTERPERSONAL PROBLEMS
This item identifies problems with relating to other people including significant manipulative behavior, social isolation, or significant conflictual relationships. The presence of any DSM personality disorder may be rated here.

<table>
<thead>
<tr>
<th>Questions to Consider</th>
<th>Ratings and Descriptions</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Does the individual have any manipulative behaviors? • Does the individual socially isolate themselves? • Is the individual diagnosed with personality disorders?</td>
<td>0  No evidence of notable interpersonal problems identified.</td>
</tr>
<tr>
<td></td>
<td>1  History or evidence of some interpersonal problems; behavior is probably sub-threshold for the diagnosis of personality disorder. Mild but consistent antisocial or narcissistic behavior is rated here.</td>
</tr>
<tr>
<td></td>
<td>2  Individual’s relationship problems are beginning to interfere with their life functioning and may warrant a DSM personality disorder diagnosis.</td>
</tr>
<tr>
<td></td>
<td>3  Individual’s interpersonal problems have a significant impact on the individual’s long-term functioning. Interpersonal problems are disabling and block the individual’s ability to function independently.</td>
</tr>
</tbody>
</table>

### MH7. ANTISOCIAL BEHAVIOR
This item rates the degree to which an individual engages in behavior that is consistent with the presence of an Antisocial Personality Disorder.

<table>
<thead>
<tr>
<th>Questions to Consider</th>
<th>Ratings and Descriptions</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Does the individual vandalize? • Does the individual steal? • Is the individual violent? • Is the individual diagnosed with an antisocial behavior disorder?</td>
<td>0  Individual shows no evidence of antisocial behavior.</td>
</tr>
<tr>
<td></td>
<td>1  There is a history, suspicion or evidence of some problems associated with antisocial behavior including but not limited to lying, stealing, manipulation of others, acts of sexual aggression, or violence towards people, property or animals. The individual may have some difficulties in school and home behavior. Problems are recognizable but not notably deviant for age, sex and community.</td>
</tr>
<tr>
<td></td>
<td>2  Clear evidence of antisocial behavior including but not limited to lying, stealing, manipulating others, sexual aggression, violence towards people, property, or animals. An individual rated at this level will likely meet criteria for a diagnosis of Antisocial Personality Disorder.</td>
</tr>
<tr>
<td></td>
<td>3  Evidence of a severe level of aggressive or antisocial behavior, as described above, that places the individual or community at significant risk of physical harm due to these behaviors. This could include frequent episodes of unprovoked, planned aggressive or other antisocial behavior.</td>
</tr>
</tbody>
</table>
MH8. ANGER CONTROL
This item captures the individual’s ability to identify and manage their anger when frustrated.

Questions to Consider
- How does the individual manage feelings of anger?
- Does the individual get violent when angry?
- Does the individual have a hard time dealing with criticism or rejection?

Ratings and Descriptions
0  No evidence of any anger control problems.
1  History, suspicion of, or evidence of some problems with controlling anger. Individual may sometimes become verbally aggressive when frustrated. Peers and family are aware of and may attempt to avoid stimulating angry outbursts.
2  Individual’s difficulties with controlling anger are impacting functioning in at least one life domain. Individual’s temper has resulted in significant trouble with peers, family and/or school. Anger may be associated with physical violence. Others are likely quite aware of anger potential.
3  Individual’s temper or anger control problem is dangerous. Individual frequently gets into fights that are often physical. Others likely fear the individual.

MH9. EATING DISTURBANCES
This item includes problems with eating including disturbances in body image, refusal to maintain normal body weight and recurrent episodes of binge eating. These ratings are consistent with DSM Eating Disorders.

Questions to Consider
- Does the individual have any issues with eating?
- Is the individual overly picky?
- Does the individual have any eating rituals?

Ratings and Descriptions
0  This rating is for an individual with no evidence of eating disturbances.

Some evidence of eating disturbance is present. This could include some preoccupation with weight, calorie intake, or body size or type when of normal weight or below weight. This could also include some binge eating patterns.

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

Dangerous level of eating disturbance. This could include significantly low weight where hospitalization is required or excessive binge-purge behaviors (at least once per day).

End of the Mental Health Module
DEVELOPMENTAL
This item describes the presence of limited cognitive capacity or developmental disabilities that challenges the caregiver’s ability to parent.

Questions to Consider
- Has the caregiver been identified with any developmental disabilities or intellectual disabilities?

Ratings and Descriptions

<table>
<thead>
<tr>
<th>Rating</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>No evidence of any needs; no need for action. Caregiver has no developmental needs.</td>
</tr>
<tr>
<td>1</td>
<td>Identified need that requires monitoring, watchful waiting, or preventive action based on history, suspicion or disagreement. Caregiver has developmental challenges. The developmental challenges do not currently interfere with parenting.</td>
</tr>
<tr>
<td>2</td>
<td>Need is interfering with the provision of care; action is required to ensure that the identified need is addressed. Caregiver has developmental challenges that interfere with the capacity to parent the child.</td>
</tr>
<tr>
<td>3</td>
<td>Need prevents the provision of care; requires immediate and/or intensive action. Caregiver has severe developmental challenges that make it impossible to parent the child at this time.</td>
</tr>
</tbody>
</table>

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

Questions to Consider
- Do caregivers have any substance use needs that make parenting difficult?
- Does anyone else in the family have a serious substance use need that is impacting the resources for caregiving?

Ratings and Descriptions

<table>
<thead>
<tr>
<th>Rating</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>No evidence of any needs; no need for action. No evidence of caregiver substance use issues.</td>
</tr>
<tr>
<td>1</td>
<td>Identified need that requires monitoring, watchful waiting, or preventive action based on history, suspicion or disagreement. There is a history of, suspicion or mild use of substances and/or caregiver is in recovery from substance use difficulties where there is no interference in their ability to parent.</td>
</tr>
<tr>
<td>2</td>
<td>Need is interfering with the provision of care; action is required to ensure that the identified need is addressed. Caregiver has some substance abuse difficulties that interfere with their capacity to parent.</td>
</tr>
<tr>
<td>3</td>
<td>Need prevents the provision of care; requires immediate and/or intensive action. Caregiver has substance abuse difficulties that make it impossible to parent the child at this time.</td>
</tr>
</tbody>
</table>

*A rating of ‘1,’ ‘2,’ or ‘3’ on this item triggers the completion of the [B] Substance Use Disorder Module.
**[B] SUBSTANCE USE DISORDER MODULE**

The items in this module focus on different elements/issues related to using substances. This module is to be completed when the Substance Use item is rated ‘1,’ ‘2’ or ‘3.’

*Rate the following items within the last 30 days unless specified by anchor descriptions.*

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### SUD1. SEVERITY OF USE

*This item rates the frequency and severity of the individual’s current substance use.*

<table>
<thead>
<tr>
<th>Questions to Consider</th>
<th>Ratings and Descriptions</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Is the individual currently using substances? If so, how frequently?</td>
<td>0  Individual is currently abstinent and has maintained abstinence for at least six months.</td>
</tr>
<tr>
<td>• Is there evidence of physical dependence on substances?</td>
<td>1  Individual is currently abstinent but only in the past 30 days or individual has been abstinent for more than 30 days but is living in an environment that makes substance use difficult.</td>
</tr>
<tr>
<td></td>
<td>2  Individual actively uses alcohol or drugs but not daily.</td>
</tr>
<tr>
<td></td>
<td>3  Individual uses alcohol and/or drugs on a daily basis.</td>
</tr>
</tbody>
</table>

---

### SUD2. DURATION OF USE

*This item identifies the length of time that the individual has been using drugs or alcohol.*

<table>
<thead>
<tr>
<th>Questions to Consider</th>
<th>Ratings and Descriptions</th>
</tr>
</thead>
<tbody>
<tr>
<td>• How long has the individual been using drugs and/or alcohol?</td>
<td>0  Individual has begun use in the past year.</td>
</tr>
<tr>
<td></td>
<td>1  Individual has been using alcohol or drugs for at least one year but has had periods of at least 30 days where the individual did not have any use.</td>
</tr>
<tr>
<td></td>
<td>2  Individual has been using alcohol or drugs for at least one year (but less than five years), but not daily.</td>
</tr>
<tr>
<td></td>
<td>3  Individual has been using alcohol or drugs daily for more than the past year or intermittently for at least five years.</td>
</tr>
</tbody>
</table>

---

### SUD3. STAGE OF RECOVERY

*This item identifies where the individual is in their recovery process.*

<table>
<thead>
<tr>
<th>Questions to Consider</th>
<th>Ratings and Descriptions</th>
</tr>
</thead>
<tbody>
<tr>
<td>• In relation to stopping substance use, at what stage of change is the individual?</td>
<td>0  Individual is in maintenance stage of recovery. Individual is abstinent and able to recognize and avoid risk factors for future alcohol or drug use.</td>
</tr>
<tr>
<td></td>
<td>1  Individual is actively trying to use treatment to remain abstinent.</td>
</tr>
<tr>
<td></td>
<td>2  Individual is in contemplation phase, recognizing a problem but not willing to take steps for recovery.</td>
</tr>
<tr>
<td></td>
<td>3  Individual is in denial regarding the existence of any substance use problem.</td>
</tr>
</tbody>
</table>
### SUD4. PEER INFLUENCES
This item rates the impact that the individual’s social group has on their alcohol and drug use.

<table>
<thead>
<tr>
<th>Questions to Consider</th>
<th>Ratings and Descriptions</th>
</tr>
</thead>
<tbody>
<tr>
<td>• What role do the individual’s peers play in their alcohol and drug use?</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>3</td>
</tr>
</tbody>
</table>

### SUD5. ENVIRONMENTAL INFLUENCES
This item rates the impact of the individual’s community environment on their alcohol and drug use.

<table>
<thead>
<tr>
<th>Questions to Consider</th>
<th>Ratings and Descriptions</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Are there factors in the individual’s community that impacts their alcohol and drug use?</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>3</td>
</tr>
</tbody>
</table>

### SUD6. RECOVERY SUPPORT IN COMMUNITY
This item describes the individual’s participation in recovery programs such as AA, NA, or other types of recovery groups or activities that are community-based.

<table>
<thead>
<tr>
<th>Questions to Consider</th>
<th>Ratings and Descriptions</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Does the individual attend or participate in recovery groups or activities?</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>3</td>
</tr>
</tbody>
</table>
### SUD7. ACUTE INTOXICATION
This item describes reversible, substance-related, maladaptive psychological or behavioral changes causing physiological effects of the central nervous system by recent ingestion of or exposure to a substance: alcohol, illicit drug, medication, or toxin (Medical Dictionary.com).

#### Questions to Consider
- Is there evidence of acute intoxication (e.g., withdrawal symptoms)?
- Are substance intoxication difficulties interfering with functioning?

#### Ratings and Descriptions

<table>
<thead>
<tr>
<th>Rating</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>Individual has no identified substance intoxication difficulties at the present time.</td>
</tr>
<tr>
<td>1</td>
<td>Individual has occasional intoxication which requires preventive activities. History of occasional intoxication and/or withdrawal symptoms without evidence of current problems would be rated here.</td>
</tr>
<tr>
<td>2</td>
<td>Evidence of acute intoxication interferes with individual’s ability to function with moderate risks, requiring preventive or withdrawal management services.</td>
</tr>
<tr>
<td>3</td>
<td>Individual has a substance use problem with complications that may result in danger to self or detoxification (e.g., managing acute alcohol poisoning after binge drinking, overdose, or significant risk of withdrawal symptoms, seizures, or medical complications based on withdrawal history and substance use: amount, frequency, duration, and recent discontinuation).</td>
</tr>
</tbody>
</table>

### SUD8. WITHDRAWAL HISTORY
Withdrawal refers to a psychological and/or physical syndrome caused by abruptly stopping or reducing substance use in a habituated person. Specific symptoms and risks differ based on the substance. Withdrawal history, important in assessing current risk and planning care, considers past substance use and withdrawal experience.

#### Questions to Consider
- Is there evidence of withdrawal symptoms related to substance use?
- Do they impact functioning or affect the individual’s health?

#### Ratings and Descriptions

<table>
<thead>
<tr>
<th>Rating</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>No evidence of prior withdrawal symptoms related to substance use, medications, or toxins.</td>
</tr>
<tr>
<td>1</td>
<td>History of occasional acute withdrawal symptoms following substance use (e.g., mild nausea, mild tactile disturbances or sensitivity to light, slight headache, cannot do serial additions or uncertain about date, mild anxiety or irritability, chills or flushing, restless).</td>
</tr>
<tr>
<td>2</td>
<td>History of withdrawal symptoms after decreasing or discontinuing substance use or medications (e.g., anxiety, nausea, fever, tremor) that impact the individual’s functioning. OR, chronic physical health problems could be worsened by withdrawal symptoms.</td>
</tr>
<tr>
<td>3</td>
<td>History of significant withdrawal symptoms after decreasing or discontinuing substance use or medications (e.g., seizures, delirium tremens, rapid heartbeat). Individual may have medical condition which could be worsened due to withdrawal.</td>
</tr>
</tbody>
</table>
SUD9. WITHDRAWAL RISKS
This item describes the current risk of withdrawal from alcohol and/or other substance use and need for withdrawal management services. Severity of withdrawal risk varies by type of substance(s) used, duration and frequency of use, withdrawal history, concurrent mental and/or physical health conditions, involvement in recovery, and family/natural and environmental supports. Higher risks occur with withdrawal from alcohol and benzodiazepines or the use of multiple substances.

Ratings and Descriptions

0  The individual is fully functioning. Individual is able to tolerate and deal with mild withdrawal discomfort.

1  Individual has minimal risk of severe withdrawal. Sustained withdrawal management services without evidence of current problems could be rated here. Examples include an individual using alcohol or benzodiazepines with mild withdrawal symptoms (anxiety, sweating, and insomnia, but no tremors); not withdrawing from another substance; previously stopped using in the past year without severe withdrawal symptoms; no more than mild, stable physical health conditions; motivated to complete the withdrawal process; understands and willing to engage in treatment, and has a positive support system with safe housing.

2  Evidence of moderate level of withdrawal risks includes symptoms (sweating, anxiety, nausea, fever, and tremor), current physical symptoms (nausea or vomiting at no more than moderate intensity); no withdrawal from other substances; no more than mild, stable mental or physical health conditions; understanding, commitment, and cooperation in withdrawal management process; and at least minimally supportive family/friends and access to safe housing OR withdrawal symptoms with no tremor, but barrier to effective withdrawal management related to history of severe withdrawal symptoms, moderate or unstable mental or physical health condition(s), limited commitment, high relapse risk, or unsupportive friends/family.

3  Individual has significant or severe risk of withdrawal symptoms, seizures, or medical complications. Significant withdrawal risk is characterized by significant anxiety with moderate to severe tremor; possible concurrent withdrawal from other substances; OR moderate symptoms and not withdrawing from another substance, but with other problems that complicate withdrawal management (history of severe withdrawal symptoms, moderate to severe physical or mental health conditions, high relapse risk, questionable cooperation, significant others not supportive of the process or inadequate housing). Severe risk of withdrawal is characterized by confusion; new onset of hallucinations; seizure; or inability to understand OR severe anxiety; moderate to severe tremor; concurrent withdrawal from another substance; and either history of seizure or delirium tremens; severe, unstable physical health condition(s); uncooperative; or requiring more than hourly medical monitoring.

Questions to Consider
• How does the individual manage withdrawal symptoms?
• Is the individual’s health or safety at risk from the withdrawal symptoms?
**SUD10. AWARENESS OF RELAPSE TRIGGERS**

Relapse refers to resuming substance use after a period of recovery. This item refers to the individual’s awareness of potential triggers (emotional stresses or circumstances: exposure to rewarding substances and behaviors, environmental cues for use) that increase the likelihood of using substances.

<table>
<thead>
<tr>
<th>Questions to Consider</th>
<th>Ratings and Descriptions</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>0 Individual is aware of potential relapse triggers and actively uses recovery strategies (e.g., developed resilience and support to cope with stressors and manage challenges: craving, behavioral control, problems in relationships).</td>
</tr>
<tr>
<td></td>
<td>1 Individual is aware of relapse triggers and usually engages recovery strategies to address recovery challenges, but requires some effort to maximize and sustain efforts. Awareness might be used and built upon in treatment.</td>
</tr>
<tr>
<td></td>
<td>2 Individual is aware of some, but not all, relapse triggers or seldom uses recovery strategies to address challenges.</td>
</tr>
<tr>
<td></td>
<td>3 Individual is unaware of relapse triggers and does not use recovery strategies to address challenges.</td>
</tr>
</tbody>
</table>

---

**POSTTRAUMATIC REACTIONS**

This item describes posttraumatic reactions faced by caregiver(s), including emotional numbing and avoidance, nightmares and flashbacks, that are related to their child’s or their own traumatic experiences.

<table>
<thead>
<tr>
<th>Questions to Consider</th>
<th>Ratings and Descriptions</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>0 <em>No evidence of any needs; no need for action.</em> Caregiver has not experienced any significant trauma or has adjusted to traumatic experiences without notable posttraumatic stress reactions.</td>
</tr>
<tr>
<td></td>
<td>1 <em>Identified need that requires monitoring, watchful waiting, or preventive action based on history, suspicion or disagreement.</em> Caregiver has some adjustment problems related to their child’s or their own traumatic experiences. Caregiver may exhibit some guilt about their child’s trauma or become somewhat detached or estranged from others. These symptoms may mildly impact their ability to provide child care.</td>
</tr>
<tr>
<td></td>
<td>2 <em>Need is interfering with the provision of care; action is required to ensure that the identified need is addressed.</em> Caregiver has adjustment difficulties related to traumatic experiences, and these difficulties impact their ability to provide child care. Caregiver may have nightmares or flashbacks of the trauma.</td>
</tr>
<tr>
<td></td>
<td>3 <em>Need prevents the provision of care; requires immediate and/or intensive action.</em> Caregiver has significant adjustment difficulties associated with traumatic experiences, and these difficulties make the caregiver unable to provide child care. Symptoms might include intrusive thoughts, hypervigilance, and constant anxiety.</td>
</tr>
</tbody>
</table>

*A rating of ‘1,’ ‘2,’ or ‘3’ on this item triggers the completion of the [C] Trauma Module.

**Supplemental Information:** This is one item where speculation about why a person is displaying a certain behavior is considered. There should be an inferred link between the trauma and behavior.
[C] TRAUMA MODULE: POTENTIALLY TRAUMATIC/ADVERSE CHILDHOOD EXPERIENCES

The items in this module focus on identifying trauma experiences. This module is to be completed when the Posttraumatic Reactions item is rated ‘1,’ ‘2’ or ‘3.’

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

**Question to Consider for this Module:** Has the individual experienced adverse life events?

Rate these items within the individual’s lifetime.

---

**For the Trauma Module, the following categories and descriptions are used:**

<table>
<thead>
<tr>
<th>No</th>
<th>Yes</th>
</tr>
</thead>
<tbody>
<tr>
<td>No evidence of any trauma of this type.</td>
<td>Individual has had experience or there is suspicion that the individual has experienced this type of trauma—one incident, multiple incidents, or chronic, on-going experiences.</td>
</tr>
</tbody>
</table>

---

**ACE1. SEXUAL ABUSE**

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

**Questions to Consider**

- Has the individual disclosed sexual abuse?
- Is there suspicion or evidence that the individual has been sexually abused?

**Ratings and Descriptions**

<table>
<thead>
<tr>
<th>No</th>
<th>Yes</th>
</tr>
</thead>
<tbody>
<tr>
<td>There is no evidence that the individual has experienced sexual abuse.</td>
<td>Individual has experienced sexual abuse, or there is a suspicion that they have experienced sexual abuse – including single or multiple episodes, or chronic over an extended period of time. The abuse may have involved penetration, multiple perpetrators, and/or associated physical injury. Individual with exposure to secondary sexual abuse (e.g., witnessing sexual abuse, having a sibling sexually abused) should be rated here.</td>
</tr>
</tbody>
</table>

---

**ACE2. PHYSICAL ABUSE**

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

**Questions to Consider**

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

**Ratings and Descriptions**

<table>
<thead>
<tr>
<th>No</th>
<th>Yes</th>
</tr>
</thead>
<tbody>
<tr>
<td>There is no evidence that the individual has experienced physical abuse.</td>
<td>Individual has experienced or there is a suspicion that they experienced physical abuse – mild to severe, or repeated physical abuse with sufficient physical harm requiring medical treatment.</td>
</tr>
</tbody>
</table>
**ACE3. NEGLECT**
This item describes whether or not the individual 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).

<table>
<thead>
<tr>
<th>Questions to Consider</th>
<th>Ratings and Descriptions</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Is the individual receiving adequate supervision?</td>
<td>No * There is no evidence that the individual has experienced neglect.</td>
</tr>
<tr>
<td>• Has the individual been denied their needs for food and shelter?</td>
<td>Yes * Individual has experienced neglect, or there is a suspicion that they experienced neglect. This includes occasional neglect (e.g., individual left home alone for a short period of time when developmentally inappropriate and with no adult supervision, or occasional failure to provide adequate supervision of the individual); multiple and/or prolonged absences of adults, with minimal supervision; or failure to provide basic necessities of life (adequate food, shelter, or clothing) on a regular basis.</td>
</tr>
<tr>
<td>• Is the individual allowed access to necessary medical care? Education?</td>
<td></td>
</tr>
</tbody>
</table>

**ACE4. EMOTIONAL ABUSE**
This item describes whether or not the individual has experienced verbal and/or nonverbal emotional abuse, including belittling, shaming, and humiliating an individual, calling names, making negative comparisons to others, or telling an individual that they are “no good.” This item includes both “emotional abuse,” which would include psychological maltreatment such as insults or humiliation, and “emotional neglect,” described as the denial of emotional attention and/or support from others.

<table>
<thead>
<tr>
<th>Questions to Consider</th>
<th>Ratings and Descriptions</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Is the individual subject to name calling or shaming in their home?</td>
<td>No * There is no evidence that individual has experienced emotional abuse.</td>
</tr>
<tr>
<td>• Is the individual subject to name calling or shaming in their home?</td>
<td>Yes * Individual has experienced emotional abuse, or there is a suspicion that they have experienced emotional abuse (mild to severe, for any length of time) including: insults or occasionally being referred to in a derogatory manner, being denied emotional attention or completely ignored, or threatened/terrorized by others.</td>
</tr>
</tbody>
</table>
### ACE5. MEDICAL TRAUMA
This item describes whether or not the individual has experienced medically-related trauma, resulting from, for example, inpatient hospitalizations, outpatient procedures, and significant injuries.

<table>
<thead>
<tr>
<th>Questions to Consider</th>
<th>Ratings and Descriptions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Has the individual had any broken bones, stitches or other medical procedures?</td>
<td>No</td>
</tr>
<tr>
<td>Has the individual had to go to the emergency room, or stay overnight in the hospital?</td>
<td>Yes</td>
</tr>
</tbody>
</table>

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

### ACE6. NATURAL OR MANMADE DISASTER
This item describes the individual’s exposure to either natural or manmade disasters.

<table>
<thead>
<tr>
<th>Questions to Consider</th>
<th>Ratings and Descriptions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Has the individual been present during a natural or manmade disaster?</td>
<td>No</td>
</tr>
<tr>
<td>Does the individual watch television shows containing these themes?</td>
<td>Yes</td>
</tr>
</tbody>
</table>

### ACE7. WITNESS TO FAMILY VIOLENCE
This item describes exposure to violence within the individual’s home or family.

<table>
<thead>
<tr>
<th>Questions to Consider</th>
<th>Ratings and Descriptions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Is there frequent fighting in the individual’s family?</td>
<td>No</td>
</tr>
<tr>
<td>Does the fighting ever become physical?</td>
<td>Yes</td>
</tr>
</tbody>
</table>
### ACE 8. WITNESS TO COMMUNITY/SCHOOL VIOLENCE
This item describes the exposure to incidents of violence the individual has witnessed or experienced in their community. This includes witnessing violence at the individual’s school, educational or work setting.

<table>
<thead>
<tr>
<th>Questions to Consider</th>
<th>Ratings and Descriptions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Does the individual live in a neighborhood with frequent violence?</td>
<td>No</td>
</tr>
<tr>
<td>Has the individual witnessed or directly experienced violence at their school or work?</td>
<td>Yes</td>
</tr>
</tbody>
</table>

### ACE 9. WITNESS/VICTIM TO CRIMINAL ACTIVITY
This item describes the individual’s exposure to criminal activity. Criminal behavior includes any behavior for which an adult could go to prison including drug dealing, prostitution, assault, or battery.

<table>
<thead>
<tr>
<th>Questions to Consider</th>
<th>Ratings and Descriptions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Has the individual or someone in their family ever been the victim of a crime?</td>
<td>No</td>
</tr>
<tr>
<td>Has the individual seen criminal activity in the community or home?</td>
<td>Yes</td>
</tr>
</tbody>
</table>

**Supplemental Information:** Any behavior that could result in incarceration is considered criminal activity. An individual who has been sexually abused or witnesses a sibling being sexually abused or physically abused to the extent that assault charges could be filed would be rated here and on the appropriate abuse-specific items. An individual who has witnessed drug dealing, prostitution, assault or battery would also be rated on this item.
ACE10. WAR/TERROISM AFFECTED
This item describes the individual’s exposure to war, political violence, torture or terrorism.

Ratings and Descriptions

Questions to Consider

<table>
<thead>
<tr>
<th>Rating</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>No</td>
<td>No evidence that the individual has been exposed to war, political violence, torture or terrorism.</td>
</tr>
<tr>
<td>Yes</td>
<td>Individual has experienced, or there is suspicion that they have experienced or been affected by war, terrorism or political violence. Examples include: Family members directly related to the individual 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 individual; individual may have spent an extended amount of time in a refugee camp, or feared for their own life during war or terrorism due to bombings or shelling very near to them; individual may have been directly injured, tortured, or kidnapped in a terrorist attack; individual may have served as a soldier, guerrilla, or other combatant in their home country. Also included is an individual who did not live in war or terrorism-affected region or refugee camp, but whose family was affected by war.</td>
</tr>
</tbody>
</table>

Supplemental Information: Terrorism is defined as “the calculated use of violence or the threat of violence to inculcate fear, intended to coerce or to intimidate governments or societies in the pursuit of goals that are generally political, religious or ideological.” Terrorism includes attacks by individuals acting in isolation (e.g. sniper attacks).

ACE11. DISRUPTIONS IN CAREGIVING/ATTACHMENT LOSSES
This item documents the extent to which an individual has had one or more major changes in caregivers, potentially resulting in disruptions in attachment.

Ratings and Descriptions

Questions to Consider

<table>
<thead>
<tr>
<th>Rating</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>No</td>
<td>There is no evidence that the individual has experienced disruptions in caregiving and/or attachment losses.</td>
</tr>
<tr>
<td>Yes</td>
<td>Individual has been exposed to, or there is suspicion that they were exposed to, at least one disruption in caregiving with familiar alternative caregivers or unknown caregivers (this includes placement in foster or other out-of-home care such as residential care facilities). Individual 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.</td>
</tr>
</tbody>
</table>

Supplemental Information: Individuals who have been exposed to disruptions in caregiving involving separation from primary attachment figure(s) and/or attachment losses would be rated here. Individuals who have had placement changes, including stays in foster care, residential treatment facilities or juvenile justice settings, can be rated here. Short-term hospital stays or brief juvenile detention stays, during which the individual’s caregiver remains the same, would not be rated on this item.

End of the Trauma Module
CAREGIVER STRENGTHS

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

<table>
<thead>
<tr>
<th>Rating</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>Well-developed, centerpiece strength; may be used as a centerpiece in an intervention/action plan. There is no evidence that the caregiver is not involved with caregiving functions. The caregiver is actively and fully involved in daily family life.</td>
</tr>
<tr>
<td>1</td>
<td>Identified and useful strength. Strength will be used, maintained or built upon as part of the plan. May require some effort to develop strength into a centerpiece strength. The caregiver is generally involved in daily family life. The caregiver may occasionally be less involved for brief periods of time because they are distracted by internal stressors and/or other external events or responsibilities or there is a history of caregiver un-involvement.</td>
</tr>
<tr>
<td>2</td>
<td>Strengths have been identified but require strength-building efforts before they can be effectively utilized as part of a plan. Identified but not useful. The caregiver is involved in daily family life but only maintains minimal daily interactions for extended periods of time.</td>
</tr>
<tr>
<td>3</td>
<td>An area in which no current strength is identified; efforts may be recommended to develop a strength in this area. The caregiver is mostly uninvolved in daily family life. The caregiver may not interact with their children on a daily basis.</td>
</tr>
</tbody>
</table>

IN VOLVEMENT WITH CAREGIVING

This item refers to the degree to which the caregiver is actively involved in being a parent/caregiver.

**Ratings and Descriptions**

<table>
<thead>
<tr>
<th>Rating</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>Well-developed, centerpiece strength; may be used as a centerpiece in an intervention/action plan. There is no evidence that the caregiver is not involved with caregiving functions. The caregiver is actively and fully involved in daily family life.</td>
</tr>
<tr>
<td>1</td>
<td>Identified and useful strength. Strength will be used, maintained or built upon as part of the plan. May require some effort to develop strength into a centerpiece strength. The caregiver is generally involved in daily family life. The caregiver may occasionally be less involved for brief periods of time because they are distracted by internal stressors and/or other external events or responsibilities or there is a history of caregiver un-involvement.</td>
</tr>
<tr>
<td>2</td>
<td>Strengths have been identified but require strength-building efforts before they can be effectively utilized as part of a plan. Identified but not useful. The caregiver is involved in daily family life but only maintains minimal daily interactions for extended periods of time.</td>
</tr>
<tr>
<td>3</td>
<td>An area in which no current strength is identified; efforts may be recommended to develop a strength in this area. The caregiver is mostly uninvolved in daily family life. The caregiver may not interact with their children on a daily basis.</td>
</tr>
</tbody>
</table>

**Questions to Consider**

- How actively involved is the caregiver in the daily life of the family?
- Is the caregiver an advocate for the child?
- Would they like any help to become more involved?
**EMOTIONAL RESPONSIVENESS**
This item refers to the caregiver’s ability to understand and respond appropriately to the joys, sorrows, anxieties and other feelings of their children.

Ratings and Descriptions

0  
*Well-developed, centerpiece strength; may be used as a centerpiece in an intervention/action plan.*  
Adaptive emotional responsiveness. Parents/caregivers are emotionally empathic and attend to child’s emotional needs.

1  
*Identified and useful strength. Strength will be used, maintained or built upon as part of the plan. May require some effort to develop strength into a centerpiece strength.*  
Parents/caregivers are generally emotionally empathic and typically attend to child’s emotional needs.

2  
*Strengths have been identified but require strength-building efforts before they can be effectively utilized as part of a plan. Identified but not useful.*  
Parents/caregivers have limited adaptive emotional responsiveness.

3  
*An area in which no current strength is identified; efforts may be recommended to develop a strength in this area.*  
No evidence that parents/caregivers currently possess any capacity with regards to emotional responsiveness.

Questions to Consider

- Is the caregiver’s emotional response appropriate towards the child?
- Is caregiver empathic towards the child?

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

Ratings and Descriptions

0  
*Well-developed, centerpiece strength; may be used as a centerpiece in an intervention/action plan.*  
Caregiver is well organized and efficient. Caregiver organizational skills can drive any plan.

1  
*Identified and useful strength. Strength will be used, maintained or built upon as part of the plan. May require some effort to develop strength into a centerpiece strength.*  
Caregiver has adequate organizational skills to ensure that children’s needs are routinely met.

2  
*Strengths have been identified but require strength-building efforts before they can be effectively utilized as part of a plan. Identified but not useful.*  
Caregiver has limited ability to stay organized.

3  
*An area in which no current strength is identified; efforts may be recommended to develop a strength in this area.*  
No evidence that caregiver is able to organize household to support needed services.

Questions to Consider

- Do caregivers need or want help with managing their home?
- Can they get to appointments or manage a schedule?
- Do they get their child to appointments or school on time?
CHILD ASSESSMENT

This section describes the needs and strengths of each of the children in the family. Sometimes circumstances exist that make it difficult to decide whether a family member is best rated as a caregiver or a child. In general, every family member under the age of 18 would be rated in the child section. Young adults could be rated as caregivers if their family roles are more congruent with that designation. All of these items should be rated using a developmental framework.

AGE 0-5 CHILD FUNCTIONING

For the 0-5 Child Functioning Domain, use the following categories and action levels:

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

EARLY EDUCATION

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

Ratings and Descriptions

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

No evidence of problem with functioning in current educational environment.

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

History or evidence of problems with functioning in current daycare or preschool environment. Child may be enrolled in a special program.

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

Child is experiencing difficulties maintaining their behavior, attendance, and/or progress in this setting.

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

Child’s problems with functioning in the daycare or preschool environment place them at immediate risk of being removed from program due to their behaviors, lack of progress, or unmet needs.
### SOCIAL AND EMOTIONAL FUNCTIONING
This item rates the child’s social and relationship functioning. This includes age appropriate behavior and the ability to engage and interact with others. When rating this item, consider the child’s level of development.

#### Ratings and Descriptions

<table>
<thead>
<tr>
<th>Rating</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>No evidence of any needs; no need for action. No evidence of problems with social functioning; child has positive social relationships.</td>
</tr>
<tr>
<td>1</td>
<td>Identified need that requires monitoring, watchful waiting, or preventive action based on history, suspicion or disagreement. Child is having some problems in social relationships. Infants may be slow to respond to adults, toddlers may need support to interact with peers and preschoolers may resist social situations.</td>
</tr>
<tr>
<td>2</td>
<td>Action is required to ensure that the identified need is addressed; need is interfering with functioning. Child is having problems with their social relationships. Infants may be unresponsive to adults, and unaware of other infants. Toddlers may be aggressive and resist parallel play. Preschoolers may argue excessively with adults and peers and lack ability to play in groups even with adult support.</td>
</tr>
<tr>
<td>3</td>
<td>Need is dangerous or disabling; requires immediate and/or intensive action. Child is experiencing disruptions in their social relationships. Infants show no ability to interact in a meaningful manner. Toddlers are excessively withdrawn and unable to relate to familiar adults. Preschoolers show no joy or sustained interaction with peers or adults, and/or aggression may be putting others at risk.</td>
</tr>
</tbody>
</table>

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

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

### Questions to Consider
- Does the child’s growth and development seem age appropriate?
- Has the child been screened for any developmental problems?

### Ratings and Descriptions

<table>
<thead>
<tr>
<th>Rating</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td><strong>No evidence of any needs; no need for action.</strong> No evidence of developmental delay and/or child has no developmental problems or intellectual disability.</td>
</tr>
<tr>
<td>1</td>
<td><strong>Identified need that requires monitoring, watchful waiting, or preventive action based on history, suspicion or disagreement.</strong> There are concerns about possible developmental delay. Child may have low IQ, a documented delay, or documented borderline intellectual disability (i.e. FSIQ 70-85). Mild deficits in adaptive functioning or development are indicated.</td>
</tr>
<tr>
<td>2</td>
<td><strong>Action is required to ensure that the identified need is addressed; need is interfering with functioning.</strong> Child has mild developmental delays (e.g., deficits in social functioning, inflexibility of behavior causing functional problems in one or more settings) and/or mild to moderate Intellectual Disability/Intellectual Disability Disorder. (If available, FSIQ 55-69.) IDD impacts communication, social functioning, daily living skills, judgment, and/or risk of manipulation by others.</td>
</tr>
<tr>
<td>3</td>
<td><strong>Need is dangerous or disabling; requires immediate and/or intensive action.</strong> Child has severe to profound intellectual disability (FSIQ, if available, less than 55) and/or Autism Spectrum Disorder with marked to profound deficits in adaptive functioning in one or more areas: communication, social functioning and self-care across multiple environments.</td>
</tr>
</tbody>
</table>
MEDICAL/PHYSICAL
This item describes both health problems and chronic/acute physical conditions or impediments.

Ratings and Descriptions

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

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

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

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

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

Supplemental Information: Most transient, treatable conditions would be rated as a ‘1’. Most chronic conditions (e.g., diabetes, severe asthma, HIV) would be rated a ‘2’. The rating ‘3’ is reserved for life threatening medical conditions.
# AGE 0-5 CHILD STRENGTHS

For the *Age 0-5 Child Strengths Domain*, the following categories and action levels are used:

<table>
<thead>
<tr>
<th>Rating</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>Well-developed, centerpiece strength; may be used as a centerpiece in an intervention/action plan. Family has strong relationships and significant family strengths. This level indicates a family with much love and respect for one another. There is at least one family member who has a strong loving relationship with the child and is able to provide significant emotional or concrete support. Child is fully included in family activities.</td>
</tr>
<tr>
<td>1</td>
<td>Identified and useful strength. Strength will be used, maintained or built upon as part of the plan. May require some effort to develop strength into a centerpiece strength. Family has some good relationships and good communication. Family members are able to enjoy each other’s company. There is at least one family member who has a strong, loving relationship with the child and is able to provide limited emotional or concrete support.</td>
</tr>
<tr>
<td>2</td>
<td>Strengths have been identified but require strength-building efforts before they can be effectively utilized as part of a plan. Identified but not useful. Family needs some assistance in developing relationships and/or communications. Family members are known, but currently none are able to provide emotional or concrete support.</td>
</tr>
<tr>
<td>3</td>
<td>An area in which no current strength is identified; efforts may be recommended to develop a strength in this area. Family needs significant assistance in developing relationships and communications, or child has no identified family. Child is not included in normal family activities.</td>
</tr>
</tbody>
</table>

## FAMILY STRENGTHS

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

### Ratings and Descriptions

- **0**  
  *Well-developed, centerpiece strength; may be used as a centerpiece in an intervention/action plan.*  
  Family has strong relationships and significant family strengths. This level indicates a family with much love and respect for one another. There is at least one family member who has a strong loving relationship with the child and is able to provide significant emotional or concrete support. Child is fully included in family activities.
- **1**  
  *Identified and useful strength. Strength will be used, maintained or built upon as part of the plan. May require some effort to develop strength into a centerpiece strength.*  
  Family has some good relationships and good communication. Family members are able to enjoy each other’s company. There is at least one family member who has a strong, loving relationship with the child and is able to provide limited emotional or concrete support.
- **2**  
  *Strengths have been identified but require strength-building efforts before they can be effectively utilized as part of a plan. Identified but not useful.*  
  Family needs some assistance in developing relationships and/or communications. Family members are known, but currently none are able to provide emotional or concrete support.
- **3**  
  *An area in which no current strength is identified; efforts may be recommended to develop a strength in this area.*  
  Family needs significant assistance in developing relationships and communications, or child has no identified family. Child is not included in normal family activities.

### Questions to Consider

- Does the child have good relationships with any family member?  
- Is there potential to develop positive family relationships?  
- Is there a family member that the child can go to in time of need for support? That can advocate for the child?
INTERPERSONAL
This item is used to identify a child’s social and relationship skills. Interpersonal skills are rated independently of Social Functioning because a child can have social skills but still struggle in their relationships at a particular point in time. This strength indicates an ability to make and maintain long-standing relationships.

Ratings and Descriptions

0  Well-developed, centerpiece strength; may be used as a centerpiece in an intervention/action plan.
Significant interpersonal strengths. Child has well-developed interpersonal skills and healthy friendships.

1  Identified and useful strength. Strength will be used, maintained or built upon as part of the plan. May require some effort to develop strength into a centerpiece strength.
Child has good interpersonal skills and has shown the ability to develop healthy friendships.

2  Strengths have been identified but require strength-building efforts before they can be effectively utilized as part of a plan. Identified but not useful.
Child requires strength building to learn to develop good interpersonal skills and/or healthy friendships. Child has some social skills that facilitate positive relationships with peers and adults but may not have any current healthy friendships.

3  An area in which no current strength is identified; efforts may be recommended to develop a strength in this area.
There is no evidence of observable interpersonal skills or healthy friendships at this time and/or child requires significant help to learn to develop interpersonal skills and healthy friendships.

Questions to Consider
• How does the child interact with other children and adults?
• How does the child do in social settings?
**PLAYFULNESS**
This item rates the degree to which a child is given opportunities for and participates in age-appropriate play. Play should be understood developmentally. When rating this item, you should consider if the child is interested in play and/or whether the child needs adult support while playing. Problems with either solitary or group (e.g. parallel) play could be rated here.

<table>
<thead>
<tr>
<th>Ratings</th>
<th>Descriptions</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td><strong>Well-developed, centerpiece strength; may be used as a centerpiece in an intervention/action plan.</strong> The child consistently demonstrates the ability to make use of play to further their development. Their play is consistently developmentally appropriate, spontaneous, self-initiated and enjoyable.</td>
</tr>
<tr>
<td>1</td>
<td><strong>Identified and useful strength. Strength will be used, maintained or built upon as part of the plan. May require some effort to develop strength into a centerpiece strength.</strong> The child demonstrates play that is developmentally appropriate, self-initiated, spontaneous and enjoyable much of the time. Child needs some assistance making full use of play.</td>
</tr>
<tr>
<td>2</td>
<td><strong>Strengths have been identified but require strength-building efforts before they can be effectively utilized as part of a plan. Identified but not useful.</strong> The child demonstrates the ability to enjoy play and use it to support their development some of the time or with support of a caregiver. Even with this in place there does not appear to be investment and enjoying in the child.</td>
</tr>
<tr>
<td>3</td>
<td><strong>An area in which no current strength is identified; efforts may be recommended to develop a strength in this area.</strong> The child does not demonstrate the ability to play in a developmentally appropriate or quality manner.</td>
</tr>
</tbody>
</table>

**Questions to Consider**
- Is the child easily engaged in play?
- Does the child initiate play? Can the child sustain play?
- Does the child need adult support in initiating and sustaining play more than what is developmentally appropriate?
### PERSISTENCE AND ADAPTABILITY
This item refers to how the child reacts to new situations or experiences, how they respond to changes in routines, as well as their ability to keep trying a new task/skill, even when it is difficult for them.

<table>
<thead>
<tr>
<th>Questions to Consider</th>
<th>Ratings and Descriptions</th>
</tr>
</thead>
</table>
| • Does child show ability to hang in there even when frustrated by a challenging task? | 0  **Well-developed, centerpiece strength; may be used as a centerpiece in an intervention/action plan.**  
   The child consistently has a strong ability to adjust to changes and transitions, and continue an activity when challenged or meeting obstacles. This supports further growth and development and can be incorporated into a service plan as a centerpiece strength.  |
| • Does child routinely require adult support in trying a new skill/activity?            | 1  **Identified and useful strength. Strength will be used, maintained or built upon as part of the plan. May require some effort to develop strength into a centerpiece strength.**  
   Child with good curiosity and some ability to continue an activity that is challenging. An ambulatory child who does not walk to interesting objects, but who will actively explore them when presented to them, would be rated here. The child demonstrates a level of adaptability and ability to continue in an activity that is challenging. The child could benefit from further development in this area before it is considered a significant strength.  |
| • Can child easily and willingly transition between activities?                          | 2  **Strengths have been identified but require strength-building efforts before they can be effectively utilized as part of a plan. Identified but not useful.**  
   The child shows some ability to continue a challenging task although this needs to be more fully developed. Parents and caregivers need to be the primary support in this area.  |
| • What type of support does the child require to adapt to changes in schedules?         | 3  **An area in which no current strength is identified; efforts may be recommended to develop a strength in this area.**  
   Child’s difficulties coping with challenges places their development at risk. Child may seem frightened of new information, changes or environments.  |
AGE 6-21 CHILD FUNCTIONING

For the Age 6-21 Child Functioning Domain, use the following categories and action levels:

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

SOCIAL FUNCTIONING
This item rates social skills and relationships. It includes age-appropriate behavior and the ability to make and sustain relationships.

Questions to Consider
- Is the child pleasant and likeable?
- Do same age peers like the child?
- Do you feel that the child can act appropriately in social settings?

Ratings and Descriptions

0  No evidence of any needs; no need for action.
   No evidence of problems and/or child has developmentally appropriate social functioning.

1  Identified need that requires monitoring, watchful waiting, or preventive action based on history, suspicion or disagreement.
   There is a history or suspicion of problems in social relationships. Child is having some difficulty interacting with others and building and/or maintaining relationships.

2  Action is required to ensure that the identified need is addressed; need is interfering with functioning.
   Child is having some problems with social relationships that interfere with functioning in other life domains.

3  Need is dangerous or disabling; requires immediate and/or intensive action.
   Child is experiencing significant disruptions in social relationships. Child may have no friends or have constant conflict in relations with others, or have maladaptive relationships with others. The quality of the child’s social relationships presents imminent danger to the child’s safety, health, and/or development.
### MEDICAL/PHYSICAL
This item describes both health problems and chronic/acute physical conditions or impediments.

**Questions to Consider**
- Does the child have anything that limits their physical activities?
- How much does this interfere with the child’s life?

**Ratings and Descriptions**

<table>
<thead>
<tr>
<th>Rating</th>
<th>Description</th>
</tr>
</thead>
</table>
| 0      | No evidence of any needs; no need for action.  
No evidence that the child has any medical or physical problems, and/or they are healthy. |
| 1      | Identified need that requires monitoring, watchful waiting, or preventive action based on history, suspicion or disagreement.  
Child has mild, transient or well-managed physical or medical problems. These include well-managed chronic conditions like juvenile diabetes or asthma. |
| 2      | Action is required to ensure that the identified need is addressed; need is interfering with functioning.  
Child has serious medical or physical problems that require medical treatment or intervention. Or child has a chronic illness or a physical challenge that requires ongoing medical intervention. |
| 3      | Need is dangerous or disabling; requires immediate and/or intensive action.  
Child has life-threatening illness or medical/physical condition. Immediate and/or intense action should be taken due to imminent danger to child’s safety, health, and/or development. |

### SLEEP
This item rates the child’s sleep patterns. This item is used to describe any problems with sleep, regardless of the cause including difficulties falling asleep or staying asleep as well as sleeping too much. Both bedwetting and nightmares should be considered sleep issues.

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

**Ratings and Descriptions**

<table>
<thead>
<tr>
<th>Rating</th>
<th>Description</th>
</tr>
</thead>
</table>
| 0      | No evidence of any needs; no need for action.  
Child gets a full night’s sleep each night. |
| 1      | Identified need that requires monitoring, watchful waiting, or preventive action based on history, suspicion or disagreement.  
Child has some problems sleeping. Generally, child gets a full night’s sleep but at least once a week problems arise. This may include occasionally awakening or bed wetting or having nightmares. |
| 2      | Action is required to ensure that the identified need is addressed; need is interfering with functioning.  
Child is having problems with sleep. Sleep is often disrupted and child seldom obtains a full night of sleep. |
| 3      | Need is dangerous or disabling; requires immediate and/or intensive action.  
Child is generally sleep deprived. Sleeping is almost always difficult and the child is not able to get a full night’s sleep. |
DEVELOPMENTAL/INTELLECTUAL
This item describes the child’s development as compared to standard developmental milestones, as well as rates the presence of any developmental (motor, social and speech) or intellectual disabilities. It includes Intellectual Developmental Disorder (IDD) and Autism Spectrum Disorders. Rate the item depending on the significance of the disability and the related level of impairment in personal, social, family, school, or occupational functioning.

Ratings and Descriptions

0  No evidence of any needs; no need for action.
   No evidence of developmental delay and/or child has no developmental problems or intellectual disability.

1  Identified need that requires monitoring, watchful waiting, or preventive action based on history, suspicion or disagreement.
   There are concerns about possible developmental delay. Child may have low IQ, a documented delay, or documented borderline intellectual disability (i.e. FSIQ 70-85). Mild deficits in adaptive functioning are indicated.

2  Action is required to ensure that the identified need is addressed; need is interfering with functioning.
   Child has mild developmental delays (e.g., deficits in social functioning, inflexibility of behavior causing functional problems in one or more settings) and/or mild to moderate Intellectual Disability/Intellectual Disability Disorder. (If available, FSIQ 55-69.) IDD impacts communication, social functioning, daily living skills, judgment, and/or risk of manipulation by others.

3  Need is dangerous or disabling; requires immediate and/or intensive action.
   Child has severe to profound intellectual disability (FSIQ, if available, less than 55) and/or Autism Spectrum Disorder with marked to profound deficits in adaptive functioning in one or more areas: communication, social participation and independent living across multiple environments.

Questions to Consider

- Does the child’s growth and development seem healthy?
- Has the child reached appropriate developmental milestones (such as walking, talking)?
- Has anyone ever mentioned that the child may have developmental problems?
- Has the child developed like other same age peers?
### SEXUAL DEVELOPMENT
This item looks at broad issues of sexual development including developmentally inappropriate sexual behavior or sexual concerns, and the reactions of others to any of these factors. The child’s sexual orientation, gender identity and expression (SOGIE) could be rated here only if they are leading to difficulties. Sexually abusive behaviors are rated elsewhere.

<table>
<thead>
<tr>
<th>Ratings</th>
<th>Descriptions</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>No evidence of any needs; no need for action. No evidence of issues with sexual development.</td>
</tr>
<tr>
<td>1</td>
<td>Identified need that requires monitoring, watchful waiting, or preventive action based on history, suspicion or disagreement. History or suspicion of problems with sexual development, but does not interfere with functioning in other life domains. May include the child’s concerns about sexual orientation, gender identity and expression (SOGIE), or anxiety about the reaction of others.</td>
</tr>
<tr>
<td>2</td>
<td>Action is required to ensure that the identified need is addressed; need is interfering with functioning. Moderate to serious problems with sexual development that interferes with the child’s life functioning in other life domains.</td>
</tr>
<tr>
<td>3</td>
<td>Need is dangerous or disabling; requires immediate and/or intensive action. Severe problems with sexual development. This would include very frequent risky sexual behavior or victim of sexual exploitation.</td>
</tr>
</tbody>
</table>

#### Questions to Consider
- Are there concerns about the child’s healthy sexual development?
- Is the child sexually active?
- Does the child have less/more interest in sex than other same age peers?

### SCHOOL
This item refers to the child’s status with school. If the child has completed their schooling then use ‘0’. If child has dropped out without completing then use a ‘3’. This item reflects School Achievement, School Attendance and School Behavior.

<table>
<thead>
<tr>
<th>Ratings</th>
<th>Descriptions</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>No evidence of any needs; no need for action. There is no evidence that the child is experiencing school problems. Child has good educational functioning. Child is meeting or exceeding educational expectation at an age-expected grade level.</td>
</tr>
<tr>
<td>1</td>
<td>Identified need that requires monitoring, watchful waiting, or preventive action based on history, suspicion or disagreement. Child is functioning adequately at school, mostly meeting educational expectations at an age-expected grade level.</td>
</tr>
<tr>
<td>2</td>
<td>Action is required to ensure that the identified need is addressed; need is interfering with functioning. Child is functioning below educational expectations and/or requires a specialized educational setting in order to learn at an adequate level. Child has been truant at some point during the school year.</td>
</tr>
<tr>
<td>3</td>
<td>Need is dangerous or disabling; requires immediate and/or intensive action. Child has significant difficulties with educational functioning. Child has significant educational problems including some behavioral problems related to academic difficulties (chronic truancy, suspensions, expulsions, being held back, etc.). Child may be placed in a specialized educational setting but remains unable to learn at an adequate level.</td>
</tr>
</tbody>
</table>

#### Questions to Consider
- How is the child doing in school?
- Is the child experiencing any problems related to academic progress? Behavioral problems?
**BEHAVIORAL/MENTAL HEALTH NEEDS***

This item is used to describe the child’s current mental health and substance use needs. A formal mental health diagnosis is not required to score this item.

**Ratings and Descriptions**

- **0** *No evidence of any needs; no need for action.*
  - No mental health challenges. Child has no signs of any notable mental health conditions.

- **1** *Identified need that requires monitoring, watchful waiting, or preventive action based on history, suspicion or disagreement.*
  - History of mental health challenges. Or child may have problems with adjustment, may be somewhat depressed, withdrawn, irritable, or agitated, but this does not interfere with functioning.

- **2** *Action is required to ensure that the identified need is addressed; need is interfering with functioning.*
  - Evidence of mental health challenge or a diagnosable mental health condition that interferes with child’s functioning.

- **3** *Need is dangerous or disabling; requires immediate and/or intensive action.*
  - Child has a dangerous or disabling serious psychiatric disorder.

*A rating of ‘1,’ ‘2,’ or ‘3’ on this item triggers the completion of the [D] Behavioral/Mental Health Needs Module.

**Supplemental Information:** Any mental health need would be indicated here regardless of its specific symptom presentation. So, this item combines depression, anxiety, substance use or disruptive behavior into a single indicator of any need to connect with specialty mental health treatment.
**[D] BEHAVIORAL/MENTAL HEALTH NEEDS MODULE**

The items in this module focus on identifying mental health challenges or needs. This module is to be completed when the Behavioral/Mental Health Needs item is rated ‘1,’ ‘2’ or ‘3.’

<table>
<thead>
<tr>
<th>BMHN1. PSYCHOSIS (THOUGHT DISORDER)</th>
</tr>
</thead>
<tbody>
<tr>
<td>This item rates the symptoms of psychiatric disorders with a known neurological base, including schizophrenia spectrum and other psychotic disorders. The common symptoms of these disorders include hallucinations (i.e. experiencing things others do not experience), delusions (i.e. a false belief or an incorrect inference about reality that is firmly sustained despite the fact that nearly everybody thinks the belief is false or proof exists of its inaccuracy), disorganized thinking, and bizarre/idiosyncratic behavior.</td>
</tr>
</tbody>
</table>

### Questions to Consider

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

### Ratings and Descriptions

<table>
<thead>
<tr>
<th>Rating</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>No evidence of psychotic symptoms. Both thought processes and content are within normal range.</td>
</tr>
<tr>
<td>1</td>
<td>Evidence of disruption in thought processes or content. Child may be somewhat tangential in speech or evidence somewhat illogical thinking (age-inappropriate). This also includes a child with a history of hallucinations but none currently. Use this category for children who are below the threshold for one of the DSM diagnoses listed above.</td>
</tr>
<tr>
<td>2</td>
<td>Evidence of disturbance in thought process or content that may be impairing the child’s functioning in at least one life domain. Child may be somewhat delusional or have brief intermittent hallucinations. Speech may be at times quite tangential or illogical.</td>
</tr>
<tr>
<td>3</td>
<td>Clear evidence of dangerous hallucinations, delusions, or bizarre behavior that might be associated with some form of psychotic disorder that places the child or others at risk of physical harm.</td>
</tr>
</tbody>
</table>
BMHN2. IMPULSIVITY/HYPERACTIVITY
Problems with impulse control and impulsive behaviors, including motoric disruptions, are rated here. This includes behavioral symptoms associated with Attention-Deficit Hyperactivity Disorder (ADHD) and Impulse-Control Disorders as indicated in the DSM-5. Children with impulse problems tend to engage in behavior without thinking, regardless of the consequences. This can include compulsions to engage in gambling, violent behavior (e.g., road rage), sexual behavior, fire-starting or stealing.

Ratings and Descriptions
0  No evidence of symptoms of loss of control of behavior.
1  There is a history or evidence of mild levels of impulsivity evident in action or thought that place the child at risk of future functioning difficulties. The child may exhibit limited impulse control, e.g., child may yell out answers to questions or may have difficulty waiting one’s turn. Some motor difficulties may be present as well, such as pushing or shoving others.
2  Clear evidence of problems with impulsive, distractible, or hyperactive behavior that interferes with the child’s functioning in at least one life domain. This indicates a child with impulsive behavior who may represent a significant management problem for adults (e.g., caregivers, teachers, coaches, etc.). A child who often intrudes on others and often exhibits aggressive impulses would be rated here.
3  Clear evidence of a dangerous level of hyperactivity and/or impulsive behavior that places the child at risk of physical harm. This indicates a child with frequent and significant levels of impulsive behavior that carries considerable safety risk (e.g., running into the street, dangerous driving or bike riding). The child may be impulsive on a nearly continuous basis. The child endangers self or others without thinking.

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

BMHN3. DEPRESSION
This item rates symptoms such as irritable or depressed mood, social withdrawal, sleep disturbances, weight/eating disturbances, and loss of motivation, interest or pleasure in daily activities. This item can be used to rate symptoms of the depressive disorders as specified in DSM-5.

Ratings and Descriptions
0  No evidence of problems with depression.
1  History or suspicion of depression or evidence of depression associated with a recent negative life event with minimal impact on life domain functioning. Brief duration of depression, irritability, or impairment of peer, family, or academic functioning that does not lead to pervasive avoidance behavior.
2  Clear evidence of depression associated with either depressed mood or significant irritability. Depression has interfered significantly in child’s ability to function in at least one life domain.
3  Clear evidence of disabling level of depression that makes it virtually impossible for the child to function in any life domain. This rating is given to a child with a severe level of depression. This would include a child who stays at home or in bed all day due to depression or one whose emotional symptoms prevent any participation in school, friendship groups, or family life. Disabling forms of depressive diagnoses would be rated here.

Questions to Consider
- Is child concerned about possible depression or chronic low mood and irritability?
- Has the child withdrawn from normal activities?
- Does the child seem lonely or not interested in others?
BMHN4. ANXIETY
This item rates symptoms associated with DSM-5 Anxiety Disorders characterized by excessive fear and anxiety and related behavioral disturbances (including avoidance behaviors). Panic attacks can be a prominent type of fear response.

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

Ratings and Descriptions

0  No evidence of anxiety symptoms.
1  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 yet causing the child significant distress or markedly impairing functioning in any important context.
2  Clear evidence of anxiety associated with either anxious mood or significant fearfulness. Anxiety has interfered in the child’s ability to function in at least one life domain.
3  Clear evidence of debilitating level of anxiety that makes it virtually impossible for the child to function in any life domain.

BMHN5. OPPOSITIONAL (NON-COMPLIANCE WITH AUTHORITY)
This item rates the child’s relationship with authority figures. Generally oppositional behavior is displayed in response to conditions set by a parent, teacher or other authority figure with responsibility for and control over the child.

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

Ratings and Descriptions

0  No evidence of oppositional behaviors.
1  There is a history or evidence of mild level of defiance towards authority figures that has not yet begun to cause functional impairment. Child may occasionally talk back to teacher, parent/caregiver; there may be letters or calls from school.
2  Clear evidence of oppositional and/or defiant behavior towards authority figures that is currently interfering with the child’s functioning in at least one life domain. Behavior causes emotional harm to others. A child whose behavior meets the criteria for Oppositional Defiant Disorder in DSM-5 would be rated here.
3  Clear evidence of a dangerous level of oppositional behavior involving the threat of physical harm to others. This rating indicates that the child has severe problems with compliance with rules or adult instruction or authority.
BMHN6. CONDUCT
This item rates the degree to which a child engages in behavior that is consistent with the presence of a Conduct Disorder.

Questions to Consider
- Is the child seen as dishonest? How does the child handle telling the truth/lie?
- Has the child been part of any criminal behavior?
- Has the child ever shown violent or threatening behavior towards others?
- Has the child ever tortured animals?
- Does the child disregard or is unconcerned about the feelings of others (lack empathy)?

Ratings and Descriptions
0  No evidence of serious violations of others or laws.
1  There is a history, suspicion or evidence of some problems associated with antisocial behavior including but not limited to lying, stealing, manipulation of others, acts of sexual aggression, or violence towards people, property or animals. The child may have some difficulties in school and home behavior. Problems are recognizable but not notably deviant for age, sex and community.
2  Clear evidence of antisocial behavior including but not limited to lying, stealing, manipulating others, sexual aggression, violence towards people, property, or animals. A child rated at this level will likely meet criteria for a diagnosis of Conduct Disorder.
3  Evidence of a severe level of aggressive or antisocial behavior, as described above, that places the child or community at significant risk of physical harm due to these behaviors. This could include frequent episodes of unprovoked, planned aggressive or other antisocial behavior.

BMHN7. SUBSTANCE USE
This item describes problems related to the use of alcohol and illegal drugs, the misuse of prescription medications, and the inhalation of any chemical or synthetic substance by a child. This rating is consistent with DSM-5 Substance-Related and Addictive Disorders. This item does not apply to the use of tobacco or caffeine.

Questions to Consider
- Has the child used alcohol or drugs on more than an experimental basis?
- Do you suspect that the child may have an alcohol or drug use problem?
- Has the child been in a recovery program for the use of alcohol or illegal drugs?

Ratings and Descriptions
0  Child has no notable substance use difficulties at the present time.
1  Child has substance use problems that occasionally interfere with daily life (e.g., intoxication, loss of money, reduced work/school performance, parental concern). History of substance use problems without evidence of current problems related to use is rated here.
2  Child has a substance use problem that consistently interferes with the ability to function optimally, but does not completely preclude functioning in an unstructured setting.
3  Child has a substance use problem that represents complications to functional issues that may result in danger to self, public safety issues, or the need for detoxification of the child.
### BMHN8. EATING DISTURBANCE

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

**Ratings and Descriptions**

<table>
<thead>
<tr>
<th>Rating</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>No evidence of eating disturbances.</td>
</tr>
<tr>
<td>1</td>
<td>There is a history, suspicion or mild level of eating disturbance. This could include some preoccupation with weight, calorie intake, or body size or type when of normal weight or below weight. This could also include some binge eating patterns.</td>
</tr>
<tr>
<td>2</td>
<td>Eating disturbance impairs child’s functioning in at least one life domain. This could include a more intense preoccupation with weight gain or becoming fat when underweight, restrictive eating habits or excessive exercising in order to maintain below normal weight, and/or emaciated body appearance. This level could also include more notable binge eating episodes that are followed by compensatory behaviors in order to prevent weight gain (e.g., vomiting, use of laxatives, excessive exercising). The child may meet criteria for a DSM-5 Feeding and Eating Disorders (including Anorexia Nervosa, Bulimia Nervosa, Avoidant/Restrictive Food Intake Disorder, etc.). Food hoarding also would be rated here.</td>
</tr>
<tr>
<td>3</td>
<td>Child’s eating disturbance is dangerous or puts their health at risk. This could include significantly low weight where hospitalization is required or excessive binge-purge behaviors (at least once per day).</td>
</tr>
</tbody>
</table>

**Questions to Consider**

- How does the child feel about their body?
- Does the child seem to be overly concerned about their weight?
- Does the child ever refuse to eat, binge eat, or hoard food?
- Has the child ever been hospitalized for eating-related issues?

**Supplemental Information:** Anorexia Nervosa is characterized by refusal to maintain a body weight that is at or above the minimum normal weight for age and height, intense fear of gaining weight or becoming fat, denying the seriousness of having a low body weight, or having a distorted image of your appearance or shape. Repeated bingeing and getting rid of the extra calories from bingeing by vomiting, excessive exercise, fasting, or misuse of laxatives, diuretics, enemas or other medications characterize Bulimia Nervosa.

### BMHN9. ANGER CONTROL

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

**Ratings and Descriptions**

<table>
<thead>
<tr>
<th>Rating</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>No evidence of any anger control problems.</td>
</tr>
<tr>
<td>1</td>
<td>History, suspicion of, or evidence of some problems with controlling anger. Child may sometimes become verbally aggressive when frustrated. Peers and family are aware of and may attempt to avoid stimulating angry outbursts.</td>
</tr>
<tr>
<td>2</td>
<td>Child’s difficulties with controlling anger are impacting functioning in at least one life domain. Child’s temper has resulted in significant trouble with peers, family and/or school. Anger may be associated with physical violence. Others are likely quite aware of anger potential.</td>
</tr>
<tr>
<td>3</td>
<td>Child’s temper or anger control problem is dangerous. Child frequently gets into fights that are often physical. Others likely fear the child.</td>
</tr>
</tbody>
</table>

**Questions to Consider**

- How does the child control their emotions?
- Does the child get upset or frustrated easily?
- Does the child overreact if someone criticizes or rejects them?
- Does the child seem to have dramatic mood swings?
BMHN10. ATTACHMENT DIFFICULTIES
This item rates the level of difficulties the child has with attachment and their ability to form relationships.

Questions to Consider

- Does the child struggle with separating from caregiver?
- Does the child approach or attach to strangers?

Ratings and Descriptions

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

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

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

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

End of the Behavioral/Mental Health Needs Module
**RISK BEHAVIORS**

This item is used to describe the child’s current behaviors that could get them into serious trouble or put them in danger of harming themselves or others.

Ratings and Descriptions

- **0** No evidence of any needs; no need for action.  
  No evidence of current behaviors that could get child in trouble or put them in danger of harming themselves or others.

- **1** Identified need that requires monitoring, watchful waiting, or preventive action based on history, suspicion or disagreement.  
  Child has a history of risk behaviors or is displaying some behaviors that are not yet interfering with child’s functioning such as verbal threats of aggression or running away, sexually inappropriate but not harmful behavior or socially inappropriate behavior, or status offenses.

- **2** Action is required to ensure that the identified need is addressed; need is interfering with functioning.  
  Evidence of current risk behaviors that interfere with child’s functioning. This may include suicidal ideation without a plan, self-injurious behavior not requiring medical attention, harm to others, recent running away, or fire-setting or delinquent behavior that did not harm others.

- **3** Need is dangerous or disabling; requires immediate and/or intensive action.  
  Dangerous or disabling risk behaviors that put child or others in immediate danger. This may include current suicidal ideation or attempt, physical harm to others including battery or rape, or reckless or risk-taking behavior that puts an individual in harm’s way.

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*A rating of ‘1,’ ‘2,’ or ‘3’ on this item triggers the completion of the [E] Risk Behaviors Module.*

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**[E] RISK BEHAVIORS MODULE**

The items in this module focus on identifying behaviors that could get the child in trouble or put the child or others in danger. This module is to be completed when the Risk Behaviors item is rated ‘1,’ ‘2’ or ‘3.’

**[E] RB1. SUICIDE RISK**

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

Ratings and Descriptions

- **0** No evidence of suicidal ideation.
- **1** History of suicidal ideation, but no recent ideation or gesture. History of suicidal behaviors or significant ideation but none during the recent past.
- **2** Recent, but not acute, suicidal ideation or gesture.
- **3** Current suicidal ideation and intent OR command hallucinations that involve self-harm.
### RB2. NON-SUICIDAL SELF-INJURIOUS BEHAVIOR
This item includes repetitive, physically harmful behavior that generally serves as a self-soothing function to the child (e.g., cutting, carving, burning self, face slapping, head banging, etc.).

<table>
<thead>
<tr>
<th>Questions to Consider</th>
<th>Ratings and Descriptions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Does the behavior serve a self-soothing purpose (e.g., numb emotional pain, move the focus of emotional pain to the physical)?</td>
<td>0  No evidence of any forms of self-injury.</td>
</tr>
<tr>
<td>Does the child ever purposely hurt themselves (e.g., cutting)?</td>
<td>1  A history or suspicion of self-injurious behavior.</td>
</tr>
<tr>
<td></td>
<td>2  Engaged in self-injurious behavior (e.g., cutting, burns, piercing skin with sharp objects, repeated head banging) that does not require medical attention.</td>
</tr>
<tr>
<td></td>
<td>3  Engaged in self-injurious behavior requiring medical intervention (e.g., sutures, surgery) and that is significant enough to put the child’s health at risk.</td>
</tr>
</tbody>
</table>

### RB3. OTHER SELF-HARM (RECKLESSNESS)
This item includes reckless and dangerous behaviors that, while not intended to harm self or others, place the child or others in some jeopardy. Suicidal or self-injurious behaviors are not rated here.

<table>
<thead>
<tr>
<th>Questions to Consider</th>
<th>Ratings and Descriptions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Does the child act without thinking?</td>
<td>0  No evidence of behaviors (other than suicide or self-mutilation) that place the child at risk of physical harm.</td>
</tr>
<tr>
<td>Has the child ever talked about or acted in a way that might be dangerous to themselves (e.g., reckless behavior such as riding on top of cars, reckless driving, climbing bridges, etc.)?</td>
<td>1  There is a history or suspicion of or mild reckless or risk-taking behavior (other than suicide or self-mutilation) that places child at risk of physical harm.</td>
</tr>
<tr>
<td></td>
<td>2  Engaged in reckless or intentional risk-taking behavior (other than suicide or self-mutilation) that places the child in danger of physical harm.</td>
</tr>
<tr>
<td></td>
<td>3  Engaged in reckless or intentional risk-taking behavior (other than suicide or self-mutilation) that places the child at immediate risk of death.</td>
</tr>
</tbody>
</table>

### RB4. DANGER TO OTHERS
This item rates the child’s violent or aggressive behavior. The intention of this behavior is to cause significant bodily harm to others. A rating of ‘2’ or ‘3’ would indicate the need for a safety plan. Reckless behavior that may cause physical harm to others is not rated on this item.

<table>
<thead>
<tr>
<th>Questions to Consider</th>
<th>Ratings and Descriptions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Has the child ever injured another person on purpose?</td>
<td>0  No evidence or history of aggressive behaviors or significant verbal threats of aggression towards others (including people and animals).</td>
</tr>
<tr>
<td>Does the child get into physical fights?</td>
<td>1  History of aggressive behavior or verbal threats of aggression towards others. History of fire setting would be rated here.</td>
</tr>
<tr>
<td>Has the child ever threatened to kill or seriously injure others?</td>
<td>2  Occasional or moderate level of aggression towards others. Child has made verbal threats of violence towards others.</td>
</tr>
<tr>
<td></td>
<td>3  Acute homicidal ideation with a plan, frequent or dangerous (significant harm) level of aggression to others. Child is an immediate risk to others.</td>
</tr>
</tbody>
</table>
**RB5. SEXUAL AGGRESSION**
This item is intended to describe both aggressive sexual behavior and sexual behavior in which the child takes advantage of a younger or less powerful child. The severity and recency of the behavior provide the information needed to rate this item.

Questions to Consider
- Has the child ever been accused of being sexually aggressive towards another child?
- Has the child had sexual contact with a younger individual?

Ratings and Descriptions
0  No evidence of sexually aggressive behavior.
1  History or suspicion of sexually aggressive behavior and/or sexually inappropriate behavior within the past year that troubles others such as harassing talk or public masturbation.
2  Child engages in sexually aggressive behavior that negatively impacts functioning. For example, frequent inappropriate sexual behavior (e.g., inappropriate touching of others). Frequent disrobing would be rated here only if it was sexually provocative.
3  Child engages in a dangerous level of sexually aggressive behavior. This would indicate the rape or sexual abuse of another person involving sexual penetration.

**RB6. RUNAWAY**
This item describes the risk of running away or actual runaway behavior.

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

Ratings and Descriptions
0  Child has no history of running away or ideation of escaping from current living situation.
1  Child has no recent history of running away but has expressed ideation about escaping current living situation. Child may have threatened running away on one or more occasions or has a history of running away but not in the recent past.
2  Child has run from home once or run from one treatment setting. Also rated here is a child who has run home (parental or relative).
3  Child has run from home and/or treatment settings in the recent past and presents an imminent flight risk. A child who is currently a runaway is rated here.

**RB7. DELINQUENT BEHAVIOR**
This item includes both criminal behavior and status offenses that may result from child failing to follow required behavioral standards (e.g., truancy, curfew violations, driving without a license). Sexual offenses should be included as criminal behavior. If caught, the child could be arrested for this behavior.

Questions to Consider
- Do you know of laws that the child has broken (even if the child has not been charged or caught)?
- Has the child ever been arrested?

Ratings and Descriptions
0  No evidence or no history of delinquent behavior.
1  History or suspicion of delinquent behavior, but none in the recent past. Status offenses would generally be rated here.
2  Currently engaged in delinquent behavior (e.g., vandalism, shoplifting, etc.) that puts the child at risk.
3  Serious recent acts of delinquent activity that place others at risk of significant loss or injury, or place the child at risk of adult sanctions. Examples include car theft, residential burglary and gang involvement.
RB8. FIRE SETTING
This item refers to behavior involving the intentional setting of fires that might be dangerous to the child or others. This includes both malicious and non-malicious fire-setting. This does NOT include the use of candles or incense or matches to smoke or accidental fire-setting.

Questions to Consider
- Has the child ever started a fire?
- Has the incident of fire setting put anyone at harm or at risk of harm?

<table>
<thead>
<tr>
<th>Ratings and Descriptions</th>
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</thead>
<tbody>
<tr>
<td>0</td>
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<tr>
<td>1</td>
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<tr>
<td>2</td>
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RB9. INTENTIONAL MISBEHAVIOR
This item describes intentional behaviors that a child engages in to force others to administer consequences. This item should reflect problematic social behaviors (socially unacceptable behavior for the culture and community in which the child lives) that put the child at some risk of consequences. It is not necessary that the child be able to articulate that the purpose of their misbehavior is to provide reactions/consequences to rate this item. There is always, however, a benefit to the child resulting from this unacceptable behavior even if it does not appear this way on the face of it (e.g., child feels more protected, more in control, less anxious because of the sanctions). This item should not be rated for children who engage in such behavior solely due to developmental delays.

Questions to Consider
- Does the child intentionally do or say things to upset others or get in trouble with people in positions of authority (e.g., parents or teachers)?
- Has the child engaged in behavior that was insulting, rude or obnoxious and which resulted in sanctions for the child such as suspension, job dismissal, etc.?

<table>
<thead>
<tr>
<th>Ratings and Descriptions</th>
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<tbody>
<tr>
<td>0</td>
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<tr>
<td>1</td>
</tr>
<tr>
<td>2</td>
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<tr>
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</tbody>
</table>
RB10. BULLYING
This item rates behavior that involves intimidation (verbal or physical) of others; threatening others with harm if they do not comply with the individual’s demands is rated here. A victim of bullying is not rated here.

Questions to Consider
- Are there concerns that the child might bully other children?
- Have there been any reports that the child has picked on, made fun of, harassed or intimidated another person?
- Does the child hang around with other people who bully?

Ratings and Descriptions
0  No evidence that the child has ever engaged in bullying at school or in the community.
1  History or suspicion of bullying, or child has engaged in bullying behavior or associated with groups that have bullied other children.
2  Child has bullied other children in school or in the community. They have either bullied the other children, or led a group that bullied other children.
3  Child has repeatedly utilized threats or actual violence when bullying others in school and/or in the community.

RB11. VICTIMIZATION/EXPLOITATION
This item describes a child who has been victimized by others. This item is used to examine a history and pattern of being the object of abuse and/or whether the child is at current risk for re-victimization. It would also include children who are victimized in other ways (e.g., sexual abuse, sexual exploitation, inappropriate expectations based on a child’s level of development, a child who is forced to take on a parental level of responsibility, etc.).

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

Ratings and Descriptions
0  No evidence that the child has experienced victimization or exploitation.
1  Suspicion or history of victimization or exploitation, but the child has not been victimized to any significant degree in the past year. Child is not presently at risk for re-victimization or exploitation.
2  Child has been recently victimized (within the past year) and may be at risk of re-victimization. This might include physical or sexual abuse, significant psychological abuse by family or friend, sexual exploitation, or violent crime.
3  Child has been recently or is currently being victimized or exploited, including human trafficking (e.g., labor or sexual exploitation including the production of pornography, sexually explicit performance, sexual activity) or living in an abusive relationship, or constantly taking on responsibilities of being a parent to other family members.

End of the Risk Behaviors Module
ADJUSTMENT TO TRAUMA*

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

Ratings and Descriptions

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

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

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

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

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

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

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

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

* A rating of ‘1’, ‘2’ or ‘3’ on this item triggers the completion of the [F] Trauma Module.

**Supplemental Information:** This item covers both adjustment disorders and posttraumatic stress disorder from the DSM. Behaviors which might indicate trauma reactions include anxiousness/hyper-vigilance, regression to behavior of younger ages (e.g., toileting problems, babyish speech, failure to engage in self-feeding, bathing, and other self-care), appetite disruption, withdrawal of interest from pleasurable activities, and other signs of emotional dysregulation after significant life events.
[F] TRAUMA MODULE: POTENTIALLY TRAUMATIC/ADVERSE CHILDHOOD EXPERIENCES

The items in this module focus on identifying trauma experiences. This module is to be completed when the Adjustment to Trauma item is rated ‘1,’ ‘2’ or ‘3.’

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

Question to Consider for this Module: Has the child experienced adverse life events?

For the Trauma Module, the following categories and action levels are used:

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>No</td>
<td>No evidence of any trauma of this type.</td>
</tr>
<tr>
<td>Yes</td>
<td>Child has had experience or there is suspicion that child has experienced this type of trauma— one incident, multiple incidents, or chronic, on-going experiences.</td>
</tr>
</tbody>
</table>

Rate the following items within the child’s lifetime.

**ACE1. SEXUAL ABUSE**

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

<table>
<thead>
<tr>
<th>Questions to Consider</th>
<th>Ratings and Descriptions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Has the caregiver or child disclosed sexual abuse?</td>
<td>No There is no evidence that the child has experienced sexual abuse.</td>
</tr>
<tr>
<td>How often did the abuse occur?</td>
<td>Yes 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. Child with exposure to secondary sexual abuse (e.g., witnessing sexual abuse, having a sibling sexually abused) should be rated here.</td>
</tr>
<tr>
<td>Did the abuse result in physical injury?</td>
<td></td>
</tr>
</tbody>
</table>

**ACE2. PHYSICAL ABUSE**

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

<table>
<thead>
<tr>
<th>Questions to Consider</th>
<th>Ratings and Descriptions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Is physical discipline used in the home? What forms?</td>
<td>No There is no evidence that the child has experienced physical abuse.</td>
</tr>
<tr>
<td>Has the child ever received bruises, marks, or injury from discipline?</td>
<td>Yes 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.</td>
</tr>
</tbody>
</table>
### ACE3. NEGLECT

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

#### Questions to Consider
- Is the child receiving adequate supervision?
- Are basic needs for food and shelter being met?
- Is the child allowed access to necessary medical care? Education?

#### Ratings and Descriptions

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

### ACE4. EMOTIONAL ABUSE

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

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

#### Ratings and Descriptions

- **No** | There is no evidence that child has experienced emotional abuse.
- **Yes** | Child has experienced emotional abuse, or there is a suspicion that they have experienced emotional abuse (mild to severe, for any length of time) including: insults or occasionally being referred to in a derogatory manner by caregivers, being denied emotional attention or completely ignored, or threatened/terrorized by others.

### ACE5. MEDICAL TRAUMA

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

#### Questions to Consider
- Has the child had any broken bones, stitches or other medical procedures?
- Has the child had to go to the emergency room, or stay overnight in the hospital?

#### Ratings and Descriptions

- **No** | There is no evidence that the child has experienced any medical trauma.
- **Yes** | Child has had a medical experience that was perceived as emotionally or mentally overwhelming. This includes events that were acute in nature and did not result in ongoing medical needs; associated distress such as minor surgery, stitches or bone setting; acute injuries and moderately invasive medical procedures such as major surgery that required only short-term hospitalization; events that may have been life threatening and may have resulted in chronic health problems that alter the child’s physical functioning. A suspicion that a child has had a medical experience that was perceived as emotionally or mentally overwhelming should be rated here.

### Supplemental Information

This item takes into account the impact of the event on the child. It describes experiences in which the child is subjected to medical procedures that are experienced as upsetting and overwhelming. A child born with physical deformities who is subjected to multiple surgeries could be included. A child who must experience chemotherapy or radiation could also be included. Children who experience an accident and require immediate medical intervention that results in on-going physical limitations or deformities (e.g., burn victims) could be included here. Common medical procedures, which are generally not well received or pleasant but are also not emotionally or psychologically overwhelming for children (e.g., shots, pills) would generally not be rated here.
### ACE6. NATURAL OR MANMADE DISASTER
This item describes the child’s exposure to either natural or manmade disasters.

**Questions to Consider**
- Has the child been present during a natural or manmade disaster?
- Does the child watch television shows containing these themes or overhear adults talking about these kinds of disasters?

**Ratings and Descriptions**

<table>
<thead>
<tr>
<th>Rating</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>No</td>
<td>There is no evidence that the child has experienced, been exposed to or witnessed natural or manmade disasters.</td>
</tr>
<tr>
<td>Yes</td>
<td>Child has experienced, been exposed to or witnessed natural or manmade disasters either directly or second-hand (i.e. on television, hearing others discuss disasters). This includes disasters such as a fire or earthquake or manmade disaster; car accident, plane crashes, or bombings; observing a caregiver who has been injured in a car accident or fire or watching a neighbor’s house burn down; a disaster that caused significant harm or death to a loved one; or there is an ongoing impact or life disruption due to the disaster (e.g. caregiver loses job). A suspicion that the child has experienced, been exposed to or witnessed natural or manmade disasters either directly or second-hand would be rated here.</td>
</tr>
</tbody>
</table>

### ACE7. WITNESS TO FAMILY VIOLENCE
This item describes exposure to violence within the child’s home or family.

**Questions to Consider**
- Is there frequent fighting in the child’s family?
- Does the fighting ever become physical?

**Ratings and Descriptions**

<table>
<thead>
<tr>
<th>Rating</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>No</td>
<td>There is no evidence the child has witnessed family violence.</td>
</tr>
<tr>
<td>Yes</td>
<td>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 but no significant injuries (i.e. requiring emergency medical attention) and episodes in which significant injuries have occurred as a direct result of the violence.</td>
</tr>
</tbody>
</table>

### ACE8. WITNESS TO COMMUNITY/SCHOOL VIOLENCE
This item describes the exposure to incidents of violence the child has witnessed or experienced in their community. This includes witnessing violence at the child’s school or educational setting.

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

**Ratings and Descriptions**

<table>
<thead>
<tr>
<th>Rating</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>No</td>
<td>There is no evidence that the child has witnessed violence in the community or in school.</td>
</tr>
<tr>
<td>Yes</td>
<td>Child has witnessed or experienced violence in the community or in school, such as: fighting; friends/family injuries as a result of violence; severe and repeated instances of violence and/or the death of another person in their community/school as a result of violence; is the direct victim of violence/criminal activity in the community/school that was life threatening; or has experienced chronic/ongoing impact as a result of community/school violence (e.g., family member injured and no longer able to work). A suspicion that the child has witnessed or experienced violence in the community would be rated here.</td>
</tr>
</tbody>
</table>
### ACE9. VICTIM/WITNESS TO CRIMINAL ACTIVITY
This item describes the child’s exposure to criminal activity. Criminal behavior includes any behavior for which an adult could go to prison including drug dealing, assault or battery.

<table>
<thead>
<tr>
<th>Questions to Consider</th>
<th>Ratings and Descriptions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Has the child or someone in their family ever been the victim of a crime?</td>
<td>No</td>
</tr>
<tr>
<td>Has the child seen criminal activity in the community or home?</td>
<td>Yes</td>
</tr>
</tbody>
</table>

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

### ACE10. WAR/ TERRORISM AFFECTED
This item describes the child’s exposure to war, political violence, torture or terrorism.

<table>
<thead>
<tr>
<th>Questions to Consider</th>
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</tr>
</thead>
<tbody>
<tr>
<td>Has the child or their family lived in a war-torn region?</td>
<td>No</td>
</tr>
<tr>
<td>How close was the child to war or political violence, torture or terrorism?</td>
<td>Yes</td>
</tr>
</tbody>
</table>

**Supplemental Information:** Terrorism is defined as “the calculated use of violence or the threat of violence to inculcate fear, intended to coerce or to intimidate governments or societies in the pursuit of goals that are generally political, religious or ideological.” Terrorism includes attacks by individuals acting in isolation (e.g. sniper attacks).
ACE11. DISRUPTIONS IN CAREGIVING/ATTACHMENT LOSSES

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

Questions to Consider
- Has the child ever lived apart from their parents/caregivers?
- What happened that resulted in the child living apart from their parents/caregivers?

Ratings and Descriptions

No
There is no evidence that the child has experienced disruptions in caregiving and/or attachment losses.

Yes
Child has been exposed to, or there is suspicion that they 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). Child may or may not have had ongoing contact with primary attachment figure(s) during this disruption. Shift in caregiving may have been temporary or permanent.

Supplemental Information: Children who have been exposed to disruptions in caregiving involving separation from primary attachment figure(s) and/or attachment losses would be rated here. Children who have had placement changes, including stays in foster care, residential treatment facilities or juvenile justice settings, can be rated here. Short-term hospital stays or brief juvenile detention stays, during which the child’s caregiver remains the same, would not be rated on this item.

End of the Trauma Module
## AGE 6-21 CHILD STRENGTHS

For the **Age 6-21 Strengths Domain**, the following categories and action levels are used:

<table>
<thead>
<tr>
<th></th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>Well-developed, centerpiece strength; may be used as a centerpiece in an intervention/ action plan.</td>
</tr>
<tr>
<td>1</td>
<td>Identified and useful strength. Strength will be used, maintained or built upon as part of the plan. May require some effort to develop strength into a centerpiece strength.</td>
</tr>
<tr>
<td>2</td>
<td>Strengths have been identified but require strength-building efforts before they can be effectively utilized as part of a plan. Identified but not useful.</td>
</tr>
<tr>
<td>3</td>
<td>An area in which no current strength is identified; efforts may be recommended to develop a strength in this area.</td>
</tr>
</tbody>
</table>

### FAMILY STRENGTHS

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

#### Questions to Consider
- Does the child have good relationships with any family member?
- Is there potential to develop positive family relationships?
- Is there a family member that the child can go to in time of need for support? That can advocate for the child?

#### Ratings and Descriptions

<table>
<thead>
<tr>
<th></th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td><strong>Well-developed, centerpiece strength; may be used as a centerpiece in an intervention/ action plan.</strong></td>
</tr>
<tr>
<td></td>
<td>Family has strong relationships and significant family strengths. This level indicates a family with much love and respect for one another. There is at least one family member who has a strong loving relationship with the child and is able to provide significant emotional or concrete support. Child is fully included in family activities.</td>
</tr>
<tr>
<td>1</td>
<td><strong>Identified and useful strength. Strength will be used, maintained or built upon as part of the plan. May require some effort to develop strength into a centerpiece strength.</strong></td>
</tr>
<tr>
<td></td>
<td>Family has some good relationships and good communication. Family members are able to enjoy each other’s company. There is at least one family member who has a strong, loving relationship with the child and is able to provide limited emotional or concrete support.</td>
</tr>
<tr>
<td>2</td>
<td><strong>Strengths have been identified but require strength-building efforts before they can be effectively utilized as part of a plan. Identified but not useful.</strong></td>
</tr>
<tr>
<td></td>
<td>Family needs some assistance in developing relationships and/or communications. Family members are known, but currently none are able to provide emotional or concrete support.</td>
</tr>
<tr>
<td>3</td>
<td><strong>An area in which no current strength is identified; efforts may be recommended to develop a strength in this area.</strong></td>
</tr>
<tr>
<td></td>
<td>Family needs significant assistance in developing relationships and communications, or child has no identified family. Child is not included in normal family activities.</td>
</tr>
</tbody>
</table>
COMMUNITY LIFE
This item reflects the child’s connection to people, places or institutions in their community. This connection is measured by the degree to which the child is involved with institutions of that community which might include (but are not limited to) community centers, little league teams, jobs, after-school activities, religious groups, etc. Connections through specific people (e.g., friends and family) could be considered an important community connection, if many people who are important to the child live in the same neighborhood.

Ratings and Descriptions

0  Well-developed, centerpiece strength; may be used as a centerpiece in an intervention/action plan.
Child is well integrated into their community. The child is a member of community organizations and has positive ties to the community. For example, child may be a member of a community group (e.g. Girl or Boy Scouts) for more than one year, may be widely accepted by neighbors, or involved in other community activities, informal networks, etc.

1  Identified and useful strength. Strength will be used, maintained or built upon as part of the plan. May require some effort to develop strength into a centerpiece strength.
Child is somewhat involved with their community. This level can also indicate a child with significant community ties although they may be relatively short term.

2  Strengths have been identified but require strength-building efforts before they can be effectively utilized as part of a plan. Identified but not useful.
Child has an identified community but has only limited, or unhealthy, ties to that community.

3  An area in which no current strength is identified; efforts may be recommended to develop a strength in this area.
There is no evidence of an identified community of which child is a member at this time.

Questions to Consider
• Does the child feel like they are part of a community?
• Are there activities that the child does in the community?
### TALENTS AND INTERESTS

This item refers to hobbies, skills, artistic interests, and talents that are positive ways that young people can spend their time, and also give them pleasure and a positive sense of self.

#### Ratings and Descriptions

<table>
<thead>
<tr>
<th>Rating</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>Well-developed, centerpiece strength; may be used as a centerpiece in an intervention/action plan. Child has a talent that provides pleasure and/or self-esteem. A child with significant creative/artistic/athletic strengths would be rated here.</td>
</tr>
<tr>
<td>1</td>
<td>Identified and useful strength. Strength will be used, maintained or built upon as part of the plan. May require some effort to develop strength into a centerpiece strength. Child has a talent, interest, or hobby that has the potential to provide pleasure and self-esteem. This level indicates a child with a notable talent. For example, a child who is involved in athletics or plays a musical instrument would be rated here.</td>
</tr>
<tr>
<td>2</td>
<td>Strengths have been identified but require strength-building efforts before they can be effectively utilized as part of a plan. Identified but not useful. Child has expressed interest in developing a specific talent, interest or hobby even if that talent has not been developed to date, or whether it would provide them with any benefit.</td>
</tr>
<tr>
<td>3</td>
<td>An area in which no current strength is identified; efforts may be recommended to develop a strength in this area. There is no evidence of identified talents, interests or hobbies at this time and/or child requires significant assistance to identify and develop talents and interests.</td>
</tr>
</tbody>
</table>

#### Questions to Consider

- What does the child do with free time?
- What does the child enjoy doing?
- Is the child engaged in any pro-social activities?
- What are the things that the child does particularly well?

### OPTIMISM

This item should be rated based on the child’s sense of self in their own future. This rates the child’s future orientation.

#### Ratings and Descriptions

<table>
<thead>
<tr>
<th>Rating</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>Well-developed, centerpiece strength; may be used as a centerpiece in an intervention/action plan. Child has a strong and stable optimistic outlook for their future.</td>
</tr>
<tr>
<td>1</td>
<td>Identified and useful strength. Strength will be used, maintained or built upon as part of the plan. May require some effort to develop strength into a centerpiece strength. Child is generally optimistic about their future.</td>
</tr>
<tr>
<td>2</td>
<td>Strengths have been identified but require strength-building efforts before they can be effectively utilized as part of a plan. Identified but not useful. Child has difficulty maintaining a positive view of themselves and their life. Child’s outlook may vary from overly optimistic to overly pessimistic.</td>
</tr>
<tr>
<td>3</td>
<td>An area in which no current strength is identified; efforts may be recommended to develop a strength in this area. There is no evidence of optimism at this time and/or child has difficulties seeing positive aspects about themselves or their future.</td>
</tr>
</tbody>
</table>

#### Questions to Consider

- Does the child have a generally positive outlook on things; have things to look forward to?
- How does the child see themselves in the future?
- Is the child forward looking/sees themselves as likely to be successful?