Indiana
Child and Adolescent Needs & Strengths

Birth through Age 5

ACKNOWLEDGEMENTS

A large number of individuals have collaborated in the development of the Standard Comprehensive Child Adolescent Needs and Strengths—Early Childhood. This information integration tool is designed to support individual case planning and the planning and evaluation of service systems. The CANS is an open domain tool for use in multiple child-serving systems that address the needs and strengths of children, adolescents, and their families. The copyright is held by the Praed Foundation to ensure that it remains free to use. Training and annual certification is expected for appropriate use.

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

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TABLE OF CONTENTS

ACKNOWLEDGEMENTS 2

INTRODUCTION 4

THE CANS 4

SIX KEY PRINCIPLES OF THE CANS 4

HISTORY AND BACKGROUND OF THE CANS 5

HISTORY 5

MEASUREMENT PROPERTIES 6

RATING NEEDS & STRENGTHS 7

HOW IS THE CANS USED? 9

IT IS AN ASSESSMENT STRATEGY 9

IT GUIDES CARE AND TREATMENT/SERVICE PLANNING 9

IT FACILITATES OUTCOMES MEASUREMENT 9

IT IS A COMMUNICATION TOOL 9

CANS: A BEHAVIOR HEALTH CARE STRATEGY 9

MAKING THE BEST USE OF THE CANS 10

LISTENING USING THE CANS 10

REDIRECT THE CONVERSATION TO PARENTS'/CAREGIVERS' OWN FEELINGS AND OBSERVATIONS 11

ACKNOWLEDGE FEELINGS 11

WRAPPING IT UP 12

REFERENCES 13

CANS-EC BASIC STRUCTURE 16

CORE ITEMS 16

LIFE FUNCTIONING DOMAIN 17

STRENGTHS DOMAIN 25

CULTURAL FACTORS DOMAIN 30

CAREGIVER RESOURCES & NEEDS DOMAIN 34

BEHAVIORAL/EMOTIONAL NEEDS DOMAIN 49

RISK FACTORS DOMAIN 67

RISK BEHAVIORS DOMAIN 71

INTRODUCTION

THE CANS

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

SIX KEY PRINCIPLES OF THE CANS

- **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.
- **Each item uses a 4-level rating system designed to translate immediately into action levels.** Different action levels exist for needs and strengths. For a description of these action levels please see below.
- **Rating should describe the child, not the child in services.** If an intervention is present that is masking a need but must stay in place, this should be factored into the rating consideration and would result in a rating of an "actionable" need (i.e., '2' or '3').
- **Culture and development should be considered prior to establishing the action levels.** Cultural responsivity involves considering whether cultural factors are influencing the expression of needs and strengths. Ratings should be completed considering the individual's developmental and/or chronological age depending on the item. In other words, anger control is not relevant for a very young child but would be for an older child and young adult regardless of developmental age. Alternatively, school achievement should be considered within the framework of expectations based on the child/youth's developmental age.
- **The ratings are generally "agnostic as to etiology."** In other words, this is a descriptive tool; it is about the "what" not the "why." While most items are purely descriptive, there are a few items that consider cause and effect; see individual item descriptions for details on when the "why" is considered in rating these items.
- **A 30-day window is used to make sure assessments stay relevant to the individual's present circumstances.** The CANS is a communication tool and a measure of a child's story. The 30-day time frame should be considered in terms of whether an item is a need within the time frame within which the specific behavior may or may not have occurred. The action levels assist in understanding whether a need is currently relevant even when no specific behavior has occurred during the time frame.

HISTORY AND BACKGROUND OF THE CANS

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

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

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

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

HISTORY

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

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

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

MEASUREMENT PROPERTIES

Reliability

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

Validity

Studies have demonstrated the CANS' validity, or its ability to measure children/youth's and their caregiver's needs and strengths. In a sample of more than 1,700 cases in 15 different program types across New York State, the total scores on the relevant dimensions of the CANS-Mental Health retrospectively distinguished level of care (Lyons, 2004). The CANS assessment has also been used to distinguish needs of children in urban and rural settings (Anderson & Estle, 2001). In numerous jurisdictions, the CANS has been used to predict service utilization and costs, and to evaluate outcomes of clinical interventions and programs (Lyons, 2004; Lyons & Weiner, 2009; Lyons, 2009). Five independent research groups in four states have demonstrated the reliability and validity of decision support algorithms using the CANS (Chor, et al., 2012, 2013, 2014; Cordell, et al., 2016; Epstein, et al., 2015; Israel, et al., 2015; Lardner, 2015).

RATING NEEDS & STRENGTHS

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

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

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

Basic design for rating Needs

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

Basic design for rating Strengths

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

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

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

appropriate rating on the CANS form (or electronic record). This process should be done collaboratively with the child, family and other stakeholders.

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

The CANS is an information integration tool, intended to include multiple sources of information (e.g., child and family, referral source, treatment providers, school, and observation of the rater). As a strength-based approach, the CANS supports the belief that children, youth, and families have unique talents, skills, and life events, in addition to specific unmet needs. Strength-based approaches to assessment and service or treatment planning focus on collaborating with children and their families to discover individual and family functioning and strengths. Failure to demonstrate a child's skill should first be viewed as an opportunity to learn the skill as opposed to the problem. Focusing on the child's strengths instead of weaknesses with their families may result in enhanced motivation and improved performance. Involving the family and child in the rating process and obtaining information (evidence) from multiple sources is necessary and improves the accuracy of the rating. Meaningful use of the CANS and related information as tools (for reaching consensus, planning interventions, monitoring progress, psychoeducation, and supervision) support effective services for children, youth and families.

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

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

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

HOW IS THE CANS USED?

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

IT IS AN ASSESSMENT STRATEGY

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

IT GUIDES CARE AND TREATMENT/SERVICE PLANNING

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

IT FACILITATES OUTCOMES MEASUREMENT

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

IT IS A COMMUNICATION TOOL

When a client leaves a treatment program, a closing CANS may be completed to define progress, measure ongoing needs and help us make continuity of care decisions. Doing a closing CANS, much like a discharge summary, integrated with CANS ratings, provides a picture of how much progress has been made, and allows for recommendations for future care which ties to current needs. And finally, it allows for a shared language to talk about our child and creates opportunities for collaboration. It is our hope that this guide will help you to make the most out of the CANS and guide you in filling it out in an accurate way that helps you make good clinical decisions.

CANS: A BEHAVIOR HEALTH CARE STRATEGY

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

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

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

MAKING THE BEST USE OF THE CANS

Children have families involved in their lives, and their family can be a great asset to their treatment. To increase family involvement and understanding, it is important to talk to them about the assessment process and describe the CANS and how it will be used. The description of the CANS should include teaching the child and family about the needs and strengths rating scales, identifying the domains and items, as well as how the actionable items will be used in treatment or serving planning. When possible, share with the child and family the CANS domains and items (see the CANS Core Item list on page 16) and encourage the family to look over the items prior to your meeting with them. The best time to do this is your decision—you will have a sense of the timing as you work with each family. Families often feel respected as partners when they are prepared for a meeting or a process. A copy of the completed CANS ratings should be reviewed with each family. Encourage families to contact you if they wish to change their answers in any area that they feel needs more or less emphasis.

LISTENING USING THE CANS

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

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

- ★ **Be nonjudgmental and avoid giving person advice.** You may find yourself thinking, "If I were this person, I would do x" or "That's just like my situation, and I did x." But since you

are not that person, what you would do is not particularly relevant. Avoid making judgmental statements or telling them what you would do. It's not really about you.

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

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

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

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

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

ACKNOWLEDGE FEELINGS

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

WRAPPING IT UP

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

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

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

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

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CANS-EC BASIC STRUCTURE

CORE ITEMS

The items for the IN Child and Adolescent Needs and Strengths-Early Childhood are noted below.

Life Functioning Domain
- Family Functioning
- Early Education
- Social and Emotional Functioning
- Recreation/Play
- Developmental/Intellectual
- Motor
- Medical/Physical
- Sleep
- Relationship Permanence

Strengths Domain
- Family Strengths
- Family Cultural Identity
- Interpersonal
- Resiliency (Persistence and Adaptability)

Cultural Factors Domain
- Language
- Traditions and Cultural Rituals
- Cultural Stress

Caregiver Resources & Needs Domain
- Supervision
- Involvement with Care
- Knowledge
- Empathy for Child
- Organization
- Social Resources
- Residential Stability
- Medical/Physical

Caregiver Resources & Needs continued
- Mental Health
- Substance Use
- Developmental
- Family Stress
- Safety
- Marital/Partner Violence in the Home

Behavioral/Emotional Needs
- Attachment Difficulties
- Regulatory
- Failure to Thrive
- Depression
- Anxiety
- Atypical Behaviors
- Impulsivity/Hyperactivity
- Oppositional Behavior
- Adjustment to Trauma

Risk Factors Domain
- Birth Weight
- Prenatal Care
- Labor and Delivery
- Exposure

Risk Behaviors Domain
- Self-Harm
- Aggressive Behavior
- Intentional Misbehavior

LIFE FUNCTIONING DOMAIN

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

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

For the **Life Functioning Domain,** 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.

FAMILY FUNCTIONING

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

Questions to Consider:

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

Ratings and Descriptions

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

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

FAMILY FUNCTIONING continued

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

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

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

Child is having problems with parents, siblings and/or other family members that are impacting their functioning. Frequent arguing, difficulty maintaining positive relationships may be observed.

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

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

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

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

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

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

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

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

FAMILY FUNCTIONING continued

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

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

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***.

Questions to Consider:

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

Ratings and Descriptions

0	*No evidence of any needs; no need for action.* No evidence of problems with functioning in current educational environment.
1	*Identified need that requires monitoring, watchful waiting, or preventive action based on history, suspicion or disagreement.* History or evidence of problems with functioning in current daycare or preschool environment. Child may be enrolled in a special program.
2	*Action is required to ensure that the identified need is addressed; need is interfering with functioning.* Child is experiencing difficulties maintaining their behavior, attendance, and/or progress in educational environment.
3	*Need is dangerous or disabling; requires immediate and/or intensive action.* Child's problems with functioning in the daycare or preschool environment place them at immediate risk of being removed from program due to their behaviors, lack of progress, or unmet needs.

Supplemental Information -- Understanding the importance of early education and care in early childhood: Infants, toddlers and preschoolers often spend most of their day with alternate caregivers. It is critical that these environments meet the needs of these individuals. There has been a great deal of momentum in the field of infant mental health to promote positive care-giving practices within these environments. The same parenting practices and care-giving techniques that are taught to parents need to be promoted within early care/education settings. These experiences are often critical in supporting growth and development and allowing the child to feel positive about relationships with others outside of the home. Early care and education settings have the potential to impact a child's development, school success and overall life success.

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

EARLY EDUCATION continued

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

- Infant or child seems comfortable with caregivers and environment
- Environment has sufficient space and materials for child it serves
- Environment offers a variety of experiences and opportunities
- Allowances for individual differences, preferences and needs are tolerated
- Caregivers can offer insight into child's experiences and feelings
- Caregivers provide appropriate structure to the child's day
- Scheduled times for eating, play and rest
- Caregivers provide appropriate level of supervision and limit setting
- Child's peer interactions are observed, supported, and monitored
- Correction is handled in a calm and supportive manner
- Child is encouraged to learn and explore at their own pace
- A variety of teaching modalities are utilized
- All areas of development are valued and supported simultaneously
- Small group sizes
- Low child-adult ratios
- Safe and clean environment
- Early care/education setting provides frequent and open communication with parents

SOCIAL AND EMOTIONAL FUNCTIONING

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

Questions to Consider:

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

Ratings and Descriptions

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

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

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

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

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

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

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

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

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

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

SOCIAL AND EMOTIONAL FUNCTIONING continued

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

Social Functioning Developmental Milestones

By 3 Months	• Smiles responsively (i.e., social smile) • Imitates simple facial expressions (e.g., smiling, sticking tongue out) • Looks at caregiver's face • Coos responsively • Localizes to familiar voices and sounds • Shows interest in facial expressions • Is comforted by proximity of caregiver
By 6 Months	• Imitates some movements and facial expressions (e.g., smiling, frowning) • Engages in socially reciprocal interactions (e.g., playing simple back-and-forth games) • Seeks social engagement with vocalizations, emotional expressions, or physical contact • Watches face closely • Responds to affection with smiling, cooing, or settling • Recovers from distress when comforted by caregiver
By 9 months	• Distinguishes between familiar and unfamiliar voices • Shows some stranger wariness • Demonstrates preference for caregivers • Protests separation from caregiver • Enjoys extended play with others • Engages in back-and-forth, two-way communication using vocalizations and eye movement • Mimics other's simple gestures • Follows other's gaze and pointing
By 12 months	• Looks to caregiver for information about new situations and environments • Looks to caregiver to share emotional experiences • Responds to other people's emotions (e.g., displays somber, serious face in response to sadness in parent, smiles when parent laughs) • Offers object to imitated interaction (e.g., hands caregiver a book to hear a story) • Plays interactive games (e.g., peek-a-boo, patty-cake) • Looks at familiar people when they are named • Gives object to seek help (e.g., hands shoe to parent) • Extends arm or leg to assist with dressing
By 15 months	• Seeks and enjoys attention from others, especially caregivers • Shows affection with kisses (without pursed lips) • Demonstrates cautious or fearful behavior such as clinging to or hiding behind caregiver • Engages in parallel play with peers

	• Presents a book or toy when they want to hear a story or play • Repeats sounds or actions to get attention [continues] • Enjoys looking at picture books with caregiver • Initiates joint attention (e.g., points to show something interesting or to get others' attention)
By 18 months	• Shares humor with peers or adults (e.g., laughs at and makes funny faces or nonsense rhymes) • Likes to hand things to others during play • Engages in reciprocal displays of affection (e.g., hugs or kisses with a pucker) • Asserts autonomy (e.g., "Me do") • Reacts with concern when someone appears hurt • Leaves caregiver's side to explore nearby objects or settings • Engages in teasing behavior such as looking at caregiver and doing something "forbidden" • When pointing, looks back at caregiver to confirm joint attention
By 24 months	• Exhibits empathy (e.g., offers comfort when someone is hurt) • Attempts to exert independence frequently • Imitates others' complex actions, especially adults and older children (e.g., putting plates on a table, posture, gesture) • Enjoys being with other young children • Takes pride and pleasure in accomplishments • Primarily plays in proximity to young children; notices and imitates other young children's play • Responds to being corrected or praised
By 36 months	• Expresses affection openly and verbally • Shows affection to peers without prompting • Shares without prompts • Can wait turn in playing games • Shows concern for crying peers by taking action • Engages in associate play with peers (e.g., participate in similar activities without formal organization but with some interaction) • Shares accomplishments with others • Helps with simple household chores
By 48 months	• Pretends to play "Mom" or "Dad" or other relevant caregivers • Asks about or talks about caregiver when separated • Engages in cooperative play with other young children • Has a preferred friend • Expresses interests, likes, and dislikes
By 60 months	• Shows increased confidence associated with greater independence and autonomy • Wants to please friends • Emulates role models, real and imaginary • Values rules in social interactions • Participates in group activities that require assuming roles (e.g., Follow the Leader) • Modulates or modifies voice correctly depending on situation or listener (adult, another child, younger child)

[continues]

SOCIAL AND EMOTIONAL FUNCTIONING continued

Axis I

- Following a traumatic experience, a rating of '2' or '3' that represents a negative change in typical social functioning (e.g., decreased interest in social interactions) may be consistent with symptoms of **PTSD** *(see Adjustment to Trauma item)*
- A rating of ''2 or '3' may be consistent with social-communication symptoms of **Autism Spectrum Disorder** (ASD) and **Early Atypical Autism Spectrum Disorder** (EAASD). DC 0-5 specifies three social-communication symptoms, including:
    - Limited or atypical social-emotional responsivity, sustained social attention, or social reciprocity
    - Deficits in nonverbal social-communication behaviors
    - Peer interaction difficulties
- A rating of '2' or '3' related to demonstration of fear/anxiety-based social functioning issues (freezing, withdrawing, hiding, avoiding, refusing to speak) in situations with unfamiliar people may be consistent with symptom of various anxiety disorders, including **Social Anxiety Disorder**, **Selective Mutism**, and **Inhibition to Novelty Disorder** *(see Anxiety item)*

For children who have experienced severe social neglect and/or institutionalized care, a rating of '3' related to withdrawn, inhibited behavior with adult caregivers (e.g., absent or significantly reduced interest in interacting, reduced response to comfort) may be consistent with symptoms of **Reactive Attachment Disorder** (RAD). This disorder is extremely rare and is usually not reported in community settings *(see Attachment item).*

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

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

RECREATION/PLAY

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.

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?

Ratings and Descriptions

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

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

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

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

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

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

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

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

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

RECREATION/PLAY continued

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

Axis I

- Following a traumatic event or the permanent loss of a caregiver, a rating of '2' or '3' that represents a negative change in typical play behaviors (e.g., diminished interest in play) may be consistent with symptoms of **PTSD** or **Complicated Grief Disorder of Early Childhood** *(see Adjustment to Trauma)*
- A rating of '2' or '3' that represents a negative change in typical play behaviors (e.g., diminished interest in play) may be consistent with symptoms of **Depressive Disorder of Early Childhood** *(see Depression)*

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

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

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

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

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

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

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

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

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

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

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

DEVELOPMENTAL/INTELLECTUAL continued

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

By 3 Months	• Follows people and objects with eyes • Loses interest or protests if activity does not change
By 6 Months	• Tracks moving objects with eyes from side to side • Experiments with cause and effect (e.g., bangs spoon on table) • Smiles and vocalizes in response to own face in mirror image • Recognizes familiar people and things at a distance • Demonstrates anticipation of certain routine activities (e.g., shows excitement in anticipation of being fed)
By 9 Months	• Mouths or bangs objects • Tries to get objects that are out of reach • Looks for things they see others hide (e.g., toy under a blanket)
By 12 Months	• Watches the path of something as it falls • Has favorite objects (e.g., toys, blanket) • Explores objects and how they work in multiple ways (e.g., mouthing, touching, dropping) • Fills and dumps containers • Plays with two objects at the same time
By 15 Months	• Imitates complex gestures (e.g., signing) • Finds hidden objects easily • Uses objects for their intended purpose (e.g., drinks from a cup, smooths hair with a brush)
By 18 months	• Enacts play sequences with objects according to their use (e.g., pushing a dump truck and emptying its cargo) • Shows interest in a doll or stuffed animal • Points to at least one body part • Points to self when asked • Plays simple pretend games (e.g., feeding a doll) • Scribbles with crayon, marker, and so forth • Turns pages of book • Recognizes self in mirror
By 2 Years	• Finds things even when hidden under two or three covers or when hidden in one place and moved to another • Begins to sort shapes and colors • Completes sentences and rhymes from familiar books, stories, and songs • Plays simple make-believe games (e.g., pretend meal) • Builds towers of four or more blocks • Follows two-step instructions (e.g., "Pick up your shoes and put them in the closet")
By 3 Years	• Labels some colors correctly • Plays thematic make-believe with objects, animals, and people • Answers simple "Why" questions (e.g., "Why do we need a coat when it's cold outside?") • Shows awareness of skill limitations

	• Understands "bigger" and "smaller" • Understands concept of "two" • Enacts complex behavioral routines observed in daily life of caregivers, siblings, and peers [cont.] • Solves simple problems (e.g., obtains a desired object by opening a container) • Attends to a story for 5 minutes • Plays independently for 5 minutes
By 4 Years	• Names several colors and some numbers • Counts to five • Has rudimentary understanding of time • Shares past experiences • Remembers part of a story • Engages in make-believe play with capacity to build and elaborate on play themes • Connects actions and emotions • Responds to questions that require understanding of "same" and "different" • Draws a person with two to four body parts • Understands that actions can influence others' emotions (e.g., tries to make others laugh by telling a joke) • Waits for turn in simple game • Plays board or card games with simple rules • Describes what is going to happen next in a book • Talks about right and wrong
By 5 Years	• Counts to 10 or more things • Tells stories with beginning, middle, and end • Draws a person with at least six body parts • Acknowledges own mistakes or misbehaviors and can apologize • Distinguishes fantasy from reality most of the time • Names four colors correctly • Follows rules in simple games • Knows functions of every day household objects (e.g., money, cooking utensils) • Attends to group activity for 15 minutes (e.g., circle time, storytelling)

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

Axis I

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

Axis V

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

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

MOTOR

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

Questions to Consider:

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

Ratings and Descriptions

0	*No evidence of any needs; no need for action.* No evidence of fine or gross motor problems.
1	*Identified need that requires monitoring, watchful waiting, or preventive action based on history, suspicion or disagreement.* There is either a history of fine or gross motor problems or slow development in either or both areas.
2	*Action is required to ensure that the identified need is addressed; need is interfering with functioning.* The child has delays in either or both fine and gross motor development or challenges in the aspects of motor development related to strength, coordination, tone, or motor planning.
3	*Need is dangerous or disabling; requires immediate and/or intensive action.* The child has significant challenges in either fine or gross motor development or the related areas of strength, coordination, tone or motor planning.

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

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

In addition, the range of "normal development" is highly influenced by family and community culture. Some items in the table below may not be appropriate markers of normal development in every family or community, and it may be helpful to create cultural adaptations of specific milestones, depending on the cultural context. For example, an item that addresses the child's ability to feed themselves with a fork may not be relevant in cultures in which chopsticks are the [continues]

primary eating utensil. An obvious substitution for some families may be chopsticks; however, children may not master this skill until later than eating with a spoon because families may not encourage children to feed themselves until they are older and eating with chopsticks may require more advanced fine motor and cognitive skills than eating with a spoon (ASQ, 2014).

Developmental Milestones for Motor Development

By 3 Months	• Pushes up trunk when lying on stomach • Holds head up without support • Hands are often open (e.g., not in fists)
By 6 Months	• Swats at dangling objects • Pushes down on legs when feet are on hard surfaces • Sits without support • Rolls from tummy to back • Holds and shakes an object • Bangs two objects together • Brings hands to midline • Reaches for object with one hand
By 9 Months	• Rolls over in both directions (front to back, back to front) • Brings self to sitting position independently • Stands with support • Moves independently from one place to another (e.g., crawling, scooting) • Turns pages of a book • Reaches for and grasps objects • Passes objects from one hand to another
By 12 Months	• Takes a few steps without holding on • Walks holding onto furniture (e.g., cruises) • Moves from sitting to standing position • Stands alone • Picks up things between thumb and index finger (e.g., cereal) • Crawls forward on belly, pulling with arms, pushing with legs • Turns around while crawling • Crawls while holding an object
By 15 Months	• Explores physical environment • Pushes objects (e.g., boxes, toy cars, push toys) • Walks independently
By 18 Months	• Stacks two blocks • Walks up steps without helping • Pulls toys while walking • Helps undress themselves (e.g., pulls off hat, socks, mittens) • Eats with a spoon • Drinks from an open cup
By 2 Years	• Participates in dressing (e.g., putting arms into sleeves, pulling pants up/down, putting on hat) • Stands on tiptoes • Kicks a ball • Runs • Climbs onto and down from furniture without help • Walks up and down stairs holding on • Draws lines • Drinks using a straw • Opens cabinets, drawers, and boxes [continues]

MOTOR continues

By 3 Years	• Manipulates some buttons, levers, and moving parts • Climbs onto high and low structures • Runs fluidly • Copies a circle • Builds towers of more than six blocks • Pedals a tricycle (three wheeled bicycle) • Catches and kicks a big ball • Walks up and down steps, alternating feet
By 4 Years	• Skips, hops, and stands on one foot for up to 2 seconds • Catches a large, bounced ball most of the time • Can copy simple symbols (e.g., the "plus" sign) • Uses toilet during the day with few accidents • Pours from one container to another, cuts with supervision, and mashes own food
By 5 Years	• Stands on one foot for 10 seconds or longer • Copies a triangle and other geometric shapes • Copies some letters or numbers • Hops on one foot • Uses utensils to eat • Uses toilet independently (wipes, flushes, and washes hands) • Swings independently on a swing

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

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

MEDICAL/PHYSICAL

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

Questions to Consider:

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

Ratings and Descriptions

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

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

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

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

2 *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.

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.

Understanding medical health status in early childhood: If a child is experiencing any medical conditions, obtaining information regarding the impact to the child and the impact to the caregiver in monitoring and treating this condition are both needed to make the assessment of how to rate this item. A child may have a medical condition that is considered a chronic condition, but this is managed well by the child and family and therefore not causing problems in their functioning. A child's nutritional and physical condition should be considered in this rating as well. A child may not have a medical condition but appears tired, reports feeling badly or misses school frequently.

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

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

MEDICAL/PHYSICAL

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

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

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

SLEEP (12 months+)

This item rates the child's sleep patterns. This item is used to describe any problems with sleep, regardless of the cause, including difficulties falling asleep or staying asleep as well as sleeping too much. Both bedwetting and nightmares should be considered sleep issues. **The child must be 12 months of age (1 year old) or older to rate this item**. **If child is younger than 12 months, rate this item '0'.**

Questions to Consider:

- Does the child appear rested?
- What are the child's nap and bedtime routines?
- How does the child's sleep routine impact the family?

Ratings and Descriptions

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

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

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 disrupted often, 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.

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

Age	Typical Sleep Patterns
1-4 Weeks	Newborns typically sleep about 15 to 18 hours a day, but only in short periods of two to four hours. Premature babies may sleep longer, while colicky babies may sleep less. Since newborns do not yet have an internal biological clock, or circadian rhythm, their sleep patterns are not related to the daylight and nighttime cycles. In fact, they tend not to have much of a pattern at all. [cont.]

SLEEP (12 months+) continued

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

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

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

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

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

Axis I

- Following a stressful or traumatic event (including the permanent loss of a primary caregiver), a rating of '2' or '3' related to sleep refusal and/or sleep disturbances may be consistent with symptoms of **Post-Traumatic Stress Disorder, Adjustment Disorder,** or **Complicated Grief Disorder of Early Childhood** *(see Adjustment to Trauma item)*
- A rating of '2' or '3' related to either hyposomnia and other sleep disturbances may be consistent with symptoms of **Depressive Disorder of Early Childhood** *(see Depression item)*
- A rating of '2' or '3' related to sleep disturbances may be consistent with symptoms of **Generalized Anxiety Disorder** *(see Anxiety item)* [continues]

SLEEP (12 months+) continued

- A rating of '2' or '3' related to sleep refusal specifically without the presence of a caregiver may be consistent with symptoms of **Separation Anxiety Disorder** *(see Attachment item)*
- As part of a larger pattern of pervasive and persistent noncompliance, a rating of '2' or '3' related to sleep refusal may be a symptom of **Disorder of Dysregulated Anger and Aggression of Early Childhood (DDAA)**, or, if expressed only in one caregiving relationship, a **Relationship Specific Disorder**

When sleep disturbances are not better explained by other disorders or medical problems and medication side effects, a rating of '2' or '3' related to sleep disturbances may be consistent with a diagnosis of Sleep Disorders, including **Sleep Onset Disorder**, **Night Waking Disorder**, **Partial Arousal Sleep Disorder**, and/or **Nightmare Disorder of Early Childhood**.

RELATIONSHIP PERMANENCE

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

Questions to Consider:

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

Ratings and Descriptions

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

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

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

Child has had stable relationships but there is some concern about instability in the near future (one year) due to transitions, illness, or age. A stable relationship with only one parent may be rated here.

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

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

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

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

RELATIONSHIP PERMANENCE continued

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

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

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

STRENGTHS DOMAIN

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

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

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

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

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

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

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

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

FAMILY 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? [continues]

FAMILY STRENGTHS continued

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 can 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 can enjoy each other's company. There is at least one family member who has a strong, loving relationship with the child and can 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 can 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.

FAMILY CULTURAL IDENTITY

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

Questions to Consider:

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

Ratings and Descriptions

0	*Well-developed, centerpiece strength; may be used as a centerpiece in an intervention/action plan.* The family has defined a cultural identity and is connected to others who support their cultural identity.
1	*Identified and useful strength. Strength will be used, maintained or built upon as part of the plan. May require some effort to develop strength into a centerpiece strength.* The family is developing a cultural identity and is seeking others to support their cultural identity.
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 family is searching for a cultural identity and has not connected with others.
3	*An area in which no current strength is identified; efforts may be recommended to develop a strength in this area.* The family does not express a cultural identity.

INTERPERSONAL

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

Questions to Consider:

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

Ratings and Descriptions

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

Significant interpersonal strengths. Child has well-developed interpersonal skills and healthy friendships.

1 *Identified and useful strength. Strength will be used, maintained or built upon as part of a 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.

Supplemental Information: For children birth to 5 years old, consider the following:

- Action level '0': Child has a prosocial or "easy" temperament and, if old enough, is interested and effective at initiating relationships with other children or adults. If still an infant, child exhibits anticipatory behavior when fed or held.
- Action level '1': Child has formed a positive interpersonal relationship with at least one non-caregiver. Child responds positively to social initiations by adults but may not initiate such interactions by themselves.
- Action level '2': Child may be shy or uninterested in forming relationships with others, or – if still an infant - child may have a temperament that makes attachment to others a challenge.
- Action level '3': Child with no known interpersonal strengths. Child does not exhibit any age-appropriate social gestures (e.g., social smile, cooperative play, responsiveness to social initiations by non-caregivers). An infant that consistently exhibits gaze aversion would be rated here.

RESILIENCY (PERSISTENCE AND ADAPTABILITY)

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

Questions to Consider:

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

Ratings and Descriptions

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

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

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

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

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

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

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

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

CULTURAL FACTORS DOMAIN

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

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

Note: For children birth through five years-old, these items should be rated for the family.

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

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., translator). 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/youth 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 the family lives.
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 they live. 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.

TRADITIONS AND CULTURAL 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, Dia de los Muertos, Yom Kippur, Quinceañera, etc. This also may include daily activities that are culturally specific (e.g., wearing a hijab, praying toward Mecca at specific times, eating a specific diet, access to media), and traditions and activities to include newer cultural identities.

Questions to Consider:

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

Ratings and Descriptions

0	*No evidence of any needs; no need for action.* The family is consistently able to practice traditions and rituals consistent with their cultural identity.
1	*Identified need that requires monitoring, watchful waiting, or preventive action based on history, suspicion or disagreement.* The family is generally able to practice traditions and rituals consistent with their cultural identity; however, they sometimes experience some obstacles to the performance of these practices.
2	*Action is required to ensure that the identified need is addressed; need is interfering with functioning.* The family experiences significant barriers and is sometimes prevented from practicing traditions and rituals consistent with their cultural identity.
3	*Need is dangerous or disabling; requires immediate and/or intensive action.* The family is unable to practice traditions and rituals consistent with their cultural identity.

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 family members). Racism, negativity toward SOGIE (sexual orientation, gender identity and expression) and other forms of discrimination would be rated here.

Questions to Consider:

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

Ratings and Descriptions

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 occasional stress resulting from friction between the family's cultural identify and their current environment or living situation.

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

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

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

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

CAREGIVER RESOURCES & NEEDS DOMAIN

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

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

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

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

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

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

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

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

SUPERVISION

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

Questions to Consider:

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

Ratings and Descriptions

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

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

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

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

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

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

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

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

INVOLVEMENT WITH CARE

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

Questions to Consider:

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

Ratings and Descriptions

0	*No current need; no need for action. This may be a resource for the child.* No evidence of problems with caregiver involvement in services or interventions, and/or caregiver can act as an effective advocate for the child.
1	*Identified need that requires monitoring, watchful waiting, or preventive action based on history, suspicion or disagreement. This may be an opportunity for resource building.* Caregiver is consistently involved in the planning and/or implementation of services for the child but is not an active advocate on their behalf. Caregiver is open to receiving support, education, and information.
2	*Need is interfering with the provision of care; action is required to ensure that the identified need is addressed.* Caregiver is not actively involved in the child's services and/or interventions intended to assist the child.
3	*Need prevents the provision of care; requires immediate and/or intensive action.* Caregiver wishes for child to be removed from their care.

KNOWLEDGE

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

Questions to Consider:

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

Ratings and Descriptions

0	*No current need; no need for action. This may be a resource for the child.* No evidence of caregiver knowledge issues. Caregiver is fully knowledgeable about the child's strengths and weaknesses, talents, and limitations.
1	*Identified need that requires monitoring, watchful waiting, or preventive action based on history, suspicion or disagreement. This may be an opportunity for resource building.* Caregiver, while being generally knowledgeable about the child, has some deficits in knowledge or understanding of the child's psychological condition, talents, skills, and assets.
2	*Need is interfering with the provision of care; action is required to ensure that the identified need is addressed.* Caregiver does not know or understand the child well and significant deficits exist in the caregiver's ability to relate to the child's problems and strengths.
3	*Need prevents the provision of care; requires immediate and/or intensive action.* Caregiver has little or no understanding of the child's current condition. Caregiver's lack of knowledge about the child's strengths and needs places child at risk of significant negative outcomes.

EMPATHY FOR CHILD

This item refers to the caregiver's ability to understand and respond to the joys, sorrows, anxieties and other feelings of their children with helpful, supportive emotional responses.

Questions to Consider:

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

Ratings and Descriptions

0	*No current need; no need for action. This may be a resource for the child.* Caregiver is emotionally empathic and attends to the child's emotional needs.
1	*Identified need that requires monitoring, watchful waiting, or preventive action based on history, suspicion or disagreement. This may be an opportunity for resource building.* The caregiver can be emotionally empathic and typically attends to the child's emotional needs. There are times, however, when the caregiver is not able to attend to the child's emotional needs.
2	*Need is interfering with the provision of care; action is required to ensure that the identified need is addressed.* The caregiver is often not empathic and frequently is unable to attend to the child's emotional needs.
3	*Need prevents the provision of care; requires immediate and/or intensive action.* The caregiver has significant difficulties with emotional responsiveness. They are not empathic and rarely attend to the child's emotional needs.

ORGANIZATION

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

Questions to Consider:

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

Ratings and Descriptions

0	*No current need; no need for action. This may be a resource for the child.* Caregiver is well organized and efficient.
1	*Identified need that requires monitoring, watchful waiting, or preventive action based on history, suspicion or disagreement. This may be an opportunity for resource building.* Caregiver has minimal difficulties with organizing and maintaining household to support needed services. For example, may be forgetful about appointments or occasionally fails to return case manager calls.
2	*Need is interfering with the provision of care; action is required to ensure that the identified need is addressed.* Caregiver has moderate difficulty organizing and maintaining household to support needed services.
3	*Need prevents the provision of care; requires immediate and/or intensive action.* Caregiver is unable to organize household to support needed services.

SOCIAL RESOURCES

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

Questions to Consider:

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

Ratings and Descriptions

0	*No current need; no need for action. This may be a resource for the child.* Caregiver has significant social and family networks that actively help with caregiving.
1	*Identified need that requires monitoring, watchful waiting, or preventive action based on history, suspicion or disagreement. This may be an opportunity for resource building.* Caregiver has some family, friends or social network that actively helps with caregiving.
2	*Need is interfering with the provision of care; action is required to ensure that the identified need is addressed.* Work needs to be done to engage family, friends, or social network in helping with caregiving.
3	*Need prevents the provision of care; requires immediate and/or intensive action.* Caregiver has no family or social network to help with caregiving.

RESIDENTIAL STABILITY

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

Questions to Consider:

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

Ratings and Descriptions

0	*No current need; no need for action. This may be a resource for the child.* Caregiver has stable housing with no known risks of instability.
1	*Identified need that requires monitoring, watchful waiting, or preventive action based on history, suspicion or disagreement. This may be an opportunity for resource building.* Caregiver has relatively stable housing but either has moved in the recent past or there are indications of housing problems that might force housing disruption.
2	*Need is interfering with the provision of care; action is required to ensure that the identified need is addressed.* Caregiver has moved multiple times in the past year. Housing is unstable.
3	*Need prevents the provision of care; requires immediate and/or intensive action.* Family is homeless or has experienced homelessness in the recent past.

MEDICAL/PHYSICAL

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

Questions to Consider:

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

Ratings and Descriptions

0	*No current need; no need for action. This may be a resource for the child.* No evidence of medical or physical health problems. Caregiver is generally healthy.
1	*Identified need that requires monitoring, watchful waiting, or preventive action based on history, suspicion or disagreement. This may be an opportunity for resource building.* There is a history or suspicion of, and/or caregiver is in recovery from, medical/physical problems.
2	*Need is interfering with the provision of care; action is required to ensure that the identified need is addressed.* Caregiver has medical/physical problems that interfere with the capacity to parent the child.
3	*Need prevents the provision of care; requires immediate and/or intensive action.* Caregiver has medical/physical problems that make parenting the child currently impossible.

MENTAL HEALTH

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

Questions to Consider:

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

Ratings and Descriptions

0	*No current need; no need for action. This may be a resource for the child.* No evidence of caregiver mental health difficulties.
1	*Identified need that requires monitoring, watchful waiting, or preventive action based on history, suspicion or disagreement. This may be an opportunity for resource building.* There is a history or suspicion of mental health difficulties, and/or caregiver is in recovery from mental health difficulties.
2	*Need is interfering with the provision of care; action is required to ensure that the identified need is addressed.* Caregiver's mental health difficulties interfere with their capacity to parent.
3	*Need prevents the provision of care; requires immediate and/or intensive action.* Caregiver has mental health difficulties that make it currently impossible to parent the child.

SUBSTANCE USE

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

Questions to Consider:

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

Ratings and Descriptions

0	*No current need; no need for action. This may be a resource for the child.* No evidence of caregiver substance use issues.
1	*Identified need that requires monitoring, watchful waiting, or preventive action based on history, suspicion or disagreement. This may be an opportunity for resource building.* There is a history of, suspicion or mild use of substances and/or caregiver is in recovery from substance use difficulties where there is no interference in their ability to parent.
2	*Need is interfering with the provision of care; action is required to ensure that the identified need is addressed.* Caregiver has some substance abuse difficulties that interfere with their capacity to parent.
3	*Need prevents the provision of care; requires immediate and/or intensive action.* Caregiver has substance abuse difficulties that make it currently impossible to parent the child.

DEVELOPMENTAL

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

Questions to Consider:

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

Ratings and Descriptions

0	*No current need; no need for action. This may be a resource for the child.* No evidence of caregiver developmental disabilities or challenges. Caregiver has no developmental needs.
1	*Identified need that requires monitoring, watchful waiting, or preventive action based on history, suspicion or disagreement. This may be an opportunity for resource building.* Caregiver has developmental challenges. The developmental challenges do not currently interfere with parenting.
2	*Need is interfering with the provision of care; action is required to ensure that the identified need is addressed.* Caregiver has developmental challenges that interfere with the capacity to parent the child.
3	*Need prevents the provision of care; requires immediate and/or intensive action.* Caregiver has severe developmental challenges that make it currently impossible to parent the child.

FAMILY STRESS

This item rates the impact of managing the child's behavioral and emotional needs on the family's stress level.

Questions to Consider:

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

Ratings and Descriptions

0	*No current need; no need for action. This may be a resource for the child.* No evidence of caregiver having difficulty managing the stress of the child's needs and/or caregiver can manage the stress of child's needs.
1	*Identified need that requires monitoring, watchful waiting, or preventive action based on history, suspicion or disagreement. This may be an opportunity for resource building.* There is a history or suspicion of and/or caregiver has some problems managing the stress of child's needs.
2	*Need is interfering with the provision of care; action is required to ensure that the identified need is addressed.* Caregiver has notable problems managing the stress of child's needs. This stress interferes with their capacity to provide care.
3	*Need prevents the provision of care; requires immediate and/or intensive action.* Caregiver is unable to manage the stress associated with child's needs. This stress prevents caregiver from providing care.

SAFETY

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

Questions to Consider:

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

Ratings and Descriptions

0	*No current need; no need for action. This may be a resource for the child.* No evidence of safety issues. Household is safe and secure. Child is not at risk from others.
1	*Identified need that requires monitoring, watchful waiting, or preventive action based on history, suspicion or disagreement. This may be an opportunity for resource building.* Household is safe but concerns exist about the safety of the child due to history or others who might be abusive.
2	*Need is interfering with the provision of care; action is required to ensure that the identified need is addressed.* Child is in some danger from one or more individuals with access to the home.
3	*Need prevents the provision of care; requires immediate and/or intensive action.* Child is in immediate danger from one or more persons with unsupervised access.

MARITAL/PARTNER VIOLENCE IN THE HOME

This item describes the degree of difficulty or conflict in the parent/caregiver's relationship and the impact on parenting and providing care.

Questions to Consider:

- How are power and control handled in the caregivers' relationship with each other?
- How frequently does the child witness caregiver conflict?
- Does the caregivers' conflict escalate to verbal aggression, physical attacks or destruction of property?

Ratings and Descriptions

0 *No current need; no need for action. This may be a resource for the child.*
Parents/caregivers appear to be functioning adequately. There is no evidence of notable conflict in the parenting relationship. Disagreements are handled in an atmosphere of mutual respect and equal power.

1 *Identified need that requires monitoring, watchful waiting, or preventive action based on history, suspicion or disagreement. This may be an opportunity for resource building.*
History of marital difficulties and partner arguments. Caregivers are generally able to keep arguments to a minimum when child is present. Occasional difficulties in conflict resolution or use of power and control by one partner over another.

2 *Need is interfering with the provision of care; action is required to ensure that the identified need is addressed.*
Marital/partner difficulties including frequent arguments that escalate to verbal aggression, the use of verbal aggression by one partner to control the other, or significant destruction of property which the child often witnesses.

3 *Need prevents the provision of care; requires immediate and/or intensive action.*
Marital or partner difficulties often escalate to violence and the use of physical aggression by one partner to control the other. These episodes may exacerbate child's difficulties or put the child at greater risk.

Supplemental Information: Marital/partner violence is generally distinguished from family violence in that the former is focused on violence among caregiver partners. Since marital/partner violence is a risk factor for child abuse and might necessitate reporting, it is indicated here as only violence among caregiver partners (e.g., spouses, lovers). The child's past exposure to marital/partner violence with current or other caregivers is rated a '1'. This item would be rated a '2' if the child is exposed to marital/partner violence in the household and protective services must be called; a '3' indicates that the child is in danger due to marital/partner violence in the household and requires immediate attention.

BEHAVIORAL/EMOTIONAL NEEDS DOMAIN

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

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

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

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

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

2 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.

ATTACHMENT DIFFICULTIES

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

Questions to Consider:

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

Ratings and Descriptions

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

No evidence of attachment problems. Caregiver-child relationship is characterized by mutual satisfaction of needs and child's development of a sense of security and trust. Child seeks age-appropriate contact with caregiver for both nurturing and safety needs. [continues]

ATTACHMENT DIFFICULTIES continued

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

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

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

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

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

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

Supplemental Information – Understanding attachment in early childhood: Attachment refers to the special relationship between a child and their primary caregiver(s) that is established within the first year of life. As the infant experiences getting their needs met throughout the first months of life, they begin to associate gratification and security within the care-giving relationship. This ultimately leads to feelings of affection, and, by 8 months of age, an infant will typically exhibit preference for the primary caregiver(s). An infant that does not experience their needs being met or responded to in a consistent and predictable pattern will typically develop an insecure pattern of attachment. The benefits of a secure attachment have been researched significantly and are far reaching. Levy (1998) summarizes these benefits as promoting positive development in self-esteem, independence and autonomy, impulse control, conscience development, long-term friendships, prosocial coping skills, relationships with caregivers and adults, trust, intimacy and affection, empathy, compassion, behavioral and academic performance and the ability to form secure attachment with their own children when they become adults. However, it is important to note that most studies on attachment and its impacts have been done with Western, middle-class families (Keller, 2018). [continues]

ATTACHMENT DIFFICULTIES continued

Potential presenting symptoms of attachment issues in early childhood:

- Lack of preference for primary caregiver
- Indiscriminate affection with unfamiliar adults
- Lack of expectation for getting needs met
- Lack of comfort seeking when hurt or upset
- Comfort seeking in an odd manner
- Excessive clinginess
- Poor ability to tolerate separation
- Strange or mixed reactions to reunion with caregiver
- Low level of compliance with caregivers
- Controlling behavior
- Lack of exploratory behavior
- Low level of affection or physical contact within the caregiver-child relationship

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

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

Axis I

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

REGULATORY

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

Questions to Consider:

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

Ratings and Descriptions

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

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

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

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

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

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

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

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

REGULATORY continued

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

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

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

FAILURE TO THRIVE

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

Questions to Consider:

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

Ratings and Descriptions

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

No evidence of failure to thrive.

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

The child may have experienced past problems with growth and ability to gain weight and is currently not experiencing problems. Or the child may presently be experiencing slow development in this area.

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

The child is experiencing problems in their ability to maintain weight or growth. The child may be below the 5th percentile for age and sex, may weigh less than 80% of their ideal weight for age, have depressed weight for height, or have a rate of weight gain that causes a decrease in two or more major percentile lines over time (75th to 25th).

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

The child has one or more of all of the above and is currently at serious medical risk.

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 the DC 0-5/DSM.

Questions to Consider:

- Are the child's caregivers concerned about possible depression or chronic low mood and irritability?
- Has the child withdrawn from normal activities?
- Does the child seem listless, sad or socially withdrawn?

Ratings and Descriptions

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

No evidence of problems with depression.

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

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

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

Clear evidence of depression associated with either depressed mood or significant irritability. Depression has interfered significantly in child's ability to function in at least one life domain.

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

Clear evidence of a disabling level of depression that makes it virtually impossible for the child to function in any life domain. This rating Is given to a child with a severe level of depression. This would include a child who withdraws from activity (school, play) or interaction (with family, peers, significant adults) due to depression. Disabling forms of depressive diagnoses would be rated here.

Supplemental Information – Understanding depression in young children: An infant or young child that is attempting to cope with feelings of sadness or depression is compromised in their ability to attend to the tasks of development. Many clinicians and caregivers do not believe that an infant can experience depression, despite the fact that researchers and clinicians began documenting this condition in the early 1940s, when Anna Freud and Dorothy Burlingham recorded the reactions of young children removed from their parents during World War II. The two researchers documented a distinct grief reaction that started with protest, continued to despair, and finally, the children appeared disconnected, withdrawn, developmentally delayed, and almost resolved to their fate. A child that is traumatized in any way may first develop a traumatic response that can develop into depression and meet criteria for a depressive disorder. There are children in which it is [continues]

DEPRESSION continued

difficult to identify a specific trauma, although they appear depressed. A child may experience depression that is not reactive in nature. At times it is a challenge for the caregiver to identify or even believe a specific environmental condition may contribute to depression in young children. These factors may include a chaotic home environment, poor or limited interaction from caregivers, or preoccupation of caregiver with their own stressors.

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

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

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

Axis I

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

ANXIETY

This item rates symptoms associated with DC 0-5/DSM Anxiety Disorders characterized by fear and anxiety and related behavioral disturbances (including avoidance behaviors).

Questions to Consider:

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

Ratings and Descriptions

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

No evidence of anxiety symptoms.

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

There is a history, suspicion, or evidence of some anxiety associated with a recent negative life event. This level is used to rate either a phobia or anxiety problem that Is not yet causing the child significant distress or markedly impairing functioning in any important context. Anxiety or fear is present, but the child is able to be soothed and supported.

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

Clear evidence of anxiety associated with either anxious mood or significant fearfulness. Anxiety has interfered in the child's ability to function in at least one life domain. Child may show irritability or heightened reactions to certain situations, significant separation anxiety, or persistent reluctance or refusal to cope with fear-inducing situations.

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

Clear evidence of debilitating level of anxiety that makes it virtually impossible for the child to function in any life domain.

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

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

- Worry about certain events
- Agitation
- Fatigability
- Inattention
- Irritability (e.g., easily frustrated)
- Muscle tension and difficulty relaxing
- Sleep disturbances [continues]

ANXIETY continued

Potential presenting symptoms of anxiety in early childhood continued

- Avoidance: Fear, reluctance, or refusal to engage in certain activities
- Withdrawing: freezing, shrinking, or clinging/hiding
- Failing to speak [continues]
- Crying and/or tantruming
- Negative affect
- Physical symptoms such as stomachaches, headaches, excessive sweating, increased heart rate, increased blinking, or dizziness

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

Axis I:

- Following a stressful event, traumatic experience, and/or permanent loss of a primary caregiver, a rating of '2' or '3' may be consistent with symptoms of **Adjustment Disorder**, **PTSD**, and **Complicated Grief Disorder of Early Childhood**, respectively *(see Adjustment to Trauma item)*
- When anxiety is related to interference with a child's compulsions (repetitive behaviors that children are driven to perform according to rigid rules), a rating of '2' or '3' may be consistent with symptoms of **Obsessive-Compulsive Disorder**
- When anxiety is related to separation from the primary caregiver, a rating of '2' or '3' may be consistent with a diagnosis of **Separation Anxiety Disorder** *(see Attachment)*
- When anxiety is related to social or performance situations that involve exposure to unfamiliar people or possible scrutiny by others, a rating of '2' or '3' may be consistent with a diagnosis of **Social Anxiety Disorder (Social Phobia)**
- When anxiety manifests as a failure to speak in specific social situations (despite being able to speak in other situations), a rating of '2' or '3' may be consistent with a diagnosis of **Selective Mutism**
- When anxiety is related to the presence of novel/unfamiliar objects, people, and situations, a rating of '2' or '3' may be consistent with **Inhibition to Novelty Disorder**
- When anxiety and worry occur during two or more activities or settings and within two or more relationships, a rating of '2' or '3' may be consistent with a diagnosis of **Generalized Anxiety Disorder (GAD)**

ATYPICAL BEHAVIORS

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

Questions to Consider:

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

Ratings and Descriptions

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

No evidence of atypical behaviors (repetitive or stereotyped behaviors) in the child.

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

Atypical behaviors (repetitive or stereotyped behaviors) reported by caregivers or familiar individuals that may have mild or occasional interference in the child's functioning.

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

Atypical behaviors (repetitive or stereotyped behaviors) generally noticed by unfamiliar people and have notable interference in the child's functioning.

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

Atypical behaviors (repetitive or stereotyped behaviors) occur with high frequency and are disabling or dangerous.

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

ATYPICAL BEHAVIORS

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

Axis I:

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

IMPULSIVITY/HYPERACTIVITY (36+ months)

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

Questions to Consider:

- Is the child unable to sit still for any length of time?
- Does the child have trouble paying attention for more than a few minutes?
- Is the child able to control their behavior, talking?
- Does the child report feeling compelled to do something despite negative consequences?

Ratings and Descriptions

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

No evidence of hyperactivity problems.

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

This rating is used to indicate a child with evidence of some problems with hyperactivity or impulse control that is not impacting their functioning. Child may have some difficulties staying on task for an age-appropriate time period.

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

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

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

Severe impairment of impulse control. Frequent impulsive behavior is observed or noted that carries considerable safety risk (e.g., running into the street, dangerous bike riding). A child with profound symptoms of ADHD would be rated here.

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

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

- Being inattentive to details in play, activities of daily living or structured activities (e.g., makes developmentally unexpected accidents or mistakes)
- Having a hard time maintaining focus on activities or play
- Failing to attend to verbal requests/demands, especially when engaged in a preferred activity (e.g., caregiver needs to call the young child's name multiple times before the child notices) [continues]

IMPULSIVITY/HYPERACTIVITY continued

Potential presenting symptoms of inattention in early childhood continued

- Getting derailed when attempting to follow multistep instructions and does not complete the activity
- Having a hard time executing age-appropriate sequential activities (e.g., getting dressed, following routines in childcare or home)
- Avoiding or objecting to activities that require prolonged attention (e.g., reading a book with a parent, or working on a puzzle)
- Losing track of things that are used regularly (e.g., favorite stuffed animal, shoes)
- Getting distracted by sounds and sights (e.g., sounds from another room or objects or activities outside the window)
- Seeming to forget what they are doing in common routine activities

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

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

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

Axis I

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

OPPOSITIONAL BEHAVIOR (36+ months)

This item rates the child's relationship with authority figures. Generally oppositional behavior is displayed in response to conditions set by a parent, caregivers or other authority figure with responsibility for and control over the child. Rate this item a '0' if child is under 3 years of age.

Questions to Consider:

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

Ratings and Descriptions

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

No evidence of oppositional behaviors.

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

History or evidence of some defiance towards authority figures that has not yet begun to cause functional impairment.

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

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

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

Clear evidence of a dangerous level of oppositional behavior involving the threat of physical harm to others. This rating indicates that the child has severe problems with compliance with rules or adult instruction or authority.

ADJUSTMENT TO TRAUMA

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

Questions to Consider:

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

Ratings and Descriptions

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

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

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

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

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

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

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

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

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

ADJUSTMENT TO TRAUMA continued

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

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

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

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

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

ADJUSTMENT TO TRAUMA continued

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

Axis I

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

Axis IV

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

RISK FACTORS DOMAIN

This section focuses on contextual factors that may impact the child's behavior and developmental trajectory.

Question to Consider for this Domain: Are there any contextual factors that put the child's development at risk, or are impacting their behavior?

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

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

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

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

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

BIRTH WEIGHT

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

Questions to Consider:

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

Ratings and Descriptions

0 *Not a developmental risk factor; no need for attention or intervention.*
Child within normal range for weight at birth. A child with a birth weight of 2500 grams (5.5 pounds) or greater would be rated here.

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

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

BIRTH WEIGHT continued

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

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

PRENATAL CARE

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

Questions to Consider:

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

Ratings and Descriptions

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

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

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

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

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

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

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

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

LABOR AND DELIVERY

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

Questions to Consider:

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

Ratings and Descriptions

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

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

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

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

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

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

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

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

EXPOSURE

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

Questions to Consider:

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

Ratings and Descriptions

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

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

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

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

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

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

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

Child was exposed to environmental toxins, alcohol or drugs in utero and continues to be exposed in the home or community. Any child who evidenced symptoms of substance withdrawal at birth (e.g., crankiness, feeding problems, tremors, weak and continual crying) would be rated here. A child who ingested lead paint and exhibited symptoms would be rated here.

RISK BEHAVIORS DOMAIN

This section focuses on behaviors that can get children in trouble or put them in danger of harming themselves or others.

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

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

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

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

2 Action is required to ensure that the identified need or risk behavior is addressed.

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

SELF-HARM (12 months+)

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

Questions to Consider:

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

Ratings and Descriptions

0 *No evidence of any needs; no need for action.*
There is no evidence of self-harm behaviors.

1 *Need or risk behavior that requires monitoring, watchful waiting, or preventive action based on history, suspicion or disagreement.*
History, suspicion or some evidence of self-harm behaviors. These behaviors are controllable by caregiver.

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

SELF-HARM continued

3 *Intensive and/or immediate action is required to address the need or risk behavior.*
Child's self-harm behavior puts their safety and well-being at risk.

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

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

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

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

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

Axis I

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

AGGRESSIVE BEHAVIOR

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

Questions to Consider:

- Has the child ever tried to injure another person or animal?
- Do they hit, kick, bite, or throw things at others?

Ratings and Descriptions

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

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

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

History of aggressive behavior toward people or animals or concern expressed by caregivers about aggression.

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

Clear evidence of aggressive behavior toward people or others in the past 30 days. Caregiver's attempts to redirect or change behaviors have not been successful

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

The child exhibits a current, dangerous level of aggressive behavior that involves the threat of harm to animals or others. Caregivers are unable to mediate this dangerous behavior.

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

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

AGGRESSIVE BEHAVIOR continued

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

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

Axis I

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

INTENTIONAL MISBEHAVIOR (36 months+)

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. **Rate this item a '0' if child is under 3 years of age.**

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, caregivers 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.?

Ratings and Descriptions

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

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

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

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

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

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

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

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