CHILD AND ADOLESCENT NEEDS AND STRENGTHS (CANS)

COMPREHENSIVE MULTISYSTEM ASSESSMENT

Indiana CANS 5 to 17 Manual

Version 2.3

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A large number of individuals have collaborated in the development of the CANS-Comprehensive tool. Along with the CANS versions for developmental disabilities, juvenile justice, and child welfare, this information integration tool is designed to support individual case planning and the planning and evaluation of service systems. The CANS-Comprehensive is an open domain tool for use in service delivery systems that address the mental health of children, adolescents and their families. The copyright is held by the Praed Foundation to ensure that it remains free to use.

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John S. Lyons, PhD
Senior Policy Fellow
Chapin Hall at the University of Chicago
1313 East 60th Street
Chicago, IL 60637
jlyons@chapinhall.org

Betty A. Walton, Ph.D.
Indiana University School of Social Work &
Indiana Family Social Services Administration
Division of Mental Health and Addiction
402 W. Washington Street, W353
Indianapolis, IN 46204-2739
Betty.Walton@fssa.in.gov

Praed Foundation
http://praedfoundation.org
praedfoundation@yahoo.com

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 youth/youth serving system—children, youth, and families. As such, completion of the CANS is accomplished in order to allow for the effective communication of this shared vision for use at all levels of the system. Since its primary purpose is communication, the CANS is designed based on communication theory rather than the psychometric theories that have influenced most measurement development. There are six key principles of a communimetric measure that apply to understanding the CANS.

Six Key Principles of the CANS

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

2. **Each item uses a 4-level rating system that translates into action**. Different action levels exist for needs and strengths. For a description of these action levels please see below.

3. **Rating should describe the youth, not the youth in services.** If an intervention is present that is masking a need but must stay in place, this should be factored into the rating consideration and would result in a rating of an “actionable” need (i.e. ‘2’ or ‘3’).

4. **Culture and development should be considered prior to establishing the action levels.** Cultural sensitivity involves considering whether cultural factors are influencing the expression of needs and strengths. Ratings should be completed considering the youth’s developmental and/or chronological age depending on the item. In other words, anger control is not relevant for a very young youth but would be for an older youth or youth regardless of developmental age. Alternatively, school achievement should be considered within the framework of expectations based on the youth/youth’s developmental age.

5. **The ratings are generally “agnostic as to etiology”.** In other words this is a descriptive tool; it is about the “what” not the “why”. Only one item, Adjustment to Trauma, has any cause-effect judgments.

6. **A 30-day window is used for ratings in order to make sure assessments stay relevant to the child/youth’s present circumstances.** However, the action levels can be used to over-ride the 30-day rating period.

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 youths and parents/caregivers’ needs and strengths. Strengths are the child/youth’s assets: areas life where he or she is doing well or has an interest or ability. Needs are areas where a child/youth requires help or intervention. Care providers use an assessment process to get to know the child or youth and the families with whom they work and to understand their strengths and needs. The CANS helps care providers decide which of a child/youth’s needs are the most important to address in a treatment or service planning. The CANS also helps identify strengths, which can be the basis of a treatment or service plan. By working with the child/youth and family during the assessment process

and talking together about the CANS, care providers can develop a treatment or service plan that addresses a child/youth's strengths and needs while building strong engagement.

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

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

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

The CANS 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, 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 youth-serving entities to discuss the child/youth's needs and strengths. A review of the case record in light of the CANS assessment tool will provide information as to the appropriateness of the recovery plan and whether individual goals and outcomes are achieved.

Training and periodic certification are required for providers who administer the CANS and their supervisors. Additional training is available for CANS SuperUsers 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 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, youth 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 it's the ability to measure 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; Cardall, 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 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 preset	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, the N/A rating should be used only in the rare instances where an item does not apply to that particular youth.

To complete the CANS, a CANS trained and certified care coordinator, case worker, clinician, or other care provider, should read the anchor descriptions for each item and then record the appropriate rating on the CANS form (or electronic record). This process should be done collaboratively with the child/youth, family and other stakeholders.

Remember that the item anchor descriptions are examples of circumstances which fit each rating ('0', '1', '2', or '3'). The descriptions, however, are not inclusive and the action level ratings should be the primary rating descriptions considered (see page 6). The rater must consider the basic meaning of each level to determine the appropriate rating on an item for an individual.

The CANS is an information integration tool, intended to include multiple sources of information (e.g., child/youth and family, referral source, treatment providers, school, and observation of the rater). As a strength-based approach, the CANS supports the belief that children, youth, and families have unique talents, skills, and life events, in addition to specific unmet needs. Strength-based approaches to assessment and service or treatment planning focus on collaborating with youth and their families to discover individual and family functioning and strengths. Failure to demonstrate a child/youth's skill should first be viewed as an opportunity to learn the skill as opposed to the problem. Focusing on child/youth's strengths instead of weaknesses with their families may result in enhanced motivation and

improved performance. Involving the family and child/youth in the rating process and obtaining information (evidence) from multiple sources is necessary and improves the accuracy of the rating. Meaningful use of the CANS and related information as tools (for reaching consensus, planning interventions, monitoring progress, psychoeducation, and supervision) support effective services for children, youth and families.

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

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

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

How is the CANS Used?

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

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 in 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 to use during initial sessions either in person or over the phone if there are follow up sessions required to get a full picture of needs before treatment or service planning and beginning therapy or other services.

It guides care and treatment/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. Many users of the CANS and organizations complete the CANS every 6 months to measure change and transformation. We work with children, youth, and families and their needs tend to change over time. Needs may change in response to many factors including quality

clinical support provided. One way we determine how our supports are helping to alleviate suffering and restore functioning is by re-assessing needs, adjusting treatment or service plans, and tracking change.

It is a Communication Tool. When a client leaves a treatment programs, 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 allowing for recommendations for future care which tie to current needs. And finally, it allows for a shared language to talk about our youth and creates opportunities for collaboration. It is our hope that this guide will help you to make the most out of the CANS and guide you in filling it out in an accurate way that helps you make good clinical decisions.

CANS: A behavior health care strategy

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

It is a good idea to know the CANS and use the domains and items to help with your assessment process and information gathering sessions/clinical interviews with the youth and family. This will not only help the organization of your interviews, but will make the interview more conversational if you are not reading from a form. A conversation is more likely to give you good information, so have a general idea of the items. The CANS domains can be a good way to think about capturing information. You can start your assessment with any of the sections—Life Domain Functioning or Behavioral/Emotional Needs, Risk Behaviors or Youth 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 youth/youth need, or we can start by talking about the things that are going well and that you want to build on. Do you have a preference?"

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

Making the best use of the CANS. Children and youth have families involved in their lives, and their family can be a great asset to their treatment. To increase family involvement and understanding, it is important to talk to them about the assessment process and describe CANS and how it will be used. The description of the CANS should include teaching the youth and family about the needs and strengths rating scales, identifying the domains and items, as well as how the actionable items will be used in treatment or serving planning. When possible, have share with the youth and family the CANS domains and items (see the CANS Core Item list on page 11) and encourage the family to look over the items prior to your meeting with them. The best time is your decision—you will have a sense of the timing as you work with each family. Families often feel respected as partners when they are prepared for a meeting or a process. A copy of the completed CANS ratings should be reviewed with each 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 youth or youth that you are with the youth.

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

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

★ **Redirect the conversation to 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 the youth's perspective, you can then work on organizing and coalescing the other points of view.

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

★ **Wrapping it up.** 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 as you summarize or give them the "total picture".

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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Basic Structure of the CANS Comprehensive Tool for Youth 5 – 17

The CANS Comprehensive Multisystem Tool expands depending upon the needs of youth and the family. Basic core items are rated for all youth and unpaid caregivers. Extension modules are triggered by key core questions. A few additional questions are required for the decision models to function.

Core Items

Life Functioning Domain
Family Functioning
Living Situation
School
Social Functioning
Recreational
Developmental/Intellectual
Communication
Decision Making
Job Functioning
Legal
Medical/Physical
Sexual Development
Sleep
Independent Living Skills

Child Strengths Domain
Family Strengths
Interpersonal
Optimism
Educational
Vocational
Talents/Interests
Spiritual/Religious
Community Life
Relationship Permanence
Youth Involvement with Care
Natural Supports
Resiliency

Cultural Factors Domain
Language
Cultural Identity
Traditions and Rituals
Cultural Stress

Caregiver Needs & Resources Domain
Supervision
Involvement with Care
Knowledge
Organization
Social Resources
Residential Stability
Physical
Mental Health
Substance Use
Developmental
Accessibility to Child Care
Family Stress
Safety
Marital/Partner Violence in the Home
Abuse/Neglect

Child Behavioral /Emotional Needs Domain
Psychosis
Impulsivity/Hyperactivity
Depression
Anxiety
Oppositional
Conduct
Adjustment to Trauma
Anger Control
Substance Use

Child Risk Behaviors Domain
Suicide Risk
Self Mutilation
Other Self Harm
Danger to Others
Sexual Aggression
Runaway
Delinquency
Fire Setting
Intentional Misbehavior
Bullying

CODING DEFINITIONS

LIFE FUNCTIONING DOMAIN

	FAMILY FUNCTIONING ***"Family" ideally should be defined by the child; however, in the absence of this knowledge, consider biological and adoptive relatives and their significant others with whom the child has contact, as the definition of family. Foster families should only be considered if they have made a significant commitment to the child. For youth involved with child welfare, family refers to the person(s) fulfilling the permanency plan.***
0	Child is doing well in relationships with family members.
1	Child is doing adequately in relationships with family members although some problems may exist. For example, some family members may have some problems in their relationships with child.
2	Child is having moderate problems with parents, siblings and/or other family members. Frequent arguing, difficulties in maintaining any positive relationship may be observed.
3	Child is having severe problems with parents, siblings, and/or other family members. This would include problems of domestic violence, constant arguing, etc.
NA	Not Applicable

	LIVING SITUATION ***This item refers to how the child is functioning in his/her current living arrangement, which could be with a relative, in a foster home, shelter, etc. (If child is living with the family, ratings for Family and Living Situation would be the same.)***
0	No evidence of problem with functioning in current living environment. Child and caregivers feel comfortable and safe dealing with issues that come up in day-to-day life.
1	Mild problems with functioning in current living situation. Caregivers express some concern about child's behavior in living situation and/or child and caregiver have some difficulty dealing with issues that arise in daily life.
2	Moderate to severe problems with functioning in current living situation. Child has difficulties maintaining his/her behavior in this setting creating significant problems for others in the residence. Child and caregivers have difficulty interacting effectively with each other much of the time.
3	Profound problems with functioning in current living situation. Child is at immediate risk of being removed from living situation due to his/her behaviors.

	SCHOOL ***This item reflects the highest level of need related to school behavior, attendance, achievement or relationship with teacher(s) during the last 30 days or, if not attending school, when the child was last in school.***
0	Child is performing well in school.
1	Child is performing adequately in school although some problems may exist.
2	Child is experiencing moderate problems with school attendance, behavior, and/or achievement.
3	Child is experiencing severe problems in school with school attendance, behavior and/or achievement.

	SOCIAL FUNCTIONING ***This item refers to the child's social functioning, how they are interacting with others within the last 30 days. Consider the child's level of development.***
0	Child has positive social relationships.
1	Child is having some minor problems in social relationships Child is having some difficulty interacting with others and building and/or maintain relationships
2	Child is having some moderate problems with his/her social relationships. Child often has problems interacting with others and building and maintain relationships
3	Child is experiencing severe disruptions in his/her social relationships. Child consistently and pervasively has problems interacting with others and building and maintaining relationships.

	RECREATION ***This item is intended to reflect the child's access to and use of leisure time activities.***
0	Child has and enjoys positive recreation activities on an ongoing basis. Child makes full use of leisure time to pursue recreational activities that support his/her healthy development and enjoyment.
1	Child is doing adequately with recreational activities although some problems may exist. Child at times has difficulty using leisure time to pursue recreational activities.
2	Child is having moderate problems with recreational activities. Child may experience some problems with effective use of leisure time.
3	Child has no access to or interest in recreational activities. Child has significant difficulties making use of leisure time.

	DEVELOPMENTAL/INTELLECTUAL ***This item rates the presence of any developmental or Intellectual Disability. It includes Intellectual Developmental Disorder (IDD) and Autism Spectrum Disorders. Rate the item depending on the significance of the disability and the related level of impairment in personal, social, family school, or occupational functioning.***
0	There is no evidence of a developmental delay and/or child has no developmental problem or intellectual disability.
1	Child has some problems with physical immaturity or there are concerns about possible developmental delay. Child may have low IQ, a documented delay, learning disability, or documented borderline intellectual disability, (i.e. FSIQ 70-85). Mild deficits in adaptive functioning are indicated.
2	Child has mild developmental delays (deficits in social functioning, inflexibility of behavior causing functional problems in one or more settings) and/or mild to moderate Intellectual Disability. (If available, FSIQ 55-70.) IDD impacts communication, social functioning, daily living skills, judgment, and/or risk of manipulation by others.
3	Child has severe to profound intellectual disability (FSIQ, if available, less than 55) and/or Autism Spectrum Disorder with marked to profound deficits in adaptive functioning in one or more areas: communication, social participation and independent living across multiple environments.

	COMMUNICATION ***This item rates the child's ability to understand what is said and to express his or her thoughts.***
0	Child's receptive and expressive communication appears developmentally appropriate. There is no reason to believe that the child has any problems communicating.
1	Child has receptive communication skills but limited expressive communication skills
2	Child has both limited receptive and expressive communication skills.
3	Child is unable to communicate.

	DECISION MAKING ***This item describes the child's decision-making processes and awareness of consequences.***
0	No evidence of problems with judgment or poor decision making that result harm to development and/or well-being.
1	History of problems with judgment in which the child makes decisions that are in some way harmful to his/her development and/or well-being. For example, a child who has a history of hanging out with other children who shoplift.
2	Problems with judgment in which the child makes decisions that are in some way harmful to his/her development and/or well-being.
3	Problems with judgment that place the child at risk of significant physical harm.

	JOB FUNCTIONING ***If the youth is working, this item describes their functioning in a job setting.***
0	Youth is excelling in a job environment.
1	Youth is functioning adequately in a job environment.
2	Youth has problems with his/her development of vocational or prevocational skills.
3	Youth is having major difficulties functioning in a job environment.
NA	Child/youth is not working.

	LEGAL ***This item describes the child's involvement with the legal system. This could include involvement in the juvenile or adult criminal justice systems.***
0	Child has no known legal difficulties.
1	Child has a history of legal problems but currently is not involved with the legal system.
2	Child has some legal problems and is currently involved in the legal system.
3	Child has serious current or pending legal difficulties that place him/her at risk for a court ordered out of home placement.

	MEDICAL/PHYSICAL ***This rating describes both health problems and chronic/acute physical conditions or impediments.***
0	No current need; no need for action or intervention. No evidence that the youth has any medical or physical problems, and/or the youth is healthy.
1	Identified need requires monitoring, watchful waiting, or preventive activities. Youth has mild, transient or well-managed physical or medical problems. These include well-managed chronic conditions like juvenile diabetes or asthma.
2	Action or intervention is required to ensure that the identified need is addressed; need is interfering with youth's functioning. Youth has serious medical or physical problems that require medical treatment or intervention. Or youth has a chronic illness or a physical challenge that requires ongoing medical intervention.
3	Problems are dangerous or disabling; requires immediate and/or intensive action. Youth has life-threatening illness or medical/physical condition. Immediate and/or intense action should be taken due to imminent danger to youth's safety, health, and/or development.

	SEXUAL DEVELOPMENT ***This rating looks at broad issues of sexual development including developmentally inappropriate sexual behavior and problematic sexual behavior. Sexual orientation or gender identity issues could be rated here if they are leading to difficulties.***
0	No evidence of any problems with sexual development.
1	Mild to moderate problems with sexual development. May include concerns about sexual identity or anxiety about the reaction of others.
2	Significant problems with sexual development. May include multiple older partners or high-risk sexual behavior.
3	Profound problems with sexual development. This level would include prostitution, very frequent risky sexual behavior, or sexual aggression.

	SLEEP ***This item rates any disruptions in sleep regardless of the cause including problems with going to bed, staying asleep, waking up early or sleeping too much.***
0	Child gets a full night's sleep each night.
1	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 wakening or bed wetting or nightmares.
2	Child is having problems with sleep. Sleep is often disrupted and child seldom obtains a full night of sleep
3	Child is generally sleep deprived. Sleeping is difficult for the child and they are not able to get a full night's sleep.

	INDEPENDENT LIVING SKILLS ***This rating focuses on the presence or absence of short or long-term risks associated with impairments in independent living abilities.***
0	This level indicates a person who is fully capable of independent living. No evidence of any deficits that could impede maintaining own home.
1	This level indicates a person with mild impairment of independent living skills. Some problems exist with maintaining reasonable cleanliness, diet and so forth. Problems with money management may occur at this level. This level indicates a person who is fully capable of independent living. Youth needs to learn additional independent living skills.
2	This level indicates a person with moderate impairment of independent living skills. Notable problems with completing tasks necessary for independent living (e.g., difficulty with cooking, cleaning, and self-management when unsupervised) are apparent. Youth needs to learn independent living skills.
3	This level indicates a person with profound impairment of independent living skills. This individual would be expected to be unable to live independently given their current status. Problems require a structured living environment. Youth needs an immediate intervention to develop an independent living plan.
NA	Child is younger than 14 years old.

CHILD STRENGTHS DOMAIN

	FAMILY STRENGTHS ***Family refers to all family members as defined by the youth, or biological/adoptive relatives and significant others with whom the child is still in contact. Is the family, as defined by the child, a support and strength to the child?***
0	Family has strong relationships and excellent communication. Significant family strengths. There is at least one family member who has a strong loving relationship with the child and is able to provide significant emotional or concrete support.
1	Family has some good relationships and good communication. Moderate level of family strengths. There is at least one family member who has a strong loving relationship with the child and is able to provide limited emotional or concrete support.
2	Family needs some assistance in developing relationships and/or communications. Mild level of family strengths. Family members are known, but currently none are able to provide emotional or concrete support.
3	Family needs significant assistance in developing relationships and communications or child has no identified family.

	INTERPERSONAL ***This rating refers to the interpersonal skills of the youth with both peers and adults.***
0	Child has well-developed interpersonal skills and friends.
1	Child has good interpersonal skills and has shown the ability to develop healthy friendships.
2	Child needs assistance in developing good interpersonal skills and/or healthy friendships. Mild level of interpersonal strengths. Child has some social skills that facilitate positive relationships with peers and adults but may not have any current healthy friendships.
3	Child needs significant help in developing interpersonal skills and healthy friendships. Very limited ability to make and maintain positive friendships. Child lacks social skills and has no history of positive relationships with peer and adults.

	OPTIMISM ***This rating should be based on the child or adolescent's sense of him/herself in his/her own future. This is intended to rate the child's positive future orientation.***
0	Child has a strong and stable optimistic outlook on his/her life.
1	Child is generally optimistic.
2	Child has difficulties maintaining a positive view of him/herself and his/her life. Child may vary from overly optimistic to overly pessimistic.
3	Child has difficulties seeing *any* positives about him/herself or his/her life.

	EDUCATIONAL ***This rating refers to the strengths of the school system or the child's preschool setting, and may or may not reflect any specific educational skills possessed by the child or youth***.
0	School works closely with child and family to identify and successfully address child's educational needs OR child excels in school.
1	School works with child and family to identify and address child's educational needs OR child likes school.
2	School currently unable to adequately address child's needs. This level indicates a child who is in school but has a plan that does not appear to be effective.
3	School unable and/or unwilling to work to identify and address child's needs. This level indicates a child who is either not in school or is in a school setting that does not further his/her education.

	VOCATIONAL ***This item rates the prevocational (skills which could translate to the work environment) and vocational skills of children and youth. For example, computer skills would be rated here. Consider the child's developmental level; for example, ask a young child what they would like to be when they grow up. Scoring of this item supplements Ansell-Casey assessment.***
0	Child has vocational skills and relevant work experience.
1	Child has some vocational skills or work experience.
2	Child has some prevocational skills or vocational interests.
3	No vocational strengths identified or youth needs significant assistance developing vocational skills.

	TALENTS/INTERESTS ***This rating should be based broadly on any talent, creative or artistic skill a child or youth may have including art, theatre, music, athletics, etc.***
0	Child has a talent that provides him/her with pleasure and/or self esteem. This level indicates a child with significant creative/artistic strengths.
1	Child has a talent, interest, or hobby with the potential to provide him/her with pleasure and self esteem. This level indicates a child with a notable talent. For example, a youth who is involved in athletics or plays a musical instrument, etc. would be rated here.
2	Child has identified interests but needs assistance converting those interests into a talent or hobby.
3	Child has no identified talents, interests or hobbies.

	SPIRITUAL/RELIGIOUS ***This rating should be based on the youth's and their family's involvement in spiritual or religious beliefs and activities.***
0	Child receives comfort and support from religious and/or spiritual beliefs and practices. This level indicates a child with strong moral and spiritual strengths. Child may be very involved in a religious community or may have strongly held spiritual or religious beliefs that can sustain or comfort him/her in difficult times.
1	Child is involved in a religious community whose members provide support.
2	Child has expressed some interest in religious or spiritual belief and practices.
3	Child has no identified religious or spiritual beliefs or interest in these pursuits.

	COMMUNITY LIFE ***This rating should be based on the youth's level of involvement in the cultural aspects of life in his/her community.***
0	Child is well-integrated into his/her community. He/she is a member of community organizations and/or has positive ties to the community. This level indicates a child with extensive and substantial long-term ties with the community. For example, individual may be a member of a community group (e.g. Girl or Boy Scout etc.) for more than one year, may be widely accepted by neighbors, or involved in other community activities, informal networks, etc.
1	Child is somewhat involved with his/her community. This level indicates a child with significant community ties although they may be relatively short term (e.g. past year)
2	Child has an identified community but has only limited ties to that community.
3	Child has no identified community to which he/she is a member.

	RELATIONSHIP PERMANENCE ***This rating refers to the stability of significant relationships in the child or youth's life. This likely includes family members but may also include other individuals.***
0	This level indicates a child who has very stable relationships. Family members, friends, and community have been stable for most of his/her life and are likely to remain so in the foreseeable future. Child is involved with both parents.
1	This level indicates a child who 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	This level indicates a child who has had at least one stable relationship over his/her lifetime but has experienced other instability through factors such as divorce, moving, removal from home, and death.
3	This level indicates a child who does not have any stability in relationships. Independent living or adoption must be considered.

	YOUTH INVOLVEMENT WITH CARE ***This item refers to the youth's participation in efforts to address his/her identified needs.***
0	Child is knowledgeable of needs and helps direct planning to address them.
1	Child is knowledgeable of needs and participates in planning to address them.
2	Child is at least somewhat knowledgeable of needs but is not willing to participate in plans to address them.
3	Child is neither knowledgeable about needs nor willing to participate in any process to address them.

	NATURAL SUPPORTS ***This item refers to unpaid helpers in the child's natural environment. All family members and paid care givers are excluded.***
0	Child has significant natural supports who contribute to helping support the child's healthy development.
1	Child has identified natural supports who provide some assistance in supporting the child's healthy development.
2	Child has some identified natural supports however they are not actively contributing to the child's healthy development.
3	Child has no known natural supports (outside of family and paid caregivers).

	RESILENCY ***This rating refers to the youth's ability to recognize his or her internal strengths and use them in times of stress and in managing daily life. Resilience also refers to the youth's ability to bounce back from stressful life events.***
0	Well-developed or centerpiece strength; may be used as a protective factor and a centerpiece of a strength-based plan. Youth's internal strength in overcoming or the ability to bounce back is a core part of identity and associated with a well-developed and recognizable set of supports and strengths for dealing with challenges.
1	Useful strength is evident but requires some effort to maximize the strength. Strength might be used and built upon in treatment. Youth uses internal strengths in overcoming or the ability to bounce back for healthy development, problem solving, or dealing with stressful life events.
2	Strengths have been identified but require significant strength building efforts before they can be effectively utilized as part of a plan. Youth has limited ability to recognize and use internal strengths in overcoming or the ability to bounce back to effectively to support the youth's healthy development, problem solving or dealing with stressful life events.
3	An area in which no current strength is identified; efforts are needed to identify potential strengths. Youth is currently unable to identify internal strengths for preventing or overcoming negative life events or outcomes.

CULTURAL FACTORS DOMAIN

These items identify linguistic or cultural issues for which service providers need to make accommodations (e.g., provide interpreter, finding therapist who speaks family's primary language, and/or ensure that a child in placement has the opportunity to participate in cultural rituals associated with their cultural identity).

	LANGUAGE ***This item concerns any language-related needs a family might have that affect their participation in services. This item includes both spoken and sign language.***
0	Child and family speak English well. The child and family have no problems communicating in English and do not require the assistance of a translator.
1	Child and family speak some English but potential communication problems exist due to limits on vocabulary or understanding of the nuances of the language.
2	Child and/or significant family members do not speak English. Translator or native language speaker is needed for successful intervention but qualified individual can be identified within natural supports.
3	Child and/or significant family members do not speak English. Translator or native language speaker is needed for successful intervention and no such individual is available from among natural supports.

	CULTURAL IDENTITY ***Cultural identity refers to the child's view of his/herself as belonging to a specific cultural group. This cultural group may be defined by a number of factors including race, religion, ethnicity, geography or lifestyle.***
0	Child has clear and consistent cultural identity and is connected to others who share his/her cultural identity.
1	Child is experiencing some confusion or concern regarding cultural identity.
2	Child has significant struggles with his/her own cultural identity. Child may have cultural identity but is not connected with others who share this culture.
3	Child has no cultural identity or is experiencing significant problems due to conflict regarding his/her cultural identity.

	TRADITIONS AND RITUALS ***Cultural rituals are activities and traditions that are culturally (or family) specific including the celebration of holidays such as kwanza, cinco de mayo, etc. Rituals also may include daily activities that are culturally specific (e.g. praying toward Mecca at specific times, eating a specific diet, access to media). Rituals include being able to speak one's primary language with others.***
0	Child and family are consistently able to practice rituals consistent with their cultural identity.
1	Child and family are generally able to practice rituals consistent with their cultural identity; however, they sometimes experience some obstacles to the performance of these rituals.
2	Child and family experience significant barriers and are sometimes prevented from practicing rituals consistent with their cultural identity.
3	Child and family are unable to practice rituals consistent with their cultural identity.

	CULTURAL STRESS ***Cultural stress refers to experiences and feelings of discomfort and/or distress arising from friction (real or perceived) between an individual's own cultural identity and the predominant culture in which he/she lives. Racism would be rated here.***
0	No evidence of stress between caregiver's cultural identify and current living situation.
1	Some mild or occasional stress resulting from friction between the caregiver's cultural identify and his/her current living situation.
2	Caregiver is experiencing cultural stress that is causing problems of functioning in at least one life domain. Caregiver needs to learn how to manage culture stress.
3	Caregiver is experiencing a high level of cultural stress that is making functioning in any life domain difficult under the present circumstances. Caregiver needs immediate plan to reduce culture stress.

CAREGIVER NEEDS & RESOURCES DOMAIN

For this domain, rate the permanency plan caregiver's capacity to meet the child or youth's needs and to build strengths. Document who is rated as the "caregiver" in clinical or case notes. Domain items cannot be "Not applicable" unless parental rights have been terminated and no unpaid caregiver has been identified.

	SUPERVISION ***This rating is used to determine the caregiver's capacity to provide the level of monitoring and discipline needed by the child.***
0	Caregiver has good monitoring and discipline skills. This rating is used to indicate a caregiver circumstance in which supervision and monitoring are appropriate and functioning well.
1	Caregiver provides generally adequate supervision. May need occasional help or technical assistance. This level indicates a caregiver circumstance in which appropriate supervision and monitoring are generally adequate but inconsistent. This may include a placement in which one member is capable of appropriate monitoring and supervision but others are not capable or not consistently available.
2	Caregiver reports difficulties monitoring and/or disciplining child. Caregiver needs assistance to improve supervision skills. This level indicates a caregiver circumstance in which appropriate supervision and monitoring are very inconsistent and frequently absent.
3	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.

	INVOLVEMENT WITH CARE ***This rating should be based on the level of involvement the caregiver(s) has in the planning and provision of child welfare, treatment, education, and related services.***
0	Caregiver is actively involved in planning or implementation of services and able to act as an effective advocate for child.
1	Caregiver has history of seeking help for their children. Caregiver is open to receiving support, education, and information.
2	Caregiver does not wish to participate in services and/or interventions intended to assist their child.
3	Caregiver wishes for child to be removed from their care or is not visiting child in foster care, group home or residential care.

	KNOWLEDGE ***This rating should be based on caregiver's knowledge of the specific strengths of the child and any problems experienced by the child and their ability to understand the rationale for the treatment or management of these problems.***
0	Caregiver is knowledgeable about the child's needs and strengths. This level indicates that the present caregiver is fully knowledgeable about the child's psychological strengths and weaknesses, talents and limitations.
1	This level indicates that the present caregiver, while being generally knowledgeable about the child, has some mild deficits in knowledge or understanding of either the child's psychological condition or his/her talents, skills and assets.
2	Caregiver has clear need for information to improve how knowledgeable they are about the child. Current lack of information is interfering with their ability to parent. This level indicates that the caregiver does not know or understand the child well and that significant deficits exist in the caregiver's ability to relate to the child's problems and strengths.
3	This level indicates that the present caregiver has little or no understanding of the child's current condition. The caregiver is unable to cope with the child given his/her status at the time, not because of the needs of the child but because the caregiver does not understand or accept the situation. The lack of knowledge places the child at risk of significant negative outcomes.

	ORGANIZATION ***This rating should be based on the ability of the caregiver to participate in or direct the organization of the household, services, and related activities.***
0	Caregiver is well organized and efficient.
1	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	Caregiver has moderate difficulty organizing and maintaining household to support needed services.
3	Caregiver is unable to organize household to support needed services.

	SOCIAL RESOURCES ***This item refers to the financial and social assets (e.g. extended family) and resources that the caregiver(s) can bring to bear in addressing the multiple needs of the child and family.***
0	Caregiver has significant family and friend social network that actively helps with raising the child (e.g. child rearing).
1	Caregiver has some family or friend social network that actively help with raising the child (e.g. child rearing).
2	Caregiver has some family or friend social network that may be able to help with raising the child (e.g. child rearing).
3	Caregiver no family or social network that may be able to help with raising the child (e.g. child rearing).

	RESIDENTIAL STABILITY ***This item rates the caregiver's current and likely future housing circumstances.***
0	Caregiver has stable housing for the foreseeable future.
1	Caregiver has relatively stable housing but either has moved in the past three months or there are indications of housing problems that might force them to move in the next three months.
2	Caregiver has moved multiple times in the past year. Housing is unstable.
3	Caregiver has experienced periods of homelessness in the past six months.

	PHYSICAL ***Physical health includes medical and physical challenges faced by the caregiver(s).***
0	Caregiver is generally healthy.
1	Caregiver is in recovery from medical/physical problems.
2	Caregiver has medical/physical problems that interfere with their capacity to parent.
3	Caregiver has medical/physical problems that make it impossible for them to parent at this time.

	MENTAL HEALTH ***This item refers to the caregiver's mental health status. Serious mental illness would be rated as a '2' or '3' unless the individual is in recovery.***
0	Caregiver has no mental health needs.
1	Caregiver is in recovery from mental health difficulties.
2	Caregiver has some mental health difficulties that interfere with their capacity to parent.
3	Caregiver has mental health use difficulties that make it impossible for them to parent at this time.

	SUBSTANCE USE ***This item rates the caregiver's pattern of alcohol and/or drug use. Substance-related disorders would be rated as a '2' or '3' unless the individual is in recovery.***
0	Caregiver has no substance use needs.
1	Caregiver is in recovery from substance use difficulties.
2	Caregiver has some substance use difficulties that interfere with their capacity to parent.
3	Caregiver has substance use difficulties that make it impossible for them to parent at this time.

	DEVELOPMENTAL ***This item describes the caregiver's developmental status in terms of low IQ, intellectual or developmental disability that impairs functioning.***
0	Caregiver has no developmental needs.
1	Caregiver has developmental challenges but they do not currently interfere with parenting.
2	Caregiver has developmental challenges that interfere with their capacity to parent.
3	Caregiver has severe developmental challenges that make it impossible for them to parent at this time.

	ACCESSIBILITY TO CHILD CARE SERVICES ***This item refers to the caregiver's access to appropriate child care for young children or older youth with developmental delays.***
0	Caregiver has access to sufficient child care services.
1	Caregiver has limited access to child care services. Needs are met minimally by existing, available services.
2	Caregiver has limited access or access to limited child care services. Current services do not meet the caregiver's needs.
3	Caregiver has no access to child care services.

	FAMILY STRESS ***This item rates the impact of the managing the child's needs on the caregiver(s).***
0	Caregiver able to manage the stress of child/children's needs.
1	Caregiver has some problems managing the stress of child/children's needs.
2	Caregiver has notable problems managing the stress of child/children's needs. This stress interferes with their capacity to give care.
3	Caregiver is unable to manage the stress associated with child/children's needs. This stress prevents caregiver from parenting.

	SAFETY ***This rating refers to the safety of the assessed child. It does not refer to the safety of other family or household members based on any danger presented by the assessed child.***
0	Household is safe and secure. Child is at no risk from others. This level indicates that the present placement environment is as safe or safer for the child (in his or her present condition) as could be reasonably expected.
1	Household is safe but concerns exist about the safety of the child due to history or others in the neighborhood who might be abusive. This level indicates that the present placement environment presents some mild risk of neglect, exposure to undesirable environments (e.g. drug use or gangs in the neighborhood, etc.) but that no immediate risk is present.
2	Child is in some danger from one or more individuals with access to the household. This level indicates that the present placement environment presents a moderate level of risk to the child, including such things as the risk of neglect or abuse or exposure to individual who could harm the child.
3	Child is in immediate danger from one or more individuals with unsupervised access. This level indicates that the present placement environment presents a significant risk to the well being of the child. Risk or neglect or abuse is imminent and immediate. An individual in the environment offers the potential of significantly harming the child.

***All referents are legally required to report suspected child abuse or neglect to the hotline**

	MARITAL/PARTNER VIOLENCE IN THE HOME ***This rating describes the degree of difficulty or conflict in the parent/caregiver's relationship and the impact on parenting and childcare.***
0	Parent/caregiver(s) 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	Mild to moderate level of family problems including marital difficulties and partner arguments. Parent/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	Significant level of caregiver difficulties including frequent arguments that often escalate to verbal aggression, the use of verbal aggression by one partner to control the other or significant destruction of property. Child often witnesses these arguments between caregivers, the use of verbal aggression by one partner to control the other or significant destruction of property.
3	Profound level of caregiver or marital violence that often escalates to 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.

	ABUSE and/or NEGLECT ***This item refers to physical, emotional, or sexual abuse occurring, or at risk of occurring in the child's living situation, AND/OR the failure to provide adequate supervision and expectations and access to the basic necessities of life, including food, shelter, and clothing.***
0	No evidence of emotional, physical, sexual abuse or neglect.
1	Mild level of emotional abuse or occasional spanking without physical harm, or intention to commit harm. No sexual abuse. OR Mild level of neglect of caretaker responsibilities, such as failure to provide adequate expectations or supervision to child.
2	Moderate level of emotional abuse and/or frequent spanking or other forms of physical punishment. OR Moderate level of neglect, including some supervision and occasional unintentional failure to provide adequate food, shelter, or clothing, with rapid corrective action.
3	Severe level of emotional or physical abuse with intent to do harm and/or actual physical harm, or any form of sexual abuse. This would include regular beatings with physical harm and frequent and ongoing emotional assaults. OR Severe level of neglect, including prolonged absences by adults, without minimal supervision, and failure to provide basic necessities of life on a regular basis.

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CHILD BEHAVIORAL/EMOTIONAL NEEDS DOMAIN

	PSYCHOSIS (Thought Disturbance) ***This item is used to rate the symptoms of psychiatric disorders with a known neurological base. DSM disorders included on this dimension are Schizophrenia and other psychotic disorders (unipolar, bipolar, NOS). The common symptoms of these disorders include hallucinations, delusions, unusual thought processes, strange speech, and bizarre/idiosyncratic behavior.***
0	No evidence
1	History or suspicion of hallucinations, delusions or bizarre behavior that might be associated with some form of psychotic disorder.
2	Clear evidence of hallucinations, delusions or bizarre behavior that might be associated with some form of psychotic disorder.
3	Clear evidence of dangerous hallucinations, delusions, or bizarre behavior that might be associated with some form of psychotic disorder which places the child or others at risk of physical harm.

	IMPULSIVITY/HYPERACTIVITY ***Problems with impulse control, impulsive behaviors, including motoric disruptions would be rated here. Manic behavior would be rated here.***
0	This rating is used to indicate a child with no evidence of age-appropriate impulsivity in action or thought.
1	This rating is used to indicate a child with evidence of mild levels of impulsivity evident in either action or thought. The child may behave in a fashion that suggests limited impulse control. For instance, child may yell out answers to questions or may have difficulty waiting his turn. Child may exhibit some motor difficulties as well, for instance pushing or shoving others without waiting turn.
2	Clear evidence of problems with impulsive, distractible, or hyperactive behavior that interferes with the child's ability to function in at least one life domain. This rating is used to indicate a child with moderate levels of impulsivity evident in behavior. The child is frequently impulsive and may represent a significant management problem. A child who often intrudes on others and often exhibits aggressive impulses would be rated here.
3	Clear evidence of a dangerous level of impulsive behavior that can place the child at risk of physical harm. This rating is used to indicate a child with significant levels of impulsive evident in behavior. Frequent impulsive behavior is observed or noted that carries considerable safety risk (e.g., running into the street, dangerous driving, or bike riding). The child may be impulsive on a nearly continuous basis. He or she endangers self or others without thinking.

	DEPRESSION ***Symptoms included in this dimension are irritable or depressed mood, social withdrawal, sleep disturbances, weight/eating disturbances, and loss of motivation. This dimension can be used to rate symptoms of the following psychiatric disorders as specified in DSM: Depressive Disorders (unipolar, dysthymia, NOS), and Bipolar Disorder.***
0	No evidence
1	History or suspicion of depression or mild to moderate depression associated with a recent negative life event with minimal impact on life domain functioning. Brief duration of depression, irritability, or impairment of peer, family, or academic functioning that does not lead to gross avoidance behavior.
2	Clear evidence of depression associated with either depressed mood or significant irritability. Depression has interfered significantly in child's ability to function in at least one life domain.
3	Clear evidence of disabling level of depression that makes it virtually impossible for the child to function in any life domain. This rating is given to a child with a severe level of depression. This would include a child who stays at home or in bed all day due to depression or one whose emotional symptoms prevent any participation in school, friendship groups, or family life. Disabling forms of depressive diagnoses would be coded here. This level is used to indicate an extreme case of one of the disorders listed above.

	ANXIETY ***This item describes the child's level of fearfulness, worrying or other characteristics of anxiety.***
0	No evidence
1	History or suspicion of anxiety problems or mild to moderate anxiety associated with a recent negative life event. This level is used to rate either a mild phobia or anxiety problem or a sub-threshold level of symptoms for the other listed disorders.
2	Clear evidence of anxiety associated with either anxious mood or significant fearfulness. Anxiety has interfered significantly in child's ability to function in at least one life domain.
3	Clear evidence of debilitating level of anxiety that makes it virtually impossible for the child to function in any life domain.

	OPPOSITIONAL (Non-compliance with Authority) ***This item is intended to capture how the child relates to authority. Oppositional behavior is different from conduct disorder in that the emphasis of the behavior is on non-compliance with authority rather than inflicting damage and hurting others.***
0	No evidence
1	History or recent onset (past 6 weeks) of defiance towards authority figures. This rating indicates that the child/adolescent has mild problems with compliance with some rules or adult instructions. Child may occasionally talk back to teacher, parent/caregiver; there may be letters or calls from school.
2	Clear evidence of oppositional and/or defiant behavior towards authority figures, which is currently interfering with the child's functioning in at least one life domain. Behavior causes emotional harm to others. A child who meets the criteria for Oppositional Defiant Disorder in DSM would be rated here.
3	Clear evidence of a dangerous level of oppositional behavior involving the threat of physical harm to others. This rating indicates that the child/adolescent has severe problems with compliance with rules or adult instructions. A child rated at this level would be a severe case of Oppositional Defiant Disorder. They would be virtually always noncompliant. Child repeatedly ignores authority.

	CONDUCT ***These symptoms include antisocial behaviors like shoplifting, pathological lying, vandalism, cruelty to animals, and assault. This dimension would include the symptoms of Conduct Disorder as specified in DSM.***
0	No evidence
1	History or suspicion of problems associated with antisocial behavior including but not limited to lying, stealing, manipulating others, sexual aggression, violence towards people, property or animals. This level indicates a child with a mild level of conduct problems. The child may have some difficulties in school and home behavior. Problems are recognizable but not notably deviant for age, sex and community. This might include occasional truancy, repeated severe lying, or petty theft from family.
2	Clear evidence of antisocial behavior including but not limited to lying, stealing, manipulating others, sexual aggression, violence towards people, property, or animals. A child rated at this level should meet criteria for a diagnosis of Conduct Disorder.
3	Evidence of a severe level of conduct problems as described above that places the child or community at significant risk of physical harm due to these behaviors. This rating indicates a child with a severe conduct disorder. This could include frequent episodes of unprovoked, planned aggressive or other anti-social behavior.

	ADJUSTMENT TO TRAUMA ***This item covers the youth's reaction to any of a variety of traumatic experiences—such as emotional, physical, or sexual abuse, disasters, neglect, separation from family members, witnessing violence in their home or community, or the victimization or murder of family members or close friends.*** ***This item should be rated 1 -3 for individuals who are exhibiting any symptoms related to a traumatic or adverse experience in their past. The item allows you to rate the overall severity of the broad range of symptoms they may be experiencing. The remaining items in the CANS will allow you to rate the specific types of symptoms. (Adjustment to Trauma language Adapted from Kisiel, et al., 2011)*** ***If abuse or neglect of the child/youth has been substantiated by child welfare, the rating would automatically be a 1, 2, or 3.***
0	Child has not experienced any significant trauma.
1	History or suspicion of problems associated with traumatic life event/s. Child has some **mild** problems with adjustment due to trauma that might ease with the passage of time. This may include one or mental health difficulty (such as depression, sleep problems) that may be associated with their trauma history. Child may also be in the process of recovering from a more extreme reaction to a traumatic experience.
2	Clear evidence of **moderate** adjustment problems associated with traumatic life event/s. Adjustment is interfering with child's functioning in at least one life domain. Symptoms can vary widely and may include sleeping or eating disturbances, regressive behavior, behavior problems or problems with attachment. Child may have features of one or more diagnoses and may meet full criteria for a specific DSM diagnosis including but not limited to diagnoses of Post-Traumatic Stress Disorder (PTSD) or Adjustment Disorder.
3	Clear evidence of **severe** adjustment problems associated with traumatic life event/s, which may include flashbacks, nightmares, significant anxiety, and intrusive thoughts, re-experiencing trauma (consistent with PTSD). OR Child likely meets criteria for more than one diagnosis or may have several symptoms consistent with complex trauma (e.g. problems with attachment, affect and behavioral regulation, cognition/learning, etc.). Child has severe symptoms as a result of traumatic or adverse childhood experiences that **require intensive** or **immediate attention**.

	ANGER CONTROL ***This item captures the youth's ability to identify and manage their anger when frustrated.***
0	No evidence of any significant anger control problems.
1	Some problems with controlling anger. Child may sometimes become verbally aggressive when frustrated. Peers and family may be aware of and may attempt to avoid stimulating angry outbursts.
2	Moderate anger control problems. Child's temper has gotten him/her in significant trouble with peers, family and/or school. Anger may be associated with physical violence. Others are likely quite aware of anger potential.
3	Severe anger control problems. Child's temper is likely associated with frequent fighting that is often physical. Others likely fear him/her.

	SUBSTANCE USE ***This item describes problems related to the use of alcohol and/or illegal drugs, the misuse of prescription medications, and the inhalation of any chemical or synthetic substance by a child and youth. This rating is consistent with DSM substance-related disorders.***
0	There is no evidence of substance use.
1	The child or youth has a significant history OR substance use is suspected.
2	There is clear evidence of substance use that interferes with functioning in any life domain, (e.g. intoxication, loss of money, reduced school performance, social problems, parental concern, impaired driving, and/or legal involvement). This rating is for a child or youth with a substance misuse problem that impairs his/her ability to function, but does not preclude functioning in an unstructured setting while participating in treatment.
3	This rating is for a youth with a severe substance use problem that presents complications to functional issues which may result in danger to self, public safety issues, or the need for detoxification of the youth. Include here a youth who is intoxicated at the time of the assessment (currently under the influence).

CHILD RISK BEHAVIOR DOMAIN

	SUICIDE RISK ***This rating describes both suicidal and significant self-injurious behavior. A rating of 2 or 3 would indicate the need for a safety plan. Notice the specific time frame for each rating.***
0	No evidence or history of suicidal ideation or behavior
1	History but no recent ideation or gesture. History of suicidal behaviors or significant ideation but none during the past 30 days.
2	Recent ideation or gesture but not in past 24 hours. Recent, (last 30 days) but not acute (today) suicidal ideation or gesture.
3	Current ideation and intent OR command hallucinations that involve self-harm. Current suicidal ideation and intent in the past 24 hours.

	SELF-MUTILATION (Non-Suicidal Self-Injury) ***This rating includes repetitive, physically harmful behavior that generally serves as a self-soothing function to the child.***
0	No evidence of any forms of self-injury (e.g., cutting, burning, face slapping, head banging)
1	History of self-mutilation, but none in the last 30 days.
2	Engaged in self mutilation that does not require medical attention.
3	Engaged in self mutilation that requires medical attention.

	OTHER SELF HARM (Recklessness) ***This rating includes reckless and dangerous behaviors that, while not intended to harm self or others, place the child or others at some jeopardy. Suicidal or self-mutilative behaviors are NOT rated here.***
0	No evidence of behaviors other than suicide or self-mutilation that place the child at risk of physical harm.
1	History of behavior other than suicide or self-mutilation that places child at risk of physical harm. This includes reckless and risk-taking behavior that may endanger the child.
2	Engaged in behavior other than suicide or self-mutilation that places him/her in danger of physical harm. This includes reckless behavior or intentional risk-taking behavior.
3	Engaged in behavior other than suicide or self-mutilation that places him/her at immediate risk of death. This includes reckless behavior or intentional risk-taking behavior.

	DANGER TO OTHERS ***This rating includes actual and threatened violence. Imagined violence, when extreme, may be rated here. A rating of 2 or 3 would indicate the need for a safety plan.***
0	Child has no evidence or history of aggressive behaviors or significant verbal aggression towards others (including people and animals)
1	History of aggressive behavior or verbal aggression towards others, but no aggression during the past 30 days. History of fire setting (not in the past year) would be rated here.
2	Occasional or moderate level of aggression towards others including aggression during the past 30 days or more recent verbal aggression.
3	Frequent or dangerous (significant harm) level of aggression to others. Child or youth in immediate risk to others.

	SEXUAL AGGRESSION ***Sexually abusive behavior includes both aggressive sexual behavior and sexual behavior in which the child or adolescent takes advantage of a younger or less powerful child through seduction, coercion, or force.***
0	No evidence of any history of sexually aggressive behavior in the last year.
1	Mild problems of sexually abusive behavior. For example, occasional inappropriate sexually aggressive/harassing language or behavior. History of sexually aggressive behavior (but not in past year) OR sexually inappropriate behavior in the past year that troubles others such as harassing talk or language.
2	Moderate problems with sexually abusive behavior. For example, frequent inappropriate sexual behavior. Frequent disrobing would be rated here only if it was sexually provocative. Frequent inappropriate touching would be rated here.
3	Severe problems with sexually abusive behavior. This would indicate the rape or sexual abuse of another person involving sexual penetration.

	RUNAWAY ***In general, to classify as a runaway or elopement, the child is gone overnight or very late into the night. Impulsive behavior that represents an immediate threat to personal safety would also be rated here.***
0	This rating is for a child with no history of running away and no ideation involving escaping from the present living situation.
1	This rating is for a child with no recent history of running away but who has expressed ideation about escaping present living situation or treatment. Child may have threatened running away on one or more occasions or have a history (lifetime) of running away but not in the past year.
2	This rating is for a child who has run away from home once or run away from one treatment setting within the past year. Also rated here is a child who has runaway to home (parental or relative) in the past year.
3	This rating is for a child who has (1) run away from home and/or treatment settings with the last 7 days or (2) run away from home and/or treatment setting twice or more overnight during the past 30 days. Destination is a return to home of parent or relative.

	DELINQUENCY ***This rating includes both criminal behavior and status offenses that may result from child or youth failing to follow required behavioral standards (e.g. truancy). Sexual offenses should be included as criminal behavior. If caught, the youth could be arrested for this behavior.***
0	Child shows no evidence of or has no history of criminal or delinquent behavior.
1	History of delinquency but no acts of delinquency in past 30 days. History or criminal or delinquent behavior but none in the past 30 days. Status offenses in the past 30 days would be rated here.
2	Moderate level of criminal activity including a high likelihood of crimes committed in the past 30 days. Examples would include vandalism, shoplifting, etc.
3	Serious level of criminal or delinquent activity in the past 30 days. Examples would include car theft, residential burglary, gang involvement, etc.

	FIRE SETTING ***This item refers to behavior involving the intentional setting of fires that might be dangerous to the child or others. This does not include the use of candles or incense or matches to smoke. Notice the specific time frames for each rating level.***
0	No evidence or history of fire setting behavior.
1	History of fire setting, but not in the past six months.
2	Recent fire setting behavior (in past six months), but not of the type that has endangered the lives of others OR repeated fire-setting behavior over a period of at least two years even if not in the past six months.
3	Acute threat of fire setting: for example, set fire that endangered the lives of others (e.g. attempting to burn down a house).

	INTENTIONAL MISBEHAVIOR (Social Behavior) ***This rating describes obnoxious social behaviors that a child engages in to intentionally force adults to sanction him/her. This item should reflect problematic social behaviors (socially unacceptable behavior for the culture and community in which he/she lives) that put the child at some risk of sanctions. It is not necessary that the child have an awareness of the purpose of his/her misbehavior as it is not always conscious or planned. This item should not be rated for children who engage in such behavior solely due to developmental delays or lack of social skill.***
0	No evidence of problematic social behavior. Child does not engage in behavior that forces adults to sanction him/her.
1	**Mild** level of intentional misbehavior. This might include occasional inappropriate social behavior that forces adults to sanction the child. Infrequent inappropriate comments to strangers or unusual behavior in social settings might be included in this level.
2	**Moderate** level of intentional misbehavior. Child is intentionally engaging in problematic social behavior that is causing problems in his/her life. Child is intentionally getting in trouble in school, at home, or in the community.
3	**Severe** level of problematic social behavior. This level would be indicated by frequent serious social behavior that forces adults to seriously and/or repeatedly sanction the child. Social behaviors are sufficiently severe that they place the child at risk of significant sanctions (e.g. expulsion, removal from the community)

	BULLYING ***This time describes the behavior of a youth who bullies others.***
0	Youth has never engaged in bullying at school or in the community.
1	Youth has been involved with groups that have bully other youth either in school or the community; however, youth has not had a leadership role in these groups.
2	Youth has bullied other youth in school or community. Youth has either bullied the other youth individually or led a group that bullied youth
3	Youth has repeated utilized threats or actual violence to bully youth in school and/or community.

INDIVIDUALIZED ASSESSMENT MODULES

Complete any specific module only if indicated by core item(s) on the initial page(s)

SCHOOL MODULE

	SCHOOL BEHAVIOR ***This item rates the behavior of the child or youth in school or school-like settings. A rating of 3 would indicate a child who is still having problems after special efforts have been made, i.e., problems in a special education class***.
0	Child is behaving well in school.
1	Child is behaving adequately in school although some behavior problems exist.
2	Child is having moderate behavioral problems at school. He/she is disruptive and may have received sanctions including suspensions.
3	Child is having severe problems with behavior in school. He/she is frequently or severely disruptive. School placement may be in jeopardy due to behavior.

	SCHOOL ACHIEVEMENT ***This item describes academic achievement and functioning.***
0	Child is doing well in school, passing all classes and is on track with his/her educational plan.
1	Child is doing adequately in school although some problems with achievement exist.
2	Child is having moderate problems with school achievement. He/she may be failing some subjects. And/or be at risk for failing the current grade.
3	Child is having severe achievement problems. He/she may be failing most subjects or more than one year behind same age peers in school achievement, and/or will certainly not pass to next grade level.

	SCHOOL ATTENDANCE ***If school is not in session, rate the last 30 days when school was in session.***
0	Child attends school regularly.
1	Child has some problems attending school but generally goes to school. May miss up to one day per week on average OR may have had moderate to severe problem in the past six months but has been attending school regularly in the past month.
2	Child is having problems with school attendance. He/she is missing at least two days each week on average.
3	Child is generally truant or refusing to go to school.

DEVELOPMENTAL DISABILITIES MODULE

This module describes the child's current developmental functioning (last 30 days).
Please rate based on relevant information from all sources.

COGNTIVE ***This item identifies the individual's intellectual or cognitive capacity.***		
Questions to consider: • Has the child been tested for or diagnosed with a learning disability? • Does the child have an intellectual disability or delay?	0	Child's intellectual functioning appears to be in normal range. There is no reason to believe that the child has any problems with intellectual functioning.
	1	Child has low IQ (70 to 85) or has identified learning challenges.
	2	Child has mild intellectual disability. IQ is between 55 and 70.
	3	Child has moderate to profound intellectual disability. IQ is less than 55.

<table>
<tr><th colspan="3">DEVELOPMENTAL This item rates the level of developmental delay/disorders that are present.</th></tr>
<tr><td rowspan="4">Questions to consider:
Is the child progressing developmentally similar to peers of the same age?
Has the individual been diagnosed with a developmental disorder?</td><td>0</td><td>Child’s development appears within normal range. There is no reason to believe that the child has any developmental problems.</td></tr>
<tr><td>1</td><td>Evidence of a mild developmental delay.</td></tr>
<tr><td>2</td><td>Evidence of an Autism Spectrum Disorder, Tourette’s, Down’s Syndrome or other significant developmental delay.</td></tr>
<tr><td>3</td><td>Severe developmental disorder.</td></tr>
</table>

<table>
<tr><th colspan="3">SELF CARE/DAILY LIVING SKILLS This item rates the individual’s ability to participate in self-care activities, including eating, bathing, dressing and toileting.</th></tr>
<tr><td rowspan="4">Questions to consider:
What support and assistance does the child need to complete daily self care and living skills?
Are the child’s self care skills age appropriate?</td><td>0</td><td>Child's self care and daily living skills appear developmentally appropriate. There is no reason to believe that the child has any problems performing daily living skills.</td></tr>
<tr><td>1</td><td>Child requires verbal prompting on self care tasks or daily living skills.</td></tr>
<tr><td>2</td><td>Child requires assistance (physical prompting) on self care tasks or attendant care on one self care task (e.g. eating, bathing, dressing, and toileting).</td></tr>
<tr><td>3</td><td>Child requires attendant care on more than one of the self care tasks - eating, bathing, dressing, toileting.</td></tr>
</table>

FAMILY/CAREGIVER MODULE

	EMPLOYMENT/EDUCATIONAL FUNCTIONING ***This item rates the performance of the caregiver in school or work settings. This performance can include issues of behavior, attendance or achievement/productivity.***
0	Caregiver is gainfully employed and/or in school.
1	A mild degree of problems with school or work functioning. Caregiver may have some problems in work environment. Caregiver needs to be monitored and assessed further.
2	A moderate degree of school or work problems and/or difficulties with learning. Caregiver may have history of frequent job loss or may be recently unemployed. Caregiver needs an intervention to address employment and/or learning difficulties.
3	A severe degree of school or work problems. Caregiver is chronically unemployed and not attending any education program. Caregiver needs immediate intervention.

	LEGAL ***This item rates the family’s involvement in the criminal justice system.***
0	Caregiver has no known legal difficulties.
1	Caregiver has a history of legal problems but currently is not involved with the legal system.
2	Caregiver has some legal problems and is currently involved in the legal system.
3	Caregiver has serious current or pending legal difficulties that place him/her at risk for incarceration. Caregiver needs an immediate comprehensive and community-based intervention.

	MOTIVATION FOR CARE ***This rating captures the desire of the caregiver to support their youth in care. The person need not have an understanding of their illness; however they participate in recommended or prescribed care (e.g., taking prescribed medications and cooperating with care providers).***
0	The caregiver is engaged in his/her youth's care and supports his/her youth in participating in care.
1	The caregiver is willing for his/her youth to participate in care, however the caregiver may need prompts at times. Caregiver needs to be monitored and assessed further.
2	The caregiver is often unwilling to support his/her youth's care and is often uncooperative with service providers. Caregiver/youth needs to be engaged in care.
3	The caregiver refuses to allow his/her youth to participate in care including taking prescribed medications or cooperating with recommended care. Service coordinator needs to meet with referral source and team to revisit goals.

	FINANCIAL RESOURCES
0	Caregiver has sufficient financial resources to raise the youth (e.g., youth rearing).
1	Caregiver has some financial resources that actively help with raising the youth (e.g. youth rearing).
2	Caregiver has limited financial resources that may be able to help with raising the youth (e.g., youth rearing).
3	Caregiver has no financial resources to help with raising the youth (e.g. youth rearing). Caregiver needs financial resources

	TRANSPORTATION ***This rating reflects the caregiver's ability to provide appropriate transportation for his/her youth.***
0	Youth and his/her caregiver have no transportation needs. Caregiver is able to get his/her youth to appointments, school, activities, etc. consistently.
1	Youth and his/her caregiver have occasional transportation needs (e.g. appointments). Caregiver has difficulty getting his/her youth to appointments, school, activities, etc. no more than weekly.
2	Youth and his/her caregiver have frequent transportation needs. Caregiver has difficulty getting his/her youth to appointments, school, activities, etc. regularly (e.g., once a week). Caregiver needs assistance transporting youth and access to transportation resources.
3	Youth and his/her caregiver have no access to appropriate transportation and is unable to get his/her youth to appointments, school, activities, etc. Caregiver needs immediate intervention and development of transportation resources.

TRAUMA MODULE

Rating Guide for Characteristics of Potentially Traumatic/Adverse Experiences Section

0 – No evidence of any trauma of this type
1 – A single incident of trauma occurred or suspicion exists of this type of trauma
2 – Multiple incidents or a moderate degree of trauma of this type
3 – Repeated and severe incidents of trauma of this type

The trauma experience rating guide and language in the TRAUMA MODULE were adapted from the NCTSN CANS (Kisiel, et al., 2011).

Potentially Adverse Traumatic Experiences are rated over the lifetime of the youth:

	SEXUAL ABUSE ***This rating describes the child's experience of sexual abuse.***
0	There is **no evidence** that child has experienced sexual abuse.
1	There is a **suspicion** that the child has experienced sexual abuse **with some degree of evidence** or the child has **experienced "mild" sexual abuse** including but not limited **to direct exposure to sexually explicit materials**. Evidence for suspicion of sexual abuse could include evidence of **sexually reactive behavior** as well as **exposure to a sexualized environment** or **Internet predation**. Children who have experiences secondary sexual abuse (e.g. **witnessing sexual abuse, having a sibling sexually abused**) would also be rated here.
2	Child has experienced **one or a couple of incidents** of sexual abuse that were not chronic or severe. This might include a child who has **experienced molestation without penetration on a single occasion.**
3	Child has experienced severe or chronic sexual abuse with **multiple episodes or lasting over an extended period of time**. This abuse may have involved **penetration, multiple perpetrators, and/or associated physical injury.**

	PHYSICAL ABUSE ***This rating describes the child's experience of physical abuse.***
0	There **is no evidence** that child has experienced physical abuse.
1	There is a **suspicion** that child has experienced physical abuse but **no confirming evidence**. **Spanking** without physical harm or threat of harm also qualifies.
2	Child has experienced a **moderate level of physical abuse** and/or **repeated forms of physical punishment** (e.g. hitting, punching).
3	Child has experienced **severe and repeated physical abuse** with intent to do harm and that causes sufficient physical harm to necessitate hospital treatment.

	EMOTIONAL ABUSE ***The rating describes the degree of severity of emotional abuse, including verbal and nonverbal forms. This item includes both "emotional abuse," which would include psychological maltreatment such as insults or humiliation towards a child and "emotional neglect" defined as the denial of emotional attention and /or support from caregivers.***
0	There is **no evidence** that child has experienced emotional abuse.
1	Child has experienced **mild** emotional abuse. For instance, child may experience some **insults or is occasionally referred to in a derogatory manner** by caregivers.
2	Child has experienced a **moderate degree of emotional** abuse. For instance, child may be **consistently denied emotional attention** from caregivers, **insulted or humiliated on an ongoing basis**, or **intentionally isolated** from others.
3	Child has experienced **significant or severe** emotional abuse over an **extended period of time** (at least one year). For instance, child is **completely ignored** by caregivers, or **threatened/terrorized** by others.

	NEGLECT ***This rating describes the degree of severity of neglect an individual has experienced. Neglect can refer to a lack of food, shelter or supervision (physical neglect) or lack of access to needed medical care (medical neglect), or failure to receive an academic instruction (educational neglect).***
0	There is **no evidence** that child has experienced neglect.
1	Child has experienced **minor occasional** neglect. Child may have been left **home alone for a short period of time** with no adult supervision or there may be **occasional failure to provide adequate supervision of child**.
2	Child has experienced a **moderate level** of neglect. Child may have been left **home alone overnight** or there may be **occasional failure to provide adequate food, shelter, or clothing** with corrective action
3	Child has experienced a **severe level of neglect** including **multiple and/or prolonged absences** by adults, with minimal supervision, and **failure to provide basic necessities of life on a regular basis.**

	MEDICAL TRAUMA ***This rating describes the severity of medical trauma. Not all medical procedures are experienced as traumatic. Medical trauma results when a medical experience is perceived by the child as mentally or emotionally overwhelming. Potential medical trauma include but are not limited to the following examples: the onset of a life threatening illness; sudden painful medical events; chronic medical conditions resulting from an injury or illness or another type of traumatic event.***
0	There is **no evidence** that child has experienced any medical trauma.
1	Child has had a medical experience that was **mildly overwhelming** for the child. Examples include events that were **acute in nature** and d**id not result in ongoing medical needs and associated distress** such as minor surgery, stitches or bone setting.
2	Child has had a medical experience that was perceived as **moderately** emotionally or mentally overwhelming. Such events **might include** acute injuries and **moderately invasive medical procedures** such as major surgery that require only short term hospitalization.
3	Child has had a medical experience that was perceived as **extremely** emotionally or mentally **overwhelming**. The event itself may have been life **threatening** and may have resulted in chronic health problems that alter the child's physical functioning.

	NATURAL or MANMADE DISASTER ***This rating describes the severity of exposure to natural and manmade disasters.***
0	There is **no evidence** that child has experienced any natural or manmade disaster.
1	Child has been **exposed to disasters secondhand** (i.e. on television, hearing others discuss disasters). This would include secondhand exposure to natural disasters such as a fire or earthquake or manmade disaster, including care accident, plane crashes, or bombing.
2	Child has been **directly exposed to a disaster or witnessed the impact of a disaster on a family or friend.** For instance, a child may observe a caregiver who has been injured in a car accident or fire or watch his neighbor's house burn down.
3	Child has been directly exposed to **multiple and severe natural or manmade disasters** and /or a disaster **that caused significant harm or death to a loved one or there is an ongoing impact or life disruption** due to the disaster (e.g. house burns down, caregiver loses job).

	WITNESS TO FAMILY VIOLENCE ***This rating describes the severity of exposure to family violence.***
0	There is **no evidence** that child has witnessed family violence.
1	Child has witnessed **one episode** of family violence.
2	Child has witnessed **repeated episodes** of family violence but no significant injuries (i.e. requiring emergency medical attention).
3	Child has witnessed **repeated and severe episodes** of family violence or has had to intervene in episodes of family violence. **Significant injuries** have occurred and have been **witnessed** as a direct result of the violence.

	COMMUNITY VIOLENCE ***This rating describes the severity of exposure to community violence.***
0	There is no **evidence** that child has witnessed violence in the community.
1	Child has witnessed **occasional fighting or other forms of violence** in the community. Child has **not been directly impacted** by the community violence (i.e. violence not directed at self, family, or friends) and exposure has been limited.
2	Child has **witnessed multiple instances** of community violence and/**or the significant injury of others** in his/her community, or has **had friends/family members injured** as a result of violence or criminal activity in the community, or is the **direct victim** of violence/criminal activity that was **not life threatening.**
3	Child has witnessed or experienced **severe and repeated instances** of community violence **and/or the death of another person in his/her community** as a result of violence, or is the **direct victim** of violence/criminal activity in the community that was **life threatening**, **<u>or</u> has experienced chronic/ongoing impact as a result** of community violence (e.g. family member injured and no longer able to work).

	WITNESS/VICTIM TO CRIMINAL ACTIVITY ***This rating describes the severity of exposure to criminal activity. Criminal behavior includes any behavior for which an adult could go to prison including drug dealing, prostitution, assault, or battery.***
0	There is **no evidence** that child has been victimized or witness significant criminal activity.
1	There is **a strong suspicion or evidence** that Child is a witness of **at least one significant criminal activity.**
2	Child has witnessed **multiple criminal activities** and/or is a **direct victim** of criminal activity or **witnessed the victimization of a family or friend.**
3	Child has been **exposed to chronic and/or severe instances of criminal activity** and/or is a **direct victim** of criminal activity that was **life threatening or caused significant physical harm** or child witnessed the **death of a loved one**.

	WAR/TERRORISM AFFECTED ***This rating describes the degree of severity of exposure to war, political violence, torture or terrorism.***
0	No evidence that the youth has been exposed to war, political violence, torture or terrorism.
1	There is suspicion that the child or youth has experienced or been affected by war, terrorism or political violence.
2	Child or youth has experienced or been affected by war, terrorism or political violence. Examples include: Family members directly related to the youth may have been exposed to war, political violence, or torture resulting in displacement, injury or disability, or death; parents may have been physically or psychologically disabled from the war and are unable to adequately care for the youth; youth may have spent an extended amount of time in a refugee camp, or feared for his/her own life during war or terrorism due to bombings or shelling very near to him/her. Youth who did not live in war or terrorism-affected region or refugee camp, but family was affected by war.
3	Child or youth has been exposed to chronic and/or severe instances war or terrorism and/or is a direct victim of political violence or terrorism that was life threatening or caused significant physical harm or child witnessed the death of a loved one. Youth may have been directly injured, tortured, or kidnapped in a terrorist attack; youth may have served as a soldier, guerrilla, or other combatant in his/her home country.

Rate Traumatic Stress Symptoms for all Youth with Trauma Experience:

	EMOTIONAL AND/OR PHYSICAL DYSREGULATION ***These symptoms include difficulties modulating or expressing emotions, intense fear or helplessness, difficulties regulating sleep/wake cycle, and inability to fully engage in activities. This can include difficulties modulating or expressing emotions and energy states such as emotional outbursts or marked shifts in emotions, overly constricted emotional responses, and intense emotional responses, and/or evidence of constricted, hyperaroused, or quickly fluctuating energy level. The child may demonstrate such difficulties with a single type or a wide range of emotions and energy states. This can also include difficulties with regulation of body functions, including disturbances in sleeping, eating and elimination; over-reactivity or under-reactivity to touch and sounds ; and physical or somatic complaints. This can also include difficulties with describing emotional or bodily states. The child's behavior likely reflects their difficulty with affective and physiological regulation, especially for younger children. This can be demonstrated as excessive and chronic silly behavior, excessive body movements, difficulties regulating sleep/wake cycle, and inability to fully engage in activities.***
0	Child has **no problems** with affect regulation.
1	Child has **mild** to moderate problems with affect regulation. This rating is given to a child with some minor and occasional difficulties with affect/physiological regulation. This child could have some difficulty tolerating intense emotions and become somewhat jumpy or irritable in response to emotionally charged stimuli, or more watchful or hypervigilant in general or have some difficulties with regulating body functions (e.g. sleeping, eating or elimination). This child may also have some difficulty sustaining involvement in activities for any length of time or have some physical or somatic complaints.
2	Child has **moderate** problems with affect /physiological regulation, but is able to control affect at times. Problems with affect regulation interfere with child's functioning in some life domains. This child may be unable to modulate emotional responses or have more persistent difficulties in regulating bodily functions. This child may exhibit marked shifts in emotional responses (e.g. from sadness to irritability to anxiety) or have contained emotions with a tendency to lose control of emotions at various points (e.g. normally restricted affect punctuated by outbursts of anger or sadness). This child may also exhibit persistent anxiety, intense fear or helplessness, lethargy/loss of motivation, or affective or physiological over-arousal or reactivity (e.g. silly behavior, loose active limbs) or underarousal (e.g. lack of movement and facial expressions, slowed walking and talking).
3	Child unable to regulate affect. This rating is given to a child with **severe** and chronic problems with highly dysregulated affective and /or physiological responses. This child may have more rapid shifts in mood and an inability to modulate emotional responses (feeling out of control of their emotions or lacking control over their movement as it relates to their emotional states). This child may also exhibit tightly contained emotions with intense outbursts under stress. Alternately, this child may be characterized by extreme lethargy, loss of motivation or drive, and no ability to concentrate or sustain engagement in activities (i.e. emotionally "shut down"). This child may have more persistent and severe difficulties regulating sleep/wake cycle, eating patterns or with elimination problems.

	INTRUSIONS (Re-experiencing) ***These symptoms consist of intrusive memories or reminders of traumatic events, including nightmares, flashbacks, intense reliving of the events, and repetitive play with themes of specific traumatic experiences.***
0	This rating is given to a child with **no evidence** of intrusive symptoms.
1	For example, a child with s**ome problems with intrusive, distressing memories**, including occasional nightmares about traumatic events would be rated here.
2	This rating is given to a child with **moderate difficulties with intrusive symptoms/distressing memories**, intrusive thoughts that interfere in his/her ability to function in some life domains. For example, the child may have **recurrent frightening dreams** with or without recognizable content or recurrent distressing thoughts, images, perceptions or memories of traumatic events. The child may exhibit **trauma-specific reenactments** through **repetitive play** with themes of trauma or **intense physiological reactions** to exposure to **traumatic cues**.
3	This rating is given to a child with repeated and/or **severe intrusive symptoms/distressing memories**. This child may exhibit t**rauma-specific reenactments that include sexually or physically traumatizing other children or sexual play** with adults. This child may also exhibit **persistent flashbacks, illusions or hallucinations** that make it **difficult for the child to function**.

	HYPERAROUSAL ***This includes difficulty falling asleep, irritability or outbursts of anger, difficulty concentrating, hyper vigilance and/or exaggerated startle response. Youth may also show common physical symptoms such as stomachaches and headaches. These symptoms are a part of the DSM-5 criteria for Trauma-Related Adjustment Disorder, Posttraumatic Stress Disorder and other Trauma- and Stressor-Related Disorders.***
0	No current need; no need for action or intervention. Youth has no evidence of hyperarousal symptoms.
1	Need that requires monitoring, watchful waiting, or preventive action. This may have been a risk behavior in the past. History or evidence of hyperarousal that does not interfere with his/her daily functioning. Youth may occasionally manifest distress-related physical symptoms such as stomachaches and headaches.
2	Action or intervention is required to ensure that the identified need is addressed. Youth exhibits one significant symptom or a combination or two or more of the following hyperarousal symptoms: difficulty falling or staying asleep, irritability or outbursts of anger, difficulty concentrating, hyper vigilance and/or exaggerated startle response. Youth who frequently manifest distress-related physical symptoms such as stomach aches and headaches would be rated here. Symptoms are distressing for the youth and/ or caregiver and negatively impacts day-to-day functioning.
3	Intensive and/or immediate action is required to address the need or risk behavior. Youth exhibits multiple and/or severe hyperarousal symptoms including alterations in arousal and physiological and behavioral reactivity associated with traumatic event(s). This may include difficulty falling or staying asleep, irritability or outbursts of anger, difficulty concentrating, hyper vigilance and/or exaggerated startle response. Intensity and frequency of these symptoms are overwhelming for the youth and/or caregiver and impede day-to-day functioning in many life areas.

	ATTACHMENT DIFFICULTIES ***This item should be rated within the context of the child's significant parental or caregiver relationships.***
0	There is **no evidence** of attachment problems. Parent-child relationship is characterized by satisfaction of needs, child's development of a sense of security and trust.
1	There is evidence of **mild** problems with attachment. This could involve either mild problems with separation or mild problems of detachment.
2	This is evidence of **moderate** problems with attachment. Child is having problems with attachment that require intervention. A child who meets the criteria for an Attachment Disorder in DSM would be rated here.
3	There is evidence of **severe** problems with attachment. A child who is unable to separate or a child who appears to have severe problems with forming or maintaining relationships with caregivers would be rated here.

	DISSOCIATION ***Symptoms included in this dimension are daydreaming, spacing or blanking out, forgetfulness, fragmentation, detachment, and rapid changes in personality often associated with traumatic experiences. This dimension may be used to rate dissociative disorders (e.g., Dissociative Disorder NOS, Dissociative Identity Disorder) but can also exist when other diagnoses are primary (e.g. PTSD, depression).***
0	There is **no evidence** of dissociation.
1	Child may experience **some symptoms** of minor dissociative problems, including some emotional numbing, avoidance or detachment, and some difficulty with **forgetfulness, daydreaming, spacing or blanking out**.
2	This rating is given to a child with a **moderate level** of dissociation. This can include amnesia for traumatic experiences or inconsistent memory for trauma (e.g. remembers in one context but not another), more **persistent or perplexing difficulties with forgetfulness** (e.g., loss of time/orientation, forgets basic information about self/identify), **frequent daydreaming or trance-like** behavior. This can also include persistent symptoms of depersonalization, including experiences of feeling detached from one's self, mental processes, or body, and /or **derealization**, including experiencing a sense of unreality or disconnection from one's surroundings. This rating could be used for someone who meets criteria for Dissociative Disorder Not Otherwise Specified or another diagnosis that is specified "with dissociative features or symptoms".
3	This rating is given to a child with **severe dissociative disturbance**. This can include significant memory difficulties or may show significant problems with **depersonalization and/or derealization** associated with trauma that also **impede day-to-day functioning.** Child is **frequently forgetful or confused** about things he/she should know about (e.g., no memory for activities or whereabouts of previous day or hours). Child shows rapid changes in personality or evidence of distinct personalities. Child who meets criteria for Dissociative Identify Disorder or a more severe level of other dissociative disorders would be rated here.

	TRAUMATIC GRIEF AND SEPARATION This ***rating describes the level of traumatic grief the youth is experiencing due to death or loss/separation from significant caregivers, siblings, or other significant figures.***
0	There is **no evidence** that the child is experiencing traumatic grief or separation from the loss of significant caregivers. Either the child has not experienced a traumatic loss (e.g. death of a loved one) or the child has adjusted well to separation.
1	Child is experiencing a **mild level** of traumatic grief due to death or loss/separation from a significant person in a manner that is expected and/or appropriate given the recent nature of loss or separation.
2	Child is experiencing a **moderate level** of traumatic grief or difficulties with separation in a manner that **impairs functioning in some but not all areas**. This could include withdrawal or isolation from others or other problems with day-to-day functioning.
3	Child is experiencing **significant traumatic grief reactions**. Child exhibits **impaired functioning across several areas** (e.g. interpersonal relationships, school) for a significant period of time following the loss or separation. **Symptoms require immediate or intensive intervention**.

	NUMBING ***This item describes youth's reduced capacity to feel or experience and express a range of emotions. These numbing responses were not present before the trauma.***
0	No current need; no need for action or intervention. Youth has no evidence of numbing responses.
1	Need that requires monitoring, watchful waiting, or preventive action. This may have been a risk behavior in the past. Youth has history or evidence of problems with numbing. He/she may have a restricted range of affect or be unable to express or experience certain emotions (e.g., anger or sadness).
2	Action or intervention is required to ensure that the identified need is addressed. Youth exhibits numbing responses that impair his/her functioning in at least one life domain. Youth may have a blunted or flat emotional state or have difficulty experiencing intense emotions or feel consistently detached or estranged from others following the traumatic experience.
3	Intensive and/or immediate action is required to address the need or risk behavior. Youth exhibits significant numbing responses or multiple symptoms of numbing that put him/her at risk. This youth may have a markedly diminished interest or participation in significant activities and a sense of a foreshortened future.

	AVOIDANCE ***These symptoms include efforts to avoid stimuli associated with traumatic experiences. These symptoms are part of the DSM criteria for PTSD.***
0	This rating is given to a child with **no evidence** of avoidance symptoms.
1	This rating is given to a child who **exhibits some avoidance**. This child may exhibit **one primary avoidant symptom**, including efforts to a**void thoughts, feelings, or conversations associated with the trauma**.
2	This rating is given to a child with **moderate symptoms of avoidance**. In addition to avoiding thoughts or feelings associated with the trauma, the child may also **avoid activities, places, or people** that arouse recollections of the trauma.
3	This rating is given to a child who exhibits **significant or multiple avoidant symptoms**. This child may **avoid thoughts and feelings as well as situations and people** associated with trauma and be **unable to recall important aspects of the trauma**.

If a child has been sexually abused, rate the following items:

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

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

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

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

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

SUBSTANCE USE MODULE

	SEVERITY OF USE
0	Child is currently abstinent and has maintained abstinence for at least six months.
1	Child is currently abstinent but only in the past 30 days or child has been abstinent for more than 30 days but is living in an environment that makes avoidance of substance use difficult.
2	Child actively uses alcohol or drugs, but not daily.
3	Child uses alcohol and/or drugs on a daily basis.

	DURATION OF USE
0	Child has begun use in the past year.
1	Child has been using alcohol or drugs for at least one year but has had periods of at least 30 days where he/she did not have any use.
2	Child has been using alcohol or drugs for at least one year (but less than five years), but not daily.
3	Child has been using alcohol or drugs daily for more than the past year or intermittently for at least five years.

	STAGE OF RECOVERY
0	Child is in maintenance stage of recovery. Youth is abstinent and able to recognize and avoid risk factors for future alcohol or drug use.
1	Child is actively trying to use treatment to remain abstinent.
2	Child is in contemplation phase, recognizing a problem but not willing to take steps for recovery.
3	Child is in denial regarding the existence of any substance use problem.

	PEER INFLUENCES
0	Youth's primary peer social network does not engage in alcohol or drug use.
1	Youth has peers in his/her primary peer social network who do not engage in alcohol or drug use but has some peers who do.
2	Youth predominantly has peers who engage in alcohol or drug use, but youth is not a member of a gang.
3	Youth is a member of a peer group that consistently engages in alcohol or drug use.

	PARENTAL INFLUENCES
0	There is no evidence that youth's parents have ever engaged in substance misuse.
1	One of youth's parents has history of substance misuse, but not in the past year.
2	One or both of youth’s parents have been intoxicated with alcohol or drugs in the presence of the youth.
3	One or both of youth's parents use alcohol or drugs with the youth.

	ENVIRONMENTAL INFLUENCES ***Please rate the environment around the youth’s living situation***
0	No evidence that the child's environment stimulates or exposes the child to any alcohol or drug use.
1	Mild problems in the child's environment that might expose the child to alcohol or drug use.
2	Moderate problems in the child's environment that clearly expose the child to alcohol or drug use.
3	Severe problems in the child's environment that stimulate the child to engage in alcohol or drug.

	ACUTE INTOXIACATION ***This item describes reversible, substance-related, maladaptive psychological or behavioral changes causing physiologic effects on the central nervous system by recent ingestion of or exposure to a substance: alcohol, illicit drug, medication, or toxin (Medical Dictionary.com)***
0	No current need no need for action or intervention. Individual has no identified substance intoxication difficulties at the present time.
1	Identified need requires monitoring, watchful waiting, or preventive activities. Individual has occasional intoxication which requires preventive activities. History of occasional intoxication and/or withdrawal symptoms without evidence of current problems would be rated here.
2	Action or intervention is required to ensure that the identified need is addressed; need is interfering with individual's functioning. Evidence of acute intoxication interferes with individual's ability to function with moderate risks, requiring preventive or withdrawal management services.
3	Problems are dangerous, requiring immediate and/or intensive intervention. Individual has a substance use problem with complications that may result in danger to self or detoxication (e.g., managing acute alcohol poisoning after binge drinking, overdose, or significant risk of withdrawal symptoms, seizures, or medical complications based on withdrawal history and substance use: amount, frequency, duration, and recent discontinuation).

	WITHDRAWAL HISTORY ***Withdrawal refers to a psychological and/or physical syndrome caused by abruptly stopping or reducing substance use in a habituated person. Specific symptoms and risks differ based on the substance. Withdrawal history, important in assess current risk and planning care, considers past substance use and withdrawal experiences.***
0	No current need no need for action or intervention. No evidence of prior withdrawal symptoms related to substance use, medications, or toxins.
1	Identified need requires monitoring, watchful waiting, or preventive activities. History of occasional acute withdrawal symptoms following substance use (e.g. mild nausea, mild tactile disturbances or sensitivity to light, slight headache, cannot do serial additions or uncertain about date, mild anxiety or irritability, chills or flushing, restless)
2	Action or intervention is required to ensure that the identified need is addressed; need is interfering with individual's functioning. History of withdrawal symptoms after decreasing or discontinuing substance use or medications (e.g. anxiety, nausea, fever, tremor) that impact the individual's functioning. OR Chronic physical health problems could be worsened by withdrawal symptoms.
3	Problems are dangerous, requiring immediate and/or intensive intervention. History of significant withdrawal symptoms and risks after decreasing or discontinuing substance use or medications (e.g. seizures, delirium tremens, rapid heartbeat). Individual may have medical condition which could be worsened due to withdrawal.

	AWARENESS OF RELAPSE TRIGGERS ***Relapse refers to resuming substance use after a period of recovery. This item refers to the individual's awareness of potential triggers (emotional stresses or circumstances: exposure to rewarding substances and behaviors, environmental cues for use) that increase the likelihood of using substances.***
0	No current need no need for action or intervention. Youth is aware of potential relapse triggers and actively uses recovery strategies (e.g. developed resilience and support to cope with stressors and manage challenges: craving, behavioral control, problems in relationships).
1	Identified need requires monitoring as youth is aware of relapse triggers and usually engages recovery strategies to address recovery challenges, but requires some effort to maximize and sustain efforts. Awareness might be used and built upon in treatment.
2	Action or intervention is required to ensure that the identified need is addressed; need is interfering with individual's functioning. Youth is aware of some, but not all relapse triggers or seldom uses recovery strategies to address challenges.
3	Problems are dangerous, requiring immediate and/or intensive intervention. Youth is unaware of relapse triggers and does not use recovery strategies to address challenges

VIOLENCE MODULE

Historical Risk Factors

Historical risk factors are rated over the lifetime of the youth.

	HISTORY OF PHYSICAL ABUSE
0	There is no evidence of a history of physical abuse
1	Youth has experienced corporal punishment.
2	Youth has experienced physical abuse on one or more occasions from caregiver or parent.
3	Youth has experienced extreme physical abuse that has resulted in physical injuries that required medical care

	HISTORY OF VIOLENCE
0	There is no evidence of any history of violent behavior by the youth.
1	Youth has engaged in mild forms of violent behavior including vandalism, minor destruction of property, physical fights in which no one was injured (e.g. shoving, wrestling).
2	Youth has engaged in moderate forms of violent behavior including fights in which participants were injured. Cruelty to animals would be rated here unless it resulted in significant injury or death of the animal.
3	Youth has initiated unprovoked violent behaviors on other people that resulted in injuries to these people. Cruelty to animals that resulted in significant injury or death to the animal would be rated here.

	WITNESS TO DOMESTIC VIOLENCE
0	There is no evidence that youth has witnessed domestic violence.
1	Youth has witnessed physical violence in household on at least one occasion but the violence did not result in injury.
2	Youth has witnessed repeated domestic violence that has resulted in the injury of at least one family member that required medical treatment.
3	Youth has witness to murder or rape of a family member.

	WITNESS TO ENVIRONMENTAL VIOLENCE
0	There is no evidence that youth has witnessed violence in his/her environment and youth does not watch an excessive amount of violent media.
1	Youth has not witness violence in his/her environment but watches an excessive amount of violent media including movies and video games.
2	Youth has witnessed at least one occasion of violence in his/her environment.
3	Youth has witnessed a murder or rape.

Emotional/Behavioral Risks (Violence)

	FRUSTRATION MANAGEMENT
0	Youth appears to be able to manage frustration well. No evidence of problems of frustration management.
1	Youth has some mild problems with frustration. He/she may anger easily when frustrated; however, he/she is able to calm self down following an angry outburst.
2	Youth has problems managing frustration. His/her anger when frustrated is causing functioning problems in school, at home, or with peers.
3	Youth becomes explosive and dangerous to others when frustrated. He/she demonstrates little self control in these situations and others must intervene to restore control

	HOSTILITY
0	Youth appears to not experience or express hostility except in situations where most people would become hostile.
1	Youth appears hostile but does not express it. Others experience youth as being angry.
2	Youth expresses hostility regularly.
3	Youth is almost always hostile either in expression or appearance. Others may experience youth as 'full of rage' or 'seething'

	PARANOID THINKING
0	Youth does not appear to engage in any paranoid thinking.
1	Youth is suspicious of others but is able to test out these suspicions and adjust their thinking appropriately.
2	Youth believes that others are 'out to get' him/her. Youth has trouble accepting that these beliefs may not be accurate. Youth at times is suspicious and guarded but at other times can be open and friendly. Suspicions can be allayed with reassurance.
3	Youth believes that others plan to cause them harm. Youth is nearly always suspicious and guarded.

	SECONDARY GAINS FROM ANGER
0	Youth either does not engage in angry behavior or, when they do become angry, does not appear to derive any benefits from this behavior.
1	Youth unintentionally has benefited from angry behavior; however, there is no evidence that youth intentionally uses angry behavior to achieve desired outcomes.
2	Youth sometimes uses angry behavior to achieve desired outcomes with parents, caregivers, teachers, or peers.
3	Youth routinely uses angry behavior to achieve desired outcomes with parents, caregivers, teachers or peers. Others in youth's life appear intimidated.

	VIOLENT THINKING
0	There is no evidence that youth engages in violent thinking.
1	Youth has some occasional or minor thoughts about violence.
2	Youth has violent ideation. Language is often characterized as having violent themes and problem solving often refers to violent outcomes.
3	Youth has specific homicidal ideation or appears obsessed with thoughts about violence. For example, a youth who spontaneously and frequently draws only violent images may be rated here.

Violence Resiliency Factors

	AWARENESS OF VIOLENCE POTENTIAL
0	Youth is completely aware of his/her level of risk of violence. Youth knows and understands risk factors. Youth accepts responsibility for past and future behaviors. Youth is able to anticipate future challenging circumstances. A youth with no violence potential would be rated here.
1	Youth is generally aware of his/her potential for violence. Youth is knowledgeable about his/her risk factors and is generally able to take responsibility. Youth may be unable to anticipate future circumstances that may challenge him/her.
2	Youth has some awareness of his/her potential for violence. Youth may have tendency to blame others but is able to accept some responsibility for his/her actions.
3	Youth has no awareness of his/her potential for violence. Youth may deny past violent acts or explain them in terms of justice or as deserved by the victim.

	RESPONSE TO CONSEQUENCES
0	Youth is clearly and predictably responsive to identified consequences. Youth is regularly able to anticipate consequences and adjust behavior.
1	Youth is generally responsive to identified consequences; however, not all appropriate consequences have been identified or he/she may sometimes fail to anticipate consequences.
2	Youth responds to consequences on some occasions but sometimes does not appear to care about consequences for his/her violent behavior.
3	Youth is unresponsive to consequences for his/her violent behavior.

	COMMITMENT TO SELF CONTROL
0	Youth fully committed to controlling his/her violent behavior.
1	Youth is generally committed to control his/her violent behavior; however, youth may continue to struggle with control in some challenging circumstances.
2	Youth ambivalent about controlling his/her violent behavior.
3	Youth not interested in controlling his/her violent behavior at this time.

	TREATMENT INVOLVEMENT
0	Youth fully involved in his/her own treatment. Family supports treatment as well.
1	Youth or family involved in treatment but not both. Youth may be somewhat involved in treatment, while family members are active or youth may be very involved in treatment while family members are unsupportive.
2	Youth and family are ambivalent about treatment involvement. Youth and/or family may be skeptical about treatment effectiveness or suspicious about clinician intentions.
3	Youth and family are uninterested in treatment involvement. A youth with treatment needs who is not currently in treatment would be rated here.

SEXUALLY AGGRESSIVE BEHAVIOR MODULE

	RELATIONSHIP ***Please rate the most recent episode of sexual behavior***
0	There is no evidence of victimizing others. All parties in sexual activity appear to be consenting. No power differential.
1	Although parties appear to be consenting, there is a significant power differential between parties in the sexual activity with this child or adolescent being in the position of authority.
2	Child is clearly victimizing at least one other individual with sexually abusive behavior.
3	Child is severely victimizing at least one other individual with sexually abusive behavior. This may include physical harm that results from either the sexual behavior or physical force associated with sexual behavior.

	PHYSICAL FORCE/THREAT ***Please rate the highest level from the most recent episode of sexual behavior***
0	There is no evidence of the use of any physical force or threat of force in either the commission of the sex act or in attempting to hide it.
1	Evidence of the use of the threat of force in an attempt to discourage the victim from reporting the sex act.
2	Evidence of the use of mild to moderate force in the sex act. There is some physical harm or risk of physical harm.
3	Evidence of severe physical force in the commission of the sex act. Victim harmed or at risk for physical harm from the use of force.

	PLANNING ***Please rate the highest level from the most recent episode of sexual behavior***
0	There is no evidence of any planning. Sexual activity appears entirely opportunistic.
1	Some evidence of efforts to get into situations where likelihood of opportunities for sexual activity are enhanced.
2	Evidence of some planning of sex act.
3	Considerable evidence of predatory sexual behavior in which victim is identified prior to the act, and the act is premeditated.

	AGE DIFFERENTIAL ***Please rate the highest level from the most recent episode of sexual behavior***
0	Ages of the perpetrator and victim and/or participants essentially equivalent (less than 3 years apart).
1	Age differential between perpetrator and victim and/or participants is 3 to 4 years.
2	Age differential between perpetrator and victim at least 5 years, but perpetrator less than 13 years old.
3	Age differential between perpetrator and victim at least 5 years and perpetrator 13 years old or older.

	TYPE OF SEX ACT ***Please rate the highest level from the most recent episode of sexual behavior***
0	Sex act(s) involve touching or fondling only.
1	Sex act(s) involve fondling plus possible penetration with fingers or oral sex.
2	Sex act(s) involve penetration into genitalia or anus with body part.
3	Sex act involves physically dangerous penetration due to differential size or use of an object.

	RESPONSE TO ACCUSATION
0	Child admits to behavior and expresses remorse and desire to not repeat.
1	Child partially admits to behaviors and expresses some remorse.
2	Child admits to behavior but does not express remorse.
3	Child neither admits to behavior nor expresses remorse. Child is in complete denial.

	TEMPORAL CONSISTENCY
0	This level indicates a child who has never exhibited sexually abusive behavior or who has developed this behavior only in the past three months following a clear stressor.
1	This level indicates a child who has been sexually abusive during the past two years OR child who has become sexually abusive in the past three months despite the absence of any clear stressors.
2	This level indicates a child who has been sexually abusive for an extended period of time (e.g. more than two years), but who has had significant symptom-free periods.
3	This level indicates a child who has been sexually abusive for an extended period of time (e.g. more than two years) without significant symptom-free periods.

	HISTORY OF SEXUALLY ABUSIVE BEHAVIOR ***(toward others)***
0	Child or adolescent has only one incident of sexually abusive behavior that has been identified and/or investigated.
1	Child or adolescent has two or three incidents of sexually abusive behavior that have been identified and/or investigated.
2	Child or adolescent has four to ten incidents of sexually abusive behavior that have been identified and/or investigated with more than one victim.
3	Child or adolescent has more than ten incidents of sexually abusive behavior with more than one victim.

	SEVERITY OF SEXUAL ABUSE
0	There is no history of any form of sexual abuse.
1	History of occasional fondling or being touched inappropriately, however, not occurring on a regular basis or by someone in a caregiver capacity or suspicion of history of sexual abuse without confirming evidence.
2	This level is to indicate a moderate level of sexual abuse. This may involve a child who has been fondled on an ongoing basis or sexually penetrated (anal or genital) once by someone not in a caregiver capacity.
3	This level is to indicate a severe level of sexual abuse involving penetration on an ongoing basis by someone either in a caregiver capacity or in close emotional relation to the child.

	PRIOR TREATMENT
0	There is no history of prior treatment or history of outpatient treatment with notable positive outcomes.
1	Prior outpatient treatment had some degree of success.
2	Prior residential treatment ended successful completion of the program.
3	Prior residential or outpatient treatment resulted in little or no success.

RUNAWAY MODULE

	FREQUENCY OF RUNNING
0	Youth has only run once in past year.
1	Youth has run on multiple occasions in past year.
2	Youth runs often but not always.
3	Youth runs at every opportunity.

	CONSISTENCY OF DESTINATION
0	Youth always runs to the same location.
1	Youth generally runs to the same location or neighborhood
2	Youth runs to the same community but the specific locations change.
3	Youth runs to no planned destination.

	SAFETY OF DESTINATION
0	Youth runs to a safe environment that meets his/hers basic needs (e.g. food, shelter).
1	Youth runs to generally safe environments; however, they might be somewhat unstable or variable.
2	Youth runs to generally unsafe environments that cannot meet his/her basic needs.
3	Youth runs to very unsafe environments where the likelihood that he/she will be victimized is high.

	INVOLVEMENT IN ILLEGAL ACTIVITIES
0	Youth does not engage in illegal activities while on run beyond those involved with the running itself.
1	Youth engages in status offenses beyond those involved with the running itself while on run (e.g. curfew violations, underage drinking).
2	Youth engages in delinquent activities while on run.
3	Youth engages in dangerous delinquent activities while on run (e.g. prostitution).

	LIKELIHOOD OF RETURN ON OWN
0	Youth will return from run on his/her own without prompting.
1	Youth will return from run when found but not without being found.
2	Youth will make him/her difficult to find and/or might passively resist return once found.
3	Youth makes repeated and concerted efforts to hide so as to not be found and/or resists return.

	INVOLVEMENT WITH OTHERS
0	Youth runs by self with no involvement of others. Others may discourage behavior or encourage youth to return from run. .
1	Others enable youth running by not discouraging youth's behavior.
2	Others involved in running by actively helping or encouraging youth.
3	Youth actively is encouraged to run by others. Others actively cooperate to facilitate running behavior.

	REALISTIC EXPECTATIONS
0	Youth has realistic expectations about the implications of his/her running behavior.
1	Youth has reasonable expectations about the implications of his/her running behavior but may be hoping for a somewhat 'optimistic' outcome.
2	Youth has unrealistic expectations about the implications of their running behavior.
3	Youth has obviously false or delusional expectations about the implications of their running behavior.

	PLANNING
0	Running behavior is completely spontaneous and emotionally impulsive.
1	Running behavior is somewhat, but not carefully planned.
2	Running behavior is planned.
3	Running behavior is carefully planned and orchestrated to maximize likelihood of not being found.

JUVENILE JUSTICE (JJ) MODULE

	SERIOUSNESS
0	Youth has engaged only in status violations (e.g. curfew, runaway).
1	Youth has engaged in delinquent behavior.
2	Youth has engaged in criminal behavior.
3	Youth has engaged in criminal behavior that places other citizens at risk of significant physical harm.

	HISTORY ***Please rate using time frames provided in the anchors***
0	Current criminal/delinquent behavior is the first known occurrence.
1	Youth has engaged in multiple criminal/delinquent acts in the past one year.
2	Youth has engaged in multiple criminal/delinquent acts for more than one year but has had periods of at least 3 months where he/she did not engage in delinquent behavior.
3	Youth has engaged in multiple criminal/delinquent acts for more than one year without any period of at least 3 months where he/she did not engage in criminal or delinquent behavior.

	PLANNING
0	No evidence of any planning. Criminal/delinquent behavior appears opportunistic or impulsive.
1	Evidence suggests that youth places him/herself into situations where the likelihood of criminal/delinquent behavior is enhanced.
2	Evidence of some planning of criminal/delinquent behavior.
3	Considerable evidence of significant planning of criminal/delinquent behavior. Behavior is clearly premeditated.

	PEER INFLUENCES
0	Youth's primary peer social network does not engage in criminal/delinquent behavior.
1	Youth has peers in his/her primary peer social network who do not engage in criminal/delinquent behavior but has some peers who do.
2	Youth predominantly has peers who engage in delinquent behavior but youth is not a member of a gang.
3	Youth is a member of a gang whose membership encourages or requires illegal behavior as an aspect of gang membership.

	PARENTAL CRIMINAL BEHAVIOR
0	There is no evidence that youth's parents have ever engaged in criminal/delinquent behavior.
1	One of youth's parents has history of criminal/delinquent behavior but youth has not been in contact with this parent for at least one year.
2	One of youth's parents has history of criminal/delinquent behavior and youth has been in contact with this parent in the past year.
3	Both of youth's parents have history of criminal/delinquent behavior.

	ENVIRONMENTAL INFLUENCES ***Please rate the environment around the youth's living situation.***
0	There is **no evidence** that the child's environment stimulates or exposes the child to any criminal/delinquent behavior.
1	There are **mild** problems in the child's environment that might expose the child to criminal/delinquent behavior.
2	There are **moderate** problems in the child's environment that clearly expose the child to criminal/delinquent behavior.
3	There are **severe** problems in the child's environment that stimulate the child to engage in criminal/delinquent behavior.

FIRE SETTING MODULE

	HISTORY ***Please rate using time frames provided in the following descriptions.***
0	There is only one known occurrence of fire setting behavior.
1	Youth has engaged in multiple acts of fire setting in the past year.
2	Youth has engaged in multiple acts of fire setting for more than one year but has had periods of at least 6 months where he/she did not engage in fire setting behavior.
3	Youth has engaged in multiple acts of fire setting for more than one year without any period of at least 3 months where he/she did not engage in fire setting behavior.

	PLANNING ***Please rate most recent incident.***
0	There is no evidence of any planning. Fire setting behavior appears opportunistic or impulsive.
1	Evidence suggests that youth places him/herself into situations where the likelihood of fire setting behavior is enhanced.
2	Evidence of some planning of fire setting behavior.
3	Considerable evidence of significant planning of fire setting behavior. Behavior is clearly premeditated.

	INTENTION TO HARM ***Please rate most recent incident.***
0	Child did not intend to harm others with fire. He/she took efforts to maintain some safety.
1	Child did not intend to harm others but took no efforts to maintain safety.
2	Child intended to seek revenge or scare others but did not intend physical harm, only intimidation.
3	Child intended to injure or kill others.

	COMMUNITY SAFETY
0	Child presents no risk to the community. He/she could be unsupervised in the community.
1	Child engages in fire setting behavior that represents a risk to community property.
2	Child engages in fire setting behavior that places community residents in some danger of physical harm. This danger may be an indirect effect of the youth's behavior.
3	Child engages in fire setting behavior that intentionally places community members in danger of significant physical harm. Child attempts to use fires to hurt others.

	REMORSE
0	Child accepts responsibility for behavior and is truly sorry for any damage/risk caused. Child is able to apologize directly to affected people.
1	Child accepts responsibility for behavior and appears to be sorry for any damage/risk caused. However, child is unable or unwilling to apologize to affected people.
2	Child accepts some responsibility for behavior but also blames others. May experience sorrow at being caught or receiving consequences. May express sorrow/remorse but only in an attempt to reduce consequences.
3	Child accepts no responsibility and does not appear to experience any remorse.

	LIKELIHOOD OF FUTURE FIRE SETTING
0	Child is unlikely to set fires in the future. Child able and willing to exert self-control over fire setting.
1	Child presents mild to moderate risk of fire setting in the future. Should be monitored but does not require ongoing treatment/intervention.
2	Child remains at risk of fire setting if left unsupervised. Child struggles with self-control.
3	Child presents a real and present danger of fire setting in the immediate future. Child unable or unwilling to exert self-control over fire setting behavior.