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Early Childhood Child and Adolescent Needs and Strengths (CANS), Birth to Five

Indiana

Multi-System Comprehensive Version

GLOSSARY OF ITEMS

Indiana University School of Social Work

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GLOSSARY FOR THE Birth to 5 CANS-Indiana

Introduction

The early childhood or Birth to Five CANS assessment tool is developmentally appropriate for infants, toddlers and preschoolers. Similar to the Comprehensive Child and Adolescent Needs and Strengths (CANS, Lyons, 2009) 5 to 17 tool, the early childhood version considers basic life dimensions or domains (social/emotional needs, risk factors, risk behaviors, daily life functioning, child strengths, acculturation and caregiver strengths and needs).

Early childhood mental health often is described from the perspective of a healthy child within a child-family system. The World Association for Infant Mental Health describes infant mental health as "the ability to develop physically, cognitively, and socially in a manner which allows them to master the primary emotional tasks of early childhood without serious disruption caused by harmful life events. Because infants grow in a context of nurturing environments, infant mental health involves the psychological balance of the infant-family system" (Osofsky & Fitzgerald, 2000, v 1, p.25). Similarly, the Zero to Three Infant Mental Health Task Force Steering Committee (2001) defines infant mental health as "the young child's capacity to experience, regulate, and express emotions, form close and secure interpersonal relationships, and explore the environment and learn."

When rating the CANS domains, assume the child is healthy with typical emotional development including:

Established sleeping and eating patterns,
Demonstrating arousal and focused attention,
Sustained attention, concentration and persistence,
Inhibition of outburst to developmentally appropriate expectations,
Expression of autonomy in a socially acceptable manner,
Enduring and supportive relationship with primary caregivers
Initiates play, discovery and learning,
Persists when discouraged or distracted,
Recovers from disruption, transition or disappointment, and
Emotionally responses match social-cultural context (CIMH, 2005).

Use evidence of such normal emotional development to rate Child Strengths on the CANS. Use evidence of harmful life events or limitations in a young child's capacity to complete normal developmental functions to rate the early childhood CANS needs.

Differences in rating specific items for an infant, toddler or preschooler are highlighted. Additionally, the CANS Birth to Five Glossary includes information about normal early childhood development, indications of need and questions that can be asked of parents and other caregivers. References are added as additional resources. For young children, it is essential that needs are rated with the infant or child's family and caregiver, reflecting the child and family's experiences and current functioning.

The decision support and information management tools [CANS 5 to 17, CANS Birth to Five, and Adult Needs and Strength Assessment (ANSA)] support communication in a complex environment. They serve to integrate information from whatever sources are available. To accurately reflect the needs and strengths/resources of a young child and family, consider the six key characteristics of a Communimetric tool and scoring guidelines.

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 ("0-3") level rating system. The levels are designed to translate immediately into action levels. Different action levels exist for needs and strengths.

3. Consider cultural and developmental factors before rating any item and establishing the action level.

4. Rating should describe the child, not the child in services. If an intervention is present that is masking a need but must stay in place, it is factored into the rating and would result in the rating of an 'actionable' need (i.e. '2' or '3').

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". The CANS describes what is happening with the child and family, but does not seek to assign a cause for a behavior or situation.

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

Rating and Action Levels for Need Items

Scoring Needs

Score	Level of Need	Appropriate Action
0	No evidence of need	No action needed
1	Significant history or possible need which is not interfering with functioning	Watchful waiting/ Prevention/ Additional assessment
2	Need interferes with functioning	Action/Intervention
3	Need is dangerous or disabling	Immediate/Intensive action

0 – no evidence – This rating indicates that there is no reason to believe that a particular need exists. It does not state that the need categorically does not exist, it merely indicates that based on current assessment information there is no reason to address this need.

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1 - watchful waiting/prevention – This level of rating indicates that you need to keep an eye on this area, further assess or think about putting in place some preventive actions to make sure things do not get worse.

2 - action needed – This level of rating implies that something must be done to address the identified need. The need is sufficiently problematic that it is interfering in the child or family's life in a notable way.

3 - immediate/intensive action – This level rating indicates a need that requires immediate or intensive effort to address. Dangerous or disabling levels of needs are rated with this level. A child who is asked to leave a child care or preschool setting or whose behavior is dangerous to the child or others would be rated with a '3' on the relevant need. Immediate and/or intensive actions are indicated.

Rating and Actions for Child Strengths

The "strengths rating scale" is used only for the Child Strength items.

Scoring Strengths

	Level of Strength	**Appropriate Action**
0	Centerpiece strength	Central to planning
1	Strength present	Useful in planning
2	Identified strength	Build/Develop strength
3	No strength identified	Strength creation or identification may be indicated

A **"0"** would indicate that this is a significant and functional strength that could become the centerpiece in service planning.

A **"1"** would indicate that the strength clearly exists and could become part of the service plan.

A **"2"** would indicate that a potential strength has been identified but requires building and development to become useful to the child.

A **"3"** would indicate that no strength has been identified at this time. A rating at this level would suggest that in this area the effort would be towards identifying and building strengths that can become useful to the child.

Remember that strengths are NOT the opposite of needs. Increasing strengths, while addressing behavioral and emotional needs, results in better functioning and outcomes than just focusing on the needs. Identifying areas where strengths can be built is an important element of service planning.

Early Childhood CANS Birth to Five Domains

Life Domain Functioning

Child Strengths

Acculturation

Caregiver Strengths & Needs

Child Behavioral/Emotional Needs

Child Risk Factors

Child Risk Behaviors

Details for specific items in each domain follow.

LIFE FUNCTIONING DOMAIN

Life domains are the different areas in a child and family's life.

Family Functioning

This item rates how the child is functioning within his/her family. It is recommended that the definition of family come from the child's perspective (i.e., who the child describes as his/her family). If you do not know this information, then we recommend a definition of family that includes biological relatives and their significant others with whom the child is still in contact.

Ratings	Family Functioning anchor definitions are examples of what family functioning looks like for each rating.
0	No evidence of problems in interaction 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 including sibling rivalry or under-responsive to child's needs.
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, and aggression with siblings.

This item is rating the way in which the child relates to others within the family. It is helpful to observe and ask about:

- the types of activities the family is involved in and if there is mutual enjoyment and investment in these activities,
- the amount of time spent together,
- how the family identifies strategies for supporting one another,
- how the family reacts to challenges,
- how they react to successes of all or individual members, and
- the family's assessment of their level of support and love of one another.

When stressors occur between family members such as marital/relationship violence, consider how, as a result of emotional trauma, witnessing or being aware of violence often negatively impacts the child's ability to function optimally with family members.

Of all the factors that may impact a child, the ongoing nature of their family relationships has perhaps the greatest potential to positively or negatively affect a child. The child typically spends a great portion of their day with family and relies on the routine and structure of the family to offer them a framework for all other experiences. Family relationships first offer a child the experience of safety and security that facilitates a feeling of trust and optimism about the world and others in it. A child learns how to communicate needs, accept support and cope with disappointments and frustrations all

within their first relationships. Family functioning often becomes the model for how a child will approach all other relationships with teachers, caregivers, peers and other authority figures. When a child experiences challenges within relationships outside of the home, the family relationships serve to assist the child in coping with these challenges and further developing the ability to persist in these challenges. Parents serve this role for the child as well as siblings. Children learn how to interact with peers often by "practicing" these interactions with their siblings. Sibling interactions require the basic skills of sharing, cooperating, compromising and expressing feelings and needs which are critical in peer interaction.

When assessing family relationships (functioning), it is important to carefully listen to families' descriptions of the relationships, encourage dialogue about the relationships as well as observe the relationships. Look for evidence of family relationship needs which negatively impact the child's functioning.

Evidence of Family Functioning Needs

Adapted from Cornett (2011) & Cornett & Podrobinok (2009)

Negative Parent/Child Relationships	Negative Sibling Relationships
• Interactions Appear Strained and Difficult • Low Level of Physical Contact; Little Initiation of Physical Contact • Minimal Eye Contact, Flat or Negative Affect • Skewed Family Boundaries • Little Time Spent in Interactions • Extreme Reactions to Infractions or Disappointments; Difficulty Reestablishing Positive Interaction Following Such • Few Bids for Attention or Expectations to have Needs Met	• Child Rarely Interacts with Siblings • Negative Statements on Frequent Basis Regarding Siblings • Predominantly Negative Behaviors and Interactions with Siblings • Ongoing Issues not Resolved • Inappropriate Roles/Boundaries with Siblings • Fearful Statements or Behavior regarding Sibling Interaction

Assessment activities include questioning parents and children (as appropriate to age), observing the child, observing the parent, observing of the child-parent dyad, and review of information received from chart review and others providing information. Others may include extended family, teachers, clinicians, referral source or alternate caregivers. The following suggestions may help in making the determination of the appropriate rating when questioning parents:

- Be aware of the consistency of parent responses. Do the answers to these questions conflict with other answers or not fit with the family's narrative?

- Do the responses come with some explanation that can back up their response? For example, when a parent responds that the relationship with their child is very positive can they explain why.
- Do your observations seem in sync with the parent's report? If not, this can be explored in a gentle way or just held as information that can help later when rapport is better established.

The bulleted items in the Evidence of Family Functioning Needs Table can be observed in a number of ways. It is important to attend to your own reactions in observing the relationships, as that often is a good indication of the actual nature of the relationship. If the interaction feels unpleasant and harsh for instance and the parent or child is describing satisfaction with the relationship there probably is more to consider. In addition, take into consideration that what is observed may be different due to parent anxiety about the assessment. A good way to account for this is to attempt to alleviate parent or child anxiety by assessing the positive nature and purpose of assessment and asking parent's if what is being observed seems normal or typical to them.

In summary, this item is rating functional needs associated with the child's relationships within his family. Parent Child Interaction, Family Strengths and Attachment are closely related, but there are differences. Parent Child Interaction takes into account all interactions that are critical to a healthy parent child relationship. A child may feel positively about their relationship with family although there may be deficits in the quality or nature of interactions; such strengths are rated under Family Strengths. The Attachment item also takes into account all functions of the attachment relationship that also are manifested in a child's ability to develop, explore the world and make sense of relationships. More discussion of these items will take place in the relevant sections.

Family Functioning Discussion Points:

- How would you describe the relationships between the child and others in the family?
- What types of strategies does the child have for coping with siblings when frustrated?
- How would you describe how the siblings feel and behave towards the child?
- How would you describe how the child feels and behaves towards his siblings?
- How does the child typically relate to his parents/caregivers?
- Can you describe special family activities that the child enjoys?
- Are there things about your relationship with your child that you wish were better?
- Are there stressors within the family relationships that may be affecting the child and his/her interactions within the family?

Living Situation

This item refers to the functioning of the child within their current living arrangement. When the child is potentially returning to biological parents, this item is rated independent of the Family Functioning item. When the child lives with biological parents this item is rated the same as the Family Functioning item. Hospital and shelters do not count as "living situations". If a child is presently in one of these places, rate the previous living situation.

Ratings	Anchor Definitions
0	No evidence of problems with functioning in current living environment.
1	Mild problems with functioning in current living situation. Caregivers concerned about child's behavior at home.
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.
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.

When considering the rating for this item it is important to explore the caregiver/family's perceptions of the relationship with the child. Often this may identify potential stressors that would warrant a watchful stance with the rating of a "1".

One of the most important interventions that can occur for young children in foster care is minimizing placement disruptions. Often times, concerns may be emerging despite the denial of problems presently impacting the family.

Living Situation Discussion Points:

- How is the child behaving and getting along with others in their current living situation?
- Can you describe any situations that have been difficult for family members to adjust to?
- If situations occur how do they usually get resolved?
- Have family members come to caregivers with concerns and if so how were they dealt with?
- How would you describe how the child typically reacts to others within the household?

Preschool/Day Care Functioning

This item rates the child's experiences in preschool or day care settings and the child's ability to get his/her needs met in these settings. This item also considers the presence of problems within these environments in terms of attendance, academic achievement, support from the day care or preschool staff to meet the child's needs, and child's behavioral response to these environments. If any of these areas are problematic then the item would be rated a '2' or '3' depending upon the severity of the situation. If the child does not attend preschool, day care nor is in a routine child care setting, rate this item '0'.

Ratings	Preschool/ Day Care Anchor Definition Examples
0	No evidence problems within an early care/education environment.
1	There is either a history of problems or indications that a problem may develop in the early care/education setting. Issues with attendance, behavioral or social functioning or academic performance may be beginning but not yet interfering with functioning.
2	The child demonstrates problems related to their social or emotional functioning, attendance, or behavior in an early care/education setting.
3	The child has significant challenges within an early care/education setting such that harm to the child is imminent or present.

Preschool/Day Care Functioning Discussion Points:

Infants:

- Describe the input you receive from teachers/providers at preschool/daycare regarding your infant.
- How do you feel about the care your infant receives in this setting?
- How do you feel your infant does within this setting?
- Has the staff indicated concerns regarding attendance or achievement (development)?
- If so, what have their comments been?

Toddlers:

- Describe the feedback or input you receive from staff at daycare regarding your toddler's behavior and interactions with staff and other children.
- Does your toddler seem to enjoy this setting?
- What observations have you made of your toddler in this setting?
- Are there areas or things that you wish the staff would do differently?
- What are the strengths of your child's day care or preschool provider?

Preschool Age Children:

- Describe your child's past and current preschool/day care experiences.
- What are your child's attitudes regarding preschool/school?
- Does your child's teacher seem to understand your child's needs?
- How does your child get along with staff and other children in school?
- Are there areas you wish were different?
- Would you change providers if able?

A rating of a "1" or greater on Preschool/Day Care Functioning requires further specification of these needs through the completion of four additional items in the CANS Birth to Five ***School Module****. Note: The highest level of need on any one preschool/daycare "School Module" item equals the overall Preschool/DayCare School Functioning item under Life Functioning Domain.*

Preschool/Daycare Quality

Ratings	PRESCHOOL/DAYCARE QUALITY *Please rate the highest level from the past 30 days*
0	Infant/child's preschool/daycare meets the needs of the infant/child.
1	Infant/child's preschool/daycare is marginal in its ability to meet the needs of the infant/child. Caregivers may be inconsistent or curriculum may be weak in areas.
2	Infant/child's preschool/daycare does not meet the needs of the infant/child in most areas. Care giving may not support the child's growth or promote further learning.
3	The infant/child's preschool/daycare is contributing to problems for the infant/child in one or more areas.

Infants, toddlers and preschoolers often spend the majority of their day with alternate caregivers. It is critical that these environments meet the needs of these individuals. There has been a great deal of momentum in the field of infant mental health to promote positive care-giving practices within these environments (Greenspan, 1985, 2003; Geoffroy, Cote, Parent, & Seguin, 2006). It is clear that the same parenting practices and care-giving techniques that are taught to parents need to be promoted within early care/education settings. These experiences are often critical in supporting growth and development and allowing the child to feel positive about relationships with others outside of the home.

Early care and education settings have the potential to impact a child's development, school success and overall life success. The quality of the day care environment is important to consider as well as the day care's ability to meet the needs of the individual within a larger care-giving context. It is important for infants and youth to be supported in ways that appreciates their individual needs and strengths. When assessing this item look for evidence that the parent or child can indicate that the child's uniqueness is being accepted and embraced.

Indicators of an Appropriate Early Child Care/Education Setting
Adapted from Cornett (2011) & Cornett & Podrobinok (2009)

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

Preschool/Day Care Behavior

This item rates the child's behavior in day care or preschool. This is rated independently from attendance. Sometimes children are often absent but when they are in school they behave appropriately. If the child's behavior is disruptive and multiple interventions have been tried, rate this item '2'. If the day care/preschool placement is in jeopardy due to behavior, this would be rated a "3."

Ratings	**PRESCHOOL/DAYCARE BEHAVIOR** *Please rate the highest level from the* ***past 30 days***
0	Child is behaving well in preschool/daycare.
1	Child is behaving adequately in preschool/daycare although some mild behavior problems may exist. Child may have a history of behavioral problems.
2	Child is having moderate behavioral problems at school. He/she is disruptive and many types of interventions have been implemented.
3	Child is having severe problems with behavior in preschool/daycare. He/she is frequently or severely disruptive. The threat of expulsion is present.

A reciprocal relationship has been suggested between social behavior and academic success (Welsh, Parke, Widaman & O'Neil, 2001). Recent early childhood learning standards include expectations for social as well as academic learning (Scott-Little, et al., 2006). Behavioral learning standards could include expectations to cooperate with others in play and group activities, to demonstrate understands concept of taking turns and to display effective communication skills (Holmes-Longergan, Thomas, Leong & Bodrova,

2006). Logue (2007) argues for school based social workers to become liaisons between prekindergarten programs and children by using the common language of early learning standards to support high-quality programs.

Preschool/Day Care Achievement

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

Ratings	**PRESCHOOL/DAY CARE ACHIEVEMENT** *Please rate the highest level from the* ***past 30 days***
0	Child is doing well acquiring new skills.
1	Child is doing adequately acquiring new skills with some challenges. Child may be able to compensate with extra adult support.
2	Child is having moderate problems with acquiring new skills. Child may not be able to retain concepts or meet expectations even with adult support in some areas.
3	Child is having severe achievement problems. Child may be completely unable to understand or participate in skill development in most or all areas.

The importance of early childhood development for future success is reflected in the emphasis on a child's readiness for Kindergarten and school. All facets of child development -- physical well being, motor, social, emotional, communication and cognitive skills—are included. Preschool education and early childhood research have focused on factors that predict school readiness. Grissmer, Grimm, Aiver, Murrah & Steele (2010, p. 1008) found that "together, attention, fine motor skills, and general knowledge are much stronger overall predictors of later math, reading, and science scores than early math and reading scores alone." Increased emphasis for accountability in education is impacting preschool with academic pressures on early childhood educators, toddlers and preschoolers. Young children's dispositions toward learning, social skills, as well as physical and emotional wellbeing directly impact their academic learning. Stipek (2006) argues that learning basic skills can be fun and effective.

Preschool/Day Care Attendance

This item assesses the degree to which the child attends preschool or day care.

Ratings	**PRESCHOOL/DAYCARE ATTENDANCE** *Please rate the highest level from the* ***past 30 days***
0	Child attends preschool/daycare regularly.
1	Child has some problems attending preschool/daycare but generally is present. 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 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 absent most of the time and this causes a significant challenge in achievement, socialization and following routine.

Regular attendance in an effective preschool program has been linked to readiness for and achievement in school (Logan, et al., 2011, Kmak, 2011).

Social Functioning

This item rates the child's current social and relationship functioning. This includes age appropriate behavior and the ability to make and maintain relationships during the past 30 days. For example, can an infant engage with and respond to adults? Does a toddler interact positively with peers and caregivers?

Ratings	Anchor Example Definitions
0	No evidence of problems in social functioning.
1	Child is having some minor problems in social relationships. Infants may be slow to respond to adults. Toddlers may need support to interact with peers and preschoolers may resist social situations.
2	Child is having some moderate problems with his/her social relationships. Infants may be unresponsive to adults, and unaware of other infants. Toddlers may be aggressive and resist parallel play. Preschoolers may argue excessively with adults and peers and lack ability to play in groups even with adult support.
3	Child is experiencing severe disruptions in his/her social relationships. Infants show no ability to interact in a meaningful manner. Toddlers are excessively withdrawn and unable to relate to familiar adults. Preschoolers show no joy or sustained interaction with peers or adults, and/or aggression may be putting others at risk.

Social Functioning significantly relates to all other areas of development for young children. A child that is struggling to relate to their parents, caregivers and peers will also struggle in their ability to find support for the other areas of development. The parent-child relationship, the child's capacity to socialize, and to regulate their emotions gives a child the tools to move forward in all other areas. Motivation for challenge, coping with frustration and the ability to feel good about one's accomplishments all occur through healthy relationships and supports further growth.

Social Functioning Milestones
Infants, Toddlers & Preschoolers

Adapted from Landy (2002, p. 12–27)

	Evidence of Normal Social Functioning
By 3 Months	Is available and enjoys responsive interaction with caregivers Quiets if upset when picked up Recognizes caregiver and responds with pleasure; reaches out to caregiver Enjoys being held and cuddled at times other than feeding and bedtime Smiles in response to a friendly face or voice Stops crying when parent or caregiver comes near Expresses basic emotions Uses sustained looking or sucking to calm down Entertains self by playing with hands, feet, and toes
By 7 Months	Laughs out loud Cries in response to another infant's cry Beginning to feel security with and attachment to primary caregiver Reacts to emotional displays of others Gets upset at "still" face of caregiver or if caregiver does not respond Shows fear of falling off high places Expresses emotions with recognizable and different sounds and expressions May make different emotional responses to different experiences such as hearing a vacuum or a dog barking Shouts for attention May cry if caregiver leaves Plays interactive games such as Peek-a-boo Knows difference between familiar and unfamiliar people
By 14 months	Shows more control over display of emotions Likes caregivers to be in sight Indicates social referencing or awareness of emotional signals of caregivers Demonstrates fear of strange objects and events and separation Develops fear of heights May show fear of strangers an of separation from parents Often becomes attached to a cuddly toy or a blanket Likes to hide Babbles or jabbers to get attention Can distinguish between self and others Engages in parallel play with others children with eye contact and occasional sounds Can join another person in looking at an object May point out something to another person and follow the gaze of someone else

	Recognizes peer as social partner; likes to be around other children Is capable of turn taking Imitates actions of another person
By 2 Years	Often checks caregiver's facial expression to see what caregiver is feeling Shows shame if he or she does not succeed at a task Recognizes him or herself in a mirror Experiences anxiety if an object is flawed or broken Complies about 45%of the time Gets upset if he or she cannot meet standards Labels emotions of others May be defiant; temper tantrums are at their peak Demonstrates self-conscious emotions of shame and embarrassment Shows and points Can look at something together with another person Plays close to others and joins in play together Plays games such as Hide and Seek, rolling a ball back and forth Uses personal pronouns May comfort another child Is possessive with toys, and finds it hard to share
By 4 Years	Can consistently bring to mind the memory of a caregiver Displays emotional reactions to distress of others Understands rules about what to do and what not to do Argues and justifies actions more often with parents Integrates "good" and "bad" parts of self and of others Some fear may increase Is less likely to change emotion rapidly but can switch between being stubborn and cooperative quite quickly Some sharing behavior and cooperative play, but at times acts selfishly Imitates and follow the leader Increased awareness of standards and rules Shows reciprocal and complementary roles during pretend play May have a close friend Less likely to express intense emotions, and emotions switch less rapidly so more likely to sustain social interactions Expresses less aggression and more verbal anger Seeks approval from others for accomplishments

Social Functioning Discussion Points:

- How does your infant relate to you and other family members?
- How does your infant behave differently with you, family members and others outside the family?
- Does your infant seem interested in surroundings and people around them?
- How does your child interact with peers and others outside the family?
- How would you describe your preschooler's ability to engage others, deal with conflict and play with peers?
- Can you describe any situations in which others have described concerns about your child's social functioning?
- Are there things that others point out that are positive about your child's interpersonal interactions?

Recreation/Play

This item rates the degree to which an infant/child is given opportunities for and participates in age appropriate play. Play should be understood developmentally. When rating this item, you should consider if the child is interested in play and/or whether the child needs adult support while playing. Problems with either solitary or group (e.g. parallel) play could be rated here.

Ratings	Recreation/Play Anchor Definition Examples
0	There is no evidence that infant or child has problems with recreation or play.
1	Child is doing adequately with recreational or play activities although some problems may exist. Infants may not be easily engaged in play. Toddlers and preschoolers may seem uninterested and poorly able to sustain plan. There may also be a history of these behaviors.
2	Child is having moderate problems with recreational activities. Infants resist play or do not have enough opportunities to play. Toddlers and preschoolers show little enjoyment or interest in activities within or outside the home and can only be engaged in play/recreational activities with ongoing adult interaction and support.
3	Child has no access to or interest in play or toys. Infant spends most of time not interacting with toys or people. Toddlers and preschoolers, even with adult encouragement, cannot demonstrate enjoyment in "pretend" play.

The experience of play is critical to the child in a number of ways. Play serves as a vehicle to further a child's social, emotional, physical, language and cognitive development.

Developmental Benefits Facilitated By Play

Adapted from Cornett & Podrobinok (2009)

Cognitive	Emotional	Social	Physical	Language
• Improves Attention • Improves Problem Solving • Enhances Imagination • Develops Planning and Sequencing Abilities • Promotes Awareness of How Items Function • Improves Concentration	• Facilitates the Expression of Feelings and Experiences in a Safe Manner • Alleviates Anxiety by Promoting Mastery Over Stressful Situations • Enhances Self Esteem	• Encourages Children Taking on a Variety of Social Roles • Develops Sharing, Cooperating and Compromising Abilities • Further Develops Sense of Self • Encourages Learning to Take the Perspective of Others	• Enhances Fine Motor Skills • Enhances Gross Motor Skills • Facilitates Visual Spatial Skills • Develops Balance and Coordination	• Through Interactions Learns Rhythm, Cadence, and Pace of Speech • Enhances Vocabulary Acquisition • Develops Social Conventions of Language

In assessing the characteristic of playfulness it is necessary to be aware of the developmental appropriateness as well as the emotional characteristics of the play. Ideally play should be spontaneous, self-initiated and enjoyable to the child. A child that is not enjoying play will demonstrate a flat or restricted range of affect, will not prolong the play themes and will often have little spontaneous speech associated with the play. In determining the developmental appropriateness of play the following developmental descriptions can offer some assistance.

- 0-12 months: Sensorimotor Play: This is seen in exploration of objects through such means as mouthing, touching, banging or dropping objects. As the child moves closer to 6 months they may begin to explore the characteristics of objects by poking or pulling the component parts.

- 12-18 months: Functional Play: Child demonstrates understanding of how objects are used and does such things as placing a phone to their ear, rolling a car back and forth or manipulating toys in their intended fashion.

- 18 months to 30 months: Early Symbolic Play: Begins to show capacity for pretend play. First will pretend with themselves, and then with objects and other people. The pretend sequences will become gradually more complex and detailed.

- 30 months and older: Complex Symbolic Play: Dramatic sequences are acted out in play using both props and imagination. As a child becomes older they further the ability to assign roles to others and include them in pretend play. As a child enters school age they further their ability to imitate, take turns and problem solve in play.

Recreation/Play Discussion Points:

- What are typical activities that your child enjoys?
- Describe your child's typical routine; how often is play a part of the routine?
- How would you describe your child's interest and enjoyment in play?
- What types of toys or activities are available to your child?
- Are there certain times or settings in which your child is most likely to play?
- Have there been settings in which your child does not take advantage of play opportunities?

Developmental Functioning

This item rates the presence of Mental Retardation or Developmental Disabilities only and does not refer to broader issues of healthy development. A '1' would be a low IQ child. Asperger's Syndrome would likely be rated a '2' while Autism would be rated a '3'.

Ratings	Anchor Definitions
0	Child has no developmental problems.
1	Child has some problems with or there are concerns about possible developmental delay. Child may have low IQ.
2	Child has developmental delays or mild mental retardation.
3	Child has severe and pervasive developmental delays or profound mental retardation.

This area of development is important to assess due to its impact on all other areas of development. A child that is impaired in their cognitive functioning will demonstrate limitations in other areas of development especially their language development and self-help skills. Early intervention is critical when a young child has developmental needs.

Normal Developmental Milestones

Adapted from Landy's *Pathways to Competence: Encouraging Healthy Social & Emotional Development in Young Children* (2002, pp. 12 – 27)

By 3 Months	• Watches hands • Can remember for 3-4 seconds • Usually explores environment by looking around • Follows objects that are moving up and down with eyes • Recognizes familiar faces, voices and smell
By 7 Months	• Likes to make things happen (e.g., pulls a string to get something attached to it) • Imitates gestures • Follows and searches for objects with eyes • Establishes object and person permanence • Focuses on toy or person for 2 minutes • Throws objects over side of crib to watch it fall
By 14 Months	• Understands how things happen (i.e., what causes what) • Examines toys to see how they work • Begins to engage in pretend play • Can point to pictures of objects in a picture book when prompted • Plays on own for 10 minutes or more • Follows simple directions • Copies activities such as banging a drum to make noise
By 2 Years	• Increasingly engages in pretend play • Can play in a focused way for 10 minutes • Points to body parts • Can sort by color, classification

	• Can match by size and color • Can sequence pretend play into scripts • Concentrates on self selected activities for longer periods
By 4 Years	• Engages in more elaborate pretend play • Can classify objects for their purpose • Can identify up to six geometric shapes by pointing to them when asked • Understands *nearest, longest, tallest, same* • Counts five objects and rote counts to 20 or more • Distinguishes between genders • Can name some letters and recognizes a few words • Understands the sequence of daily events

Developmental Functioning Discussion Points:

- Does your child's growth and development seem healthy?
- Has s/he reached appropriate developmental milestones (such as walking, talking)?
- Has anyone ever told you that your child may have developmental problems?
- Has your child developed like other children his/her age?

A rating of a "1" or greater on Developmental Functioning requires further specification of these needs through the completion of the ***Developmental Needs Module.*** The Developmental Module specifies the type of developmental problem and associated self care and assistive needs.

Cognitive Development

Ratings	COGNITIVE
0	No evidence of cognitive development problems.
1	Infant/child has some indicators that cognitive skills are not appropriate for age or are at the upper end of age expectations. Infants may not consistently demonstrate familiarity with routines and anticipatory behavior. Infants may seem unaware of surroundings at times. Older children may have challenges in remembering routines, and completing tasks such as sorting, or recognizing colors some of the time.
2	Infant/child has clear indicators that cognitive development is not at expected level and interferes with functioning much of the time. Infants may not have the ability to indicate wants/needs. Infants may not demonstrate anticipatory behavior all or most of the time. Older children may be unable to demonstrate understanding of simple routines or the ability to complete simple tasks.
3	Infant/child has significant delays in cognitive functioning that are seriously interfering with their functioning. Infant/child is completely reliant on caregiver to function.

Self-Care/Daily Living Skills

Ratings	**SELF-CARE DAILY LIVING SKILLS** *Please rate the highest level from the* ***past 30 days***
0	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.
1	Child requires some assistance on self-care tasks or daily living skills at a greater level than would be expected for age. Development in this area may be slow. Infants may require greater than expected level of assistance in eating and may demonstrate a lack of progression in skills.
2	Infant/child requires consistent assistance (physical prompting) on developmentally appropriate self-care tasks and/or does not appear to be developing the needed skills in this area.
3	Child is not able to function independently at all in this area.

Motor Functioning

This item refers to the child's fine and gross motor functioning. Included in this rating are hand grasping and manipulation as well as standing, walking, and sitting.

Ratings	**Motor Functioning Anchor Definitions**
0	No evidence of fine or gross motor development problems.
1	Child has some indicators that motor skills are challenging and there may be some concern that there is a delay.
2	Child has either fine or gross motor skill delays.
3	Child has significant delays in fine or gross motor development or both. Delay causes impairment in functioning.

This aspect of development is critical to assess because it supports the child's ability to move about and explore their world which is a critical need for children. A child that is challenged in this area may be experiencing a medical or neurological problem that needs to be addressed. Motor development refers to the development of both fine and gross motor skills.

Motor Developmental Milestones

Adapted from Landy (2002)

	Gross Motor Milestones	Fine Motor Milestones
By 3 Months	Gets fist to mouth Holds head in upright position Makes thrusting leg movements Rolls from side to back Turns head from side to side Can lift head by using arms when on stomach Can sit with support on lap	Will grasp objects placed in palm with entire hand May pat at object that is close Holds hand in an open or semi-open position Has control of eye muscles Focuses eyes on objects 8-10 inches away Gets hand to mouth
By 7 Months	Rolls from back to stomach and stomach to back Sits unsupported Lifts head when lying on back Pulls self to crawling position and may move backward and forward Enjoys being placed in standing position May pull self to standing by pulling up on the furniture Bounces actively if held to stand	Imitates motor play such as clapping hands Brings hands to center of body Reaches and grasps objects on purpose Lets go of objects to watch them fall Puts objects in mouth May bang objects together Can pick up small objects using raking motion Demonstrates palmar grasp (all four fingers hold object against palm of hand) Transfers objects from one hand to another
By 14 Months	Pulls self up to standing position Cruises around furniture Shifts sitting position without falling Walks, usually alone but may need adult support Walks up and down stairs with help Throws a ball	Uses pincer grasp or thumb and forefinger to purposely pick up tiny objects Scribbles with pencil or crayon Builds tower with three blocks Can put objects in shape sorter Can handle two objects at a time and pass them from hand to hand Places objects inside each other Drops and throws objects
By 2 Years	Runs with greater confidence Climbs up and down stairs unassisted Stands on tiptoes Throws and catches a ball Uses feet to pedal tricycle Climbs on chairs, turns around, and sits down Jumps 8-14 inches forward and up and down Walks backwards Walks on line Squats while playing	Copies circles and lines Stacks six blocks Puts pieces in puzzles Nests objects Puts tiny object in small container

In addition to the assessment of the child's ability to meet developmental milestones the child's coordination, muscle tone, strength, and motor planning should be considered. The child's ability to demonstrate fluid and coordinated movements develops with time and practice. As infants, the first area in which control is developed is the head. An infant's movements are often awkward although there should be improvement in this with practice. It is helpful to ask a parent how long a skill has been in place and if the level of coordination related to this skill is improving.

As children develop coordination usually continues to improve in both fine and gross motor skills. It is possible to have coordination challenges in only one area as well as both. Muscle tone can be low or high. A child with low tone often appears slumped, or challenged in supporting oneself in various positions. The child may try to compensate by locking joints or leaning on objects or caregivers. A child with high tone appears stiff and rigid. They may keep their hands closed tightly or walk on their toes. When holding a high tone child they do not feel comfortable or mold into the caregiver. A child that struggles with strength does not display the ability to sustain interactions that would be developmentally appropriate. They tire easily and do not persist in play. When this is a significant problem the child may appear distressed by breathing heavily, having skin changes or blue lips and fingernails.

Motor planning is the child's ability to initiate action and sequence movements. In infants, the ability to imitate actions would be slow or impaired if there is motor planning challenges. As a child becomes older and attempts more complex tasks the ability to move through space in a coordinated manner may appear compromised. The ability to climb, jump and judge space and intensity of movement may appear impaired. In summary, the ability to meet developmental milestones as well as the presence of coordination, strength, tone, and motor planning should be considered.

Motor Developmental Discussion Points:

- Does your child appear to be using their large and small muscles in a way that you see as typical?
- Can you describe any motor skill concerns your or others may have noticed?
- Do you see any ways in which your child's fine or gross motor development is different than your other children's or other children you have seen?
- How would you describe your child's physical abilities and coordination?

Communication

This item refers to learning disabilities involving expressive and/or receptive language. This item **does not** refer to challenges expressing feelings.

Ratings	Communication Anchor Definitions
0	Child's receptive and expressive communication appears developmentally appropriate. There is no reason to believe that Child has any problems communicating.
1	Child has a history of communication problems but currently is not experiencing problems. An infant may rarely vocalize. A toddler may have very few words and become frustrated with expressing needs. A preschooler may be difficult for others to understand.
2	Child has either receptive or expressive language problems that interfere with functioning. Infants may have trouble interpreting facial gestures or initiate gestures to communicate needs. Toddlers may not follow simple 1-step commands. Preschoolers may be unable to understand simple conversation or carry out 2-3 step commands.
3	Child has serious communication difficulties and is unable to communicate in any way including pointing and grunting.

A child's ability to process what is said to them and express their ideas is the foundation for interpersonal relationships and relates strongly to the child's experience of having their needs met. This, of course, impacts the child's ability to develop a sense of trust in their caregiver and a beginning experience of relationships that becomes the foundation for all other relationship development. A child that is frustrated in their capacity to communicate either receptively or expressively usually demonstrates this frustration in a variety of ways. The child may become aggressive, withdrawn, disconnected, hypervigilant or distrusting of peers and adults. At times, a child may hit themselves or other objects in frustration. Head banging or other self-injurious behaviors sometimes are rooted in poor communication.

Communication Developmental Milestones

Adapted from Landy (2002)

	Expected Receptive and Expressive Communication Behaviors
By 3 Months	• Coos with two or more different sounds • Pays attention to human speech • Moves in rhythm to language of caregiver • Cries if hungry or upset • Makes sucking sounds, gurgles, and squeals when awake • Babbles; repeats simple vowel and consonant sounds
By 7 Months	• Babbles with inflection, repeating same syllable in a series • Vocalizes back when someone is talking • Tries to imitate sounds • Can say a number of vowels and some consonants • Responds to a few familiar words • Responds to own name
By 14 Months	• Begins to use words to communicate • Uses two to three words • Understands a few simple words and sentences • Copies simple gestures such as waving and shaking head • Jabbers expressively • Shows communicative intent with gestures • Likes rhymes and singing games • Understands "no" but does not always do as told • Follows a few simple requests when accompanied by gestures
By 2 Years	• Expressive language increases to 50+ words • Speaks in two to three-word sentences • Listens to a story • Answers questions • Joins in songs • May understand more than can say
By 4 Years	• Language expands to include all parts of speech • Repeats three numbers • Knows more than 1,200 words • Points to colors when asked to identify them • Uses five-word sentences • Language and emotions are matched • Uses gender words: he/she, boy/girl • Uses prepositions such as *in, on,* and *under* • Uses possessives such as *hers, theirs* • Knows first and last name • Recites and sings simple songs and rhymes

Communication Discussion Points:

- Has your child ever been diagnosed with having a problem with understanding words or using words to express him/herself?
- Have you ever worried about your child's ability to understand or use words?
- Has anyone told you that your child has or could have a learning problem related to understanding others or expressing him/herself?

Medical

This item rates the child's current health status. Most transient, treatable conditions would be rate as a '1'. Most chronic conditions (e.g., diabetes, severe asthma, HIV) would be rated as a '2'. The rating of '3' is reserved for life threatening medical conditions.

Ratings	Medical Anchor Definitions
0	Child is healthy.
1	Child has some medical problems that require medical treatment.
2	Child has chronic illness that requires ongoing medical intervention.
3	Child has life threatening illness or medical condition.

If a child is experiencing any medical conditions, obtaining information regarding the impact to the child, the impact to the caregiver in monitoring and treating this condition are both needed to make the assessment of how to rate this item. A child may have a medical condition that is considered a chronic condition but this is managed well by the child and family, and therefore is not causing problems in the child's functioning.

Medical Discussion Points:

- Is your child generally healthy?
- Does s/he have any medical or physical problems?
- Does your child have to see a doctor regularly to treat any problems (such as asthma, diabetes, etc.)?
- Are there any activities in which your child cannot participate because of a medical condition?
- If your child has a medical condition, what care is routinely required?

Physical Functioning

This item is used to identify any physical limitations and could include chronic physical conditions such as limitations in vision or hearing or difficulties with fine or gross motor functioning.

Ratings	Physical Functioning Anchor Definition Examples
0	Child has no physical limitations.
1	Child has some physical condition that places mild limitations on activities. Conditions such as impaired hearing or vision would be rated here.
2	Child has physical condition that notably impacts activities. Sensory disorders such as blindness, deafness, or significant motor difficulties would be rated here.
3	Child has severe physical limitations due to multiple physical conditions.

A child may have physical limitations that are not identified as a medical condition. A child may have physical limitations related to poor nutrition. A child may not have a medical condition but appears tired, reports feeling badly or misses school frequently.

Physical Functioning Discussion Points:

- Does your child have any physical limitations?
- Are there any activities your child cannot do because of a physical condition?
- How much does this interfere with his/her life?

Sleep

This item is used to describe any problems with sleep, regardless of the cause including difficulties falling asleep or staying asleep as well as sleeping too much. Bedwetting and nightmares should be considered a sleep issue.

Ratings	Sleep Anchor Definition Examples
0	No evidence of problems with sleep.
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.

Sleep is one of the primary reasons families seek intervention. Concerns may include initiating, maintaining or excessive sleep (CIMH, 2005). This is often due to the impact that this has on parents, and siblings. The bed-time routine and actual amount of time spent asleep may be of concern to parents. Infants typically sleep 14-18 hours a day. Sleep does not have a regular circadian rhythm till approximately 6 months of age. In early childhood, children sleep approximately 8-12 hours per day and naps may continue throughout the day until the age of 3-5. Night waking is at times a concern. In infants it is not uncommon for the emergence of night waking to occur at approximately 6 months of age. Typically infants should be able to return to sleep easily or with parent support. Nightmares are also common during toddler and preschool development and may occur intermittently. They are often present when a child is attempting to master developmental

tasks. In assessing sleep concerns the following areas of questioning will help with the rating of this item:

- How much does the infant or child sleep during the day and night?
- Describe the activities that take place to assist the child in going to sleep or returning to sleep.
- Is the sleep routine variable or predictable?
- How does the sleep routine of the child affect the family?
- What are the sleeping arrangements?
- Does the child have nightmares or night terrors?
- Have the sleep problems changed over time?

Additional Sleep Discussion Points:

- How many hours does your child sleep each night on average?
- How do you or others feel sleep goes for your child?
- Does s/he have trouble falling asleep or staying asleep?
- Does the child have nightmares or bedwetting?
- Does managing your child's sleep routine interfere with the family in any way?

Relationship Permanence

This rating refers to the stability of significant relationships in the child's life. Significant relationships likely include family members, but may also include other individuals. This item identifies whether parents or other relatives have been a consistent part of the child's life *regardless of the quality* of that relationship.

Ratings	Relationship Permanence Anchor Definitions
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. Adoption must be considered.

Relationship Permanence Discussion Points:

- Does your child have relationships with adults that have lasted a lifetime?
- Is s/he in contact with both parents?
- Are there relatives in your child's life with whom s/he has long-lasting relationships?

Rate
CHILD STRENGTHS items
with the
Child Strength Rating Scale
on page 5.
Hint: No evidence of strength is rated "3".

CHILD STRENGTHS DOMAIN

Family Strengths

This item refers to the presence of a family identity, as well as love and communication among family members. Even families who are struggling often have a firm foundation that consists of a positive sense of family and strong underlying love and commitment to each other. These are the constructs this strength is intended to identify.

As with Family Functioning, the definition of family comes from the child's perspective (i.e., who the child describes as his/her family). If you do not know this information, then we recommend a definition of family that includes biological relatives and their significant others with whom the child is still in contact.

Ratings	Family Strength Anchor Definitions
0	Significant family strengths. This level indicates a family with much love and respect for one another. Family members are central in each other's lives. Child is fully included in family activities.
1	Moderate level of family strengths. This level indicates a loving family with generally good communication and ability to enjoy each other's company. There may be some problems between family members.
2	Mild level of family strengths. Family is able to communicate and participate in each other's lives; however, family members may not be able to provide significant emotional or concrete support for each other.
3	This level indicates a family with no known family strengths. Child is not included in normal family activities.

The family has the potential for significant impact on a child's life. Of all the factors that may impact a child, the ongoing nature of their family relationships has perhaps the greatest potential to positively or negatively affect a child. The child typically spends a great portion of their day with family and relies on the routine and structure of the family to offer them a framework for all other experiences. Family relationships first offer a child the experience of safety and security that facilitates a feeling of trust and optimism about the world and others in it.

A child learns how to communicate needs, accept support and cope with disappointments and frustrations all within their first relationships. This becomes the model for how a child will typically approach all other relationships with teachers, caregivers, peers and other authority figures. When a child experiences challenges within relationships outside of the home the family relationships serve to assist the child in coping with these challenges and

further developing the ability to persist in these challenges. Parents serve this role for the child as well as siblings. Children learn how to interact with peers often by "practicing" these interactions with their siblings. Sibling interactions require the basic skills of sharing, cooperating, compromising and expressing feelings and needs which are critical in peer interaction. Guralnick (1988) studied the outcomes for children in various patterns of family interaction and concluded that positive outcomes for children across several domains of development were more likely when family interactions were positive. Landesman, Jaccard, and Gunderson (1991) replicated this finding as well illustrating how positive family interactions have impact in physical development, emotional development and well being, social development, cognitive development, moral development and cultural development.

In the assessment of the nature of family relationships it is important to carefully listen to families' descriptions of the relationships, encourage dialogue about the relationships as well as observe the relationships. This item is rating the nature of the child's experience of relationships within his family. This item would be considered a strong area if the child feels positive about his relationships with family and observations support a warm and nurturing relationship.

Observable Evidence of Positive Parent and Sibling Relationships

(Cornett, 2011)

Positive Parent/Child Relationships	**Positive Sibling Relationships**
Mutual Enjoyment Initiation of Physical Contact on part of both Child and Parent Good Eye Contact, Positive Affect Demonstrated Appropriate roles and boundaries Positive Verbalizations; Age Appropriate Communication Appropriate Amount of Time Spent Together Ability to Tolerate Frustrations; Balanced Perspective Regarding Child or Parent's Strengths and Limitations Child Demonstrates Belief that Needs Will Be Met	Interactions with Siblings Occur on Regular Basis Positive Statements Made Between Siblings and/or About Siblings Balance of Negative and Positive Interactions Negative Interactions Resolved Child Perceives Siblings as Safe and Caring Appropriate Boundaries 

The items in the table above can be observed in numerous ways. It is important to attend to your own reactions in observing the relationships, as that often is a good indication of the actual nature of the relationship. If the interaction feels unpleasant and harsh for instance, and the parent or child is describing satisfaction with the relationship, there probably is more to consider. However, take into consideration that

what is observed may be different due to parent anxiety about the assessment. A good way to account for this is to attempt to alleviate parent or child anxiety by assessing the positive nature and purpose of assessment and asking parent's if what is being observed seems normal or typical to them.

When determining if the relationship is characterized by **mutual enjoyment** several indications may be present. Do the parent and child both appear to be happy, smiling and continuing the interaction, if the interaction is predominantly parent led does the child show interest by looking, responding and non verbal interchanges? Does the play or interaction result in positive comments or laughter on part of parent? All of these areas are also interpreted within the general atmosphere of the home. Does this home feel comfortable emotionally to its' members? Do the children appear comfortable asking questions, getting needs met and interacting with each other?

When observing **eye contact** it is important to keep in mind developmental considerations. As an infant grows older they move from fleeting eye contact and frequent distractions to a more responsive and coordinated level of eye contact. Very young infants may be over-stimulated by both the verbal and auditory sensory pathways being activated simultaneously and demonstrate active gaze aversion until neurological development furthers. If there are positive reactions to talking and holding when an infant is not showing eye contact such as molding, and excited movement of arms and legs, that is significant to note.

When assessing the **role of the child and appropriate boundaries** it is noteworthy to attend to what tasks the child may be asked to do, the interpretations of the child's actions and attention to the cues given for physical space or emotional needs. Does the parent describe exploitation of the child in such ways as having to high of expectations, doing chores or child caring activities that are beyond developmental expectations/abilities? Does the parent intrude into the child's space not giving them time emotionally to calm down or to be alone at times? Does the parent or child report neglect, physical or sexual abuse?

Family Strengths Discussion Points:

- How do you care about one another in your family?
- Is there usually good communication?
- Is this an area that you could use some help to develop?

Extended Family Strengths

This item rates the close relationships that the child has with extended family members.

Ratings	Extended Family Strength Anchor Definitions
0	The child has at least one relationship with an extended family member that consistently supports his caregiver and his/her own development in a positive manner.
1	The child experiences an overall positive relationship with an extended family member that could benefit from improvement in either support to the caregiver or child in some manner.
2	A relationship between the child and an extended family member is present and positive at times but needs development to be the basis of a strength-based plan.
3	There is not a relationship between the child and an extended family member or the relationship is not considered a strength. The relationship may be described as detrimental to either the caregiver or the child.

Extended family relationships can be of tremendous value to a child because of the support that this gives their primary caregiver and the child's own valuable experience of a positive relationship with another adult figure.

The level of support given to caregivers by extended family is critical to consider because it can either support or hinder the caregivers' availability to their child. When considering the support that extended family such as grandparents, aunts and uncles may offer the caregivers, it is useful to think of the areas that this support includes. Support may include actual services for the caregivers such as babysitting, shopping, transporting, or financial assistance. Caregivers may benefit from advice or information and therefore receive this type of assistance. Often caregivers will rely first and foremost on their own parents or family for the emotional support especially during the post-natal period or transitions. Lastly, parents may use their extended family to serve as role models for them regarding the parenting role (Cochran & Niego, 2002). The type(s) and benefit of extended family supports can be rated based on the indicators in the following chart.

TYPES OF EXTENDED FAMILY SUPPORT	*INDICATORS OF SUPPORT BEING OF BENEFIT TO CAREGIVER*
Provision of Services	Support is Wanted and/or Requested
Advice or Information	Support Builds Parents' Competence
Emotional Support	Support is in Line with Parents' Values and Decisions
Role Models	Support Complements Parent/Child Relationship

In addition to the support that caregivers experience from extended family the child's own experience of these relationships needs to be considered. The following aspects can be either observed or described by the caregiver or child as evidence of the benefit of these extended family relationships to the child:

- The child and extended family member spend time together in activities that are pleasurable to the child.
- The child and extended family member describe routines and traditions specific to their relationship.
- The child and extended family member characterize appropriate roles and boundaries within their relationship.
- The child is able to accept direction, structure, support and affection from the extended family member; if challenges are present in this area they are not inconsistent with reactions in other relationships and may reflect mental health or overall relationship challenges.

Extended Family Discussion Points:

- Do members of your child's extended family play an integral part in his/her life?
- What types of activities do your child and extended family members do together?
- How would you describe the importance of these relationships to you and your child?
- Do any extended family members take an active role in child-rearing?

Interpersonal Relationships

This item is used to identify a child's social and relationships skills. This item is rated independently of Social Functioning because a child can have skills but be struggling in their relationships at a particular point in time. Thus this strength indicates long standing relationship making and maintaining skills.

Ratings	Anchor Definitions
0	Significant interpersonal strengths. 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.
3	Child needs significant help in developing interpersonal skills and healthy friendships.

The infant or child's capacity to relate to others in a positive manner is a strength that can be of great benefit. Children that are perceived by others as pleasant to associate with usually experience a greater number of social interactions, as well as longer periods of time in interaction with others. The importance of a child experiencing positive

interactions with others has been researched extensively and is now proven in numerous brain development studies. In 2000, the National Research Council and Institute of Child Development argued that "human relationships, and the effects of relationships on relationships, are the building blocks of health development." They further this concept later when referring to the importance of relationships on brain development. "Developmental neurobiologists have begun to understand how experience becomes integrated into the developing architecture of the human brain… brain development therefore depends on an intimate integration of nature and nurture throughout the life course" (Shonkoff & Phillips. 2000, p. 54).

Not only do youth that are adept at relating to others have greater and more sustained interactions with others, but they are more likely to get their needs met. Infants and young children that evoke positive reactions in others are responded to in a more positive manner than those that are less sociable. Even if a young child's methods for getting their needs met when upset or stressed are less than desirable, if that same child has built up positive relationships with caregivers and other adults, they will benefit. Caregivers and authority figures also tend to be less reactive and more nurturing to children that are interpersonally strong when the need for correction or discipline occurs. The following chart lists manifestations of interpersonal skills in infant, toddlers and preschoolers/school age children.

Evidence of Interpersonal Skills in Children

(Cornett, 2011)

Interpersonal Skills in Infants	**Interpersonal Skills in Toddlers**	**Interpersonal Skills in Preschoolers/School Age**
Smiles	Reactions to Others are Synchronous	Prefers Peers
Establishes Eye Contact	Acknowledges New People with Gestures and/or Words	Initiates Conversation with Adults
Imitates Others	Establishes Appropriate Eye Contact	Accepts Praise
Initiates Physical Contact	Develops Awareness of Social Boundaries	Shares Successes
Laughs	Responds to Humor	Develops Appropriate Interpretations of Social Cues

Interpersonal Skill Strength Discussion Points:

- Do you feel that your child is pleasant and likeable?
- Is s/he ever charming?
- Do adults or other children like him/her?
- Do you feel that your child can act correctly in some social settings?

Adaptability

This item rates how the child reacts to new situations or experiences, as well as how s/he responds to changes in routines.

Ratings	Anchor Definitions
0	The child consistently has a strong ability to adjust to changes and transitions. This supports further growth and development and can be incorporated into a service plan as a centerpiece strength.
1	This child demonstrates a moderate level of adaptability that can be useful to the child. The child could benefit from further development in this area before it is considered a significant strength.
2	The child shows a mild level of ability in this area. Parents and caregivers need to be the primary support in this area.
3	The child does not demonstrate adaptability.

Adaptability Discussion Points:

For Infants:

- How would you describe your infant's bedtime routine?
- How does your infant respond to interruptions in his/her day, such as getting a diaper changed or getting into a car seat?
- How does your infant respond when a stranger visits?
- How does your infant respond when s/he goes to a familiar child care setting or has a familiar babysitter take care of him/her?

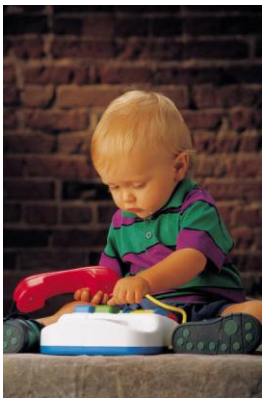
For Toddlers/Preschoolers:

- Does your child resist changes in his/her routine? If so, how?
- If your child becomes ill or stressed, do you notice changes or setbacks in his/her abilities?
- How does your child react if a routine is suddenly changed?
- How does your child respond when s/he goes to a familiar child care or preschool setting OR when s/he has to leave that setting to come home?

Persistence

This item rates the child's ability to keep trying a new task/skill, even when it is difficult for him/her.

Ratings	Persistence Anchor Definitions
0	The child consistently demonstrates a strong ability to continue an activity when challenged or meeting obstacles. This can serve as a centerpiece strength for the child.
1	The child demonstrates some ability to continue and activity that is challenging. Adults can assist a child to continue a task or activity.
2	The child shows some ability to continue a challenging task although this needs to be more fully developed. Adults are only sometimes able to support the child in this area.
3	The child does not demonstrate persistence.



Persistence Discussion Points:

For Infants:

- Will your infant keep trying a difficult skill, such as rolling over or walking, or does s/he give up easily?
- Does your infant usually want you nearby when trying a difficult task?
- When does your infant show frustration?
- Does your infant cry when frustrated?

For Toddlers/Preschoolers

- Will your child keep trying a difficult skill, such as tying shoelaces, or does s/he give up easily?
- Does your child avoid activities that cause him/her frustration?
- Does your child have temper tantrums easily when frustrated?
- Does your child require or ask for much adult help when trying a new task?
- Has learning new skills been a challenge for your child?

Curiosity

This item rates whether the child is interested in his/her surroundings and in learning and experiencing new things.

Ratings	Anchor Definitions
0	The child consistently demonstrates curiosity and takes action to explore his/her environment.
1	The child demonstrates curiosity much of the time and will take action to explore their environment some of the time.
2	The child, with encouragement, will explore and demonstrate interest in novelty or change.
3	The child does not demonstrate curiosity or exploration of his/her environment.

Curiosity is a characteristic or component of a child's personality that promotes, supports and enhances development in all areas. This component is often associated with intelligence as it is often reflected by questioning and exploring. Curiosity serves as a strong motivator and therefore results in actions that put a child in a position to learn and develop.

Developmental Benefits of Curiosity in Children
(Cornett & Podrobinok, 2009)

Motor Development	Cognitive Development	Language Development	Social and Emotional Development
• Initiates Attempts to Move and Explore the Environment Developing both Fine and Gross Motor Skills • Keeps Infant/Youth Motivated to Sustain Activity and Attempts • Curiosity Reduces the Frustration Experienced by Attempting New Tasks	• Triggers Learning by Exploring • Encourages Children to Question • Supports Lateral Thinking • Develops Understanding of Causal Relationships • Allows the Child to Enter Into New Experiences	• Encourages Imitation • Encourages Interaction both Verbally and Non Verbally • Places the Child in the Position to Observe Social Conventions of Language	• Encourages Learning Related to Social Cues, Behavior and Practices • Encourages Child to Think in the Mind of Another Supporting Reflective Functioning • Challenges the Egocentric Nature of the Child • Supports Thinking Related to Feeling States in Relationship to Behavior

Curiosity is considered a strength for young children. It is one of the primary signs of school readiness and central to success in school and later in life (Oser & Cohen, 2003). Curiosity has also shown to protect against interpersonal aggression due to greater context sensitivity (Kashdan, Afram, Brown, Birnbeck & Drvoshanov, 2010; Kashdan et al. 2012).

Assessment of curiosity occurs through a discussion with the caregiver(s) and child depending on age, as well as, observing behavior. The following list of descriptions of behavior will assist in identifying curiosity as an area of strength.

Evidence of Curiosity in Infants, Toddlers and Preschoolers/School Age Children

Adapted from Cornett (2011)

Infants	Toddlers	Preschoolers & School Age Children
• Turns Head to Listen to Sounds • Follows Activity with Eyes or Stops Movement to Watch Activity • Slows Breathing and Movement When Observing New Person or Occurrence • Explores with Mouth and Hands • Reacts to Novelty or Change • Can be Enticed to Take Action • Spontaneously Imitates Intonation and Words	• Communicates a Questioning Stance Through Gestures Resulting in Parent's Explanations of Actions or Occurrences • Actively Explores New Environments • Frequently Imitates Others Actions • Is Persistent in Learning How Items Work • Asks questions	• Requests Adults to Offer Detailed Explanations and Reasons for Behavior • Searches for Relationships between Concepts • Demonstrates Ability to Categorize • Demonstrates a Tendency to Notice Details or Changes in the Environment

Curiosity Discussion Points:

- How would you describe your child's interest in the worlds around him/her?
- Does your child seem aware of changes in the settings s/he is in?
- Is your child eager to explore?
- Does your child show interest in trying a new task or activity?

ACCULTURATION DOMAIN

Acculturation items identify cultural related needs that may require accommodation.

Language

This item looks at whether the child and family need help in communication with you or others in their world. In immigrant families, the child(ren) often becomes the translator. While in some instances, this might work well, it may become a burden on the child, or the child, say in a juvenile justice situation might not translate accurately, and so assessing this item depends on the particular circumstances.

Identity

This item refers to whether the child is experiencing any difficulties or barriers to their connection to their cultural identity. Can the child be with others who share a common culture? A newly immigrated Indian child living in a predominantly Caucasian neighborhood and attending a predominantly Caucasian school may be rated a "1" or a "2."

Ritual

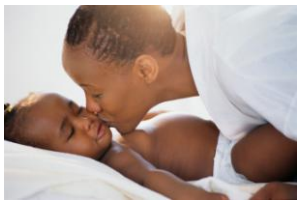
This item looks to identify whether barriers exist for a youth to engage in rituals relevant to his/her culture. For example, can a Buddhist child in a residential setting have a place to chant? Can a Muslim youth pray in the direction of Mecca at the requisite times during the day?

Cultural Stress

This item identifies circumstances in which the youth's cultural identify is met with hostility or other problems within his/her environment due to differences in the attitudes, behaviors, or beliefs of others. Racism is a form of cultural stress as are all forms of discrimination.

Cultural Differences

This item identifies cultural differences regarding child development and child rearing practices between the family and majority cultural values. Different child developmental beliefs and rearing practices which are not usually accepted, but not putting the child at risk, are rated '1'. When the family's child rearing practices are considered to be problematic for the child, rate the item '2'. If the family's child rearing culture is considered to be neglectful or abusive by the majority culture, rate the item '3'.



CAREGIVER STRENGTHS & NEEDS DOMAIN

In general, we recommend that you rate the unpaid caregiver or caregivers with whom the child is currently living. If the child has been placed, then focus on the permanency plan caregiver to whom the child will be returned. If the child is in a long term foster care or pre-adoptive placement, then rate that caregiver(s).

If the child is currently in a congregate care setting, such as a hospital, shelter, group home, or residential treatment center, rate the community caregivers where the child will be placed upon discharge from congregate care. If there is NO community (permanency plan) caregiver, this section would be rated 'Not Applicable' with a note in the case or clinical record that no caregiver is identified.

In situations where there are multiple caregivers, we recommend making the ratings based on the needs of the set of caregivers as they affect the child. For example, the supervision capacity of a father who is uninvolved in monitoring and discipline may not be relevant to the ratings. Alternatively, if the father is responsible for the children because he works the first shift and the mother works the second shift then his skills should be factored into the ratings of Supervision.

Supervision

This item refers to the caregiver's ability to provide monitoring and discipline to the rated child. Discipline is defined in the broadest sense as all of the things that parents/caregivers can do to promote positive behavior with their children. Guidance and loving supervision are among factors which promote optimal child development (CIMH, 2005).

Involvement in Treatment

A '0' on this item is reserved for caregivers who are able to advocate for their child. This requires both knowledge of their child, their rights, options, and opportunities. A '1' is used to indicate caregivers who are willing participants with service provision, but may not yet be able to serve as advocates for their child. When caregivers are not willing to participate in treatment, rate Involvement '2'. If a caregiver has given up, perhaps requesting out-of-home placement for their child, rate Involvement '3'.

Knowledge

This item is perhaps the one most sensitive to issues of cultural competence. It is natural to think that what you know, someone else should know and if they don't then it's a knowledge problem. In order to minimize the cultural issues, we recommend thinking of

this item in terms of whether there is information that if you made available to the caregivers they could be more effective in working with their child.

Organization

This item is used to rate the caregiver's ability to organize and manage their household within the context of intensive community services. Parents who need help organizing themselves and/or their family would be rated a '2' or '3'.

Social Resources

If a family has money, it can buy help. In the absence of money, families often rely on social supports to help out in times of need. This item is used to rate the availability of these supports. This item is the caregiver equivalent to the Natural Supports items for children and youth.

Residential Stability

Stable housing is the foundation of intensive community-based services. A '3' indicates problems of recent homelessness. A '1' indicates concerns about instability in the immediate future. A family having difficulty paying utilities, rent or a mortgage might be rated as a '1'. This item refers *exclusively* to the housing stability of the caregiver and should **not** reflect whether the child might be placed outside of the home.

Physical

This item refers to medical and/or physical problems that the caregiver(s) may be experiencing that limit or prevents their ability to parent the child. For example a single parent who has recently had a stroke and has mobility or communication limitations might be rated a '2' or even a '3'. If the parent has recently recovered from a serious illness or injury or if there are some concerns of problems in the immediate future they might be rated a '1'.

Mental Health

This item allows for the identification of serious mental illness among caregivers that might limit caregiver capacity. A parent with serious mental illness would likely be rated a '2' or even a '3' depending on the impact of the illness. However, a parent whose mental illness is currently well controlled by medication might be rated a '1'. This item should be rated independently from substance use.

Substance Use

This item describes the impact of any notable substance use on caregivers. If substance use interferes with parenting a rating of '2' is indicated. If it prevents care giving, a '3' would be used. A '1' indicates a caregiver currently in recovery or a situation where problems of substance use are suspected but not confirmed.

Developmental

This item describes the presence of mental retardation among caregivers. A parent with limited cognitive capacity that challenges their ability to provide parenting would be rated here. Like the Developmental item for children and youth, rating on this item should be restricted to the identification of developmental disabilities (i.e. mental retardation and other related conditions) and does not refer to a broad spectrum of developmental issues (e.g. aging is **not** rated here).

Accessibility to Child Care

This item describes the caregiver's access to child care supports such as baby-sitting or day care.

Military Transitions

This item identifies the impact of military transitions on family's care giving role.

Family Stress

This item refers to the impact the child or youth's challenges place on the family system. A very high need child or one that engages in specific behavior that is very disruptive to a family can create a substantial amount of Family Stress. Historically, this item was referred to as a burden in that raising a child with many needs can weigh on the family.

Safety (Abuse or Neglect)

This is the Child Abuse/Neglect item for Indiana's CANS. It describes whether individuals in the home present a danger to the child. This item does ***not*** describe situations in which the caregiver is unable to prevent a child from hurting him/herself despite well-intentioned efforts. If a child is involved with child welfare, the minimal rating would be a '1', perhaps if the child was being transitioned back home. A '2' or '3' on this item requires child protective services involvement.

When **Safety** is rated '1' or higher, the **Family Extension Module** identifies the daily life functional needs of families who have care giving responsibilities or to whom a child will be returning.

Marital/Partner Violence in the Home

This item refers to the degree of violence between caregivers, parents or a parent and paramour that put a child at greater risk. The violence could be verbal and/or physical and stem from power and control issues.

CHILD BEHAVIORAL/EMOTIONAL NEEDS DOMAIN

Attachment

This item rates the special relationship between the parent/primary caregiver and the child.

Ratings	Anchor Definitions
0	No evidence of problems with attachment.
1	Mild problems with attachment are present. Infants appear uncomfortable with caregivers, may resist touch, or appear anxious and clingy some of the time. Caregivers feel disconnected from infant. Older children may be overly reactive to separation or seem preoccupied with parent. Boundaries may seem inappropriate with others.
2	Moderate problems with attachment are present. Infants may fail to demonstrate stranger anxiety or have extreme reactions to separation resulting in interference with development. Older children may have ongoing problems with separation, may consistently avoid caregivers and have inappropriate boundaries with others putting them at risk.
3	Severe problems with attachment are present. Infant is unable to use caregivers to meet needs for safety and security. Older children present with either indiscriminate attachment patterns or withdrawn, inhibited attachment patterns. A child that meets the criteria for Reactive Attachment Disorder would be rated here.

Attachment refers to the special relationship between a child and their caregiver that is established within the first year of life. As the infant experiences getting their needs met throughout the first months of life they begin to associate gratification and security within the care-giving relationship. This ultimately leads to feelings of affection and by 8 months of age an infant will typically exhibit preference for the primary caregiver. An infant that does not experience their needs being met or responded to in a consistent and predictable pattern will typically develop an insecure pattern of attachment.

The benefits of a secure attachment have been researched significantly and are far reaching. Secure attachment between a child and their caregiver promotes positive development in self-esteem, independence and autonomy, impulse control, conscience development, long-term friendships, prosocial coping skills, relationships with caregivers and adults, trust, intimacy and affection, empathy, compassion, behavioral and academic performance and the ability to form secure attachments with their own children when they become adults (Levy, 1998).

Evidence of Attachment Disturbance in Young Children

Adapted from Cornett (2011)

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

Attachment Discussion Points:

Infants:

- Are you able to comfort and soothe your infant when he/she is upset?
- Is it difficult to understand what your infant wants from you?
- Do you feel that you and your baby have a special relationship?
- How does your baby react to strangers and separation from you?

Toddlers:

- Do you feel that you and your child have a special relationship?
- How does your child react to you after a separation?
- Do you feel your child is too clingy?
- Does your toddler seek help from you when he/she is hurt or needs something?
- Does your toddler choose to be with you when other adults are around?

Preschoolers:

- How would you describe your relationship with your child?
- How does your child deal with separations from you?
- Do you feel special to your child?
- What does your child do to get your attention?
- Does your child seek help from you when he/she is hurt or needs something?

Regulatory Needs

This item refers to the child's ability to control bodily functions such as eating, sleeping and elimination as well as activity level/intensity and sensitivity to external stimulation. The child's ability to control and modulate intense emotions is also rated here.

0	No evidence of regulatory problems.
1	Some problems with regulation are present. Infants may have unpredictable patterns and be difficult to console. Older children may require a great deal of structure and need more support than other children in coping with frustration and difficult emotions.
2	Moderate problems with regulation are present. Infants may demonstrate significant difficulties with transitions, and irritability such that consistent adult intervention is necessary and disruptive to the family. Older children may demonstrate severe reactions to sensory stimuli and emotions that interfere with their functioning and ability to progress developmentally. Older children may demonstrate such unpredictable patterns in their eating and sleeping routines that the family is disrupted and distressed.
3	Profound problems with regulation are present that place the child's safety, well being and/or development at risk.

Disorders of regulation are present when an infant or child displays difficulties with sleep disturbance, hypersensitivities to sensory stimulation, poor self-calming, irritability, mood deregulation and state deregulation. Sleep disturbance is determined when there is a persistent problem in the regulation of sleep-wake cycles despite parental efforts to manage the sleep routine. This would be considered when it takes over 20 minutes to fall asleep despite calming activities and bedtime routines. Frequent waking of more than two times in the night that are not related to night feedings would also qualify a sleep disturbance.

Difficulty in self-calming includes the inability to self-calm by such techniques as sucking on hands or listening to familiar voices. When a caregiver spends two to four hours a day consoling infants, self-calming is not developing as one would expect. Feeding difficulties are present when an infant does not have a regular schedule, demonstrates distress around feeding, and refuses to eat a variety of textures.

Distress with changes in routine would include the infant becoming overwhelmed by transitions, and when crying regarding such changes persists for periods of over five minutes for at least three times per day. Evidence of distress that occurs in response to sensory stimulation include resisting cuddling, distress at hair or face washed, hates car seat, resists certain positions, avoids certain textures, fear of movement and being startled by loud sounds (DeGangi, 1991).

Other children may be under-reactive, withdrawn and difficult to engage, self-absorbed (CIMH, 2005).

Regulatory Discussion Points:

Infants:

- How would you describe your infant's daily routine?
- How would you describe your infant's sleep routine?
- Do you have any concerns about your infant's eating patterns? If so, describe.
- How does your infant respond to frustration and what does it take to console her?

Toddlers:

- How would you describe your toddler's routine?
- Are there areas of concern you can describe regarding your toddler's eating and sleeping?
- How would you describe your toddler's ability to regulate their level of frustration and overall expression of emotion?

Preschoolers:

- How would you describe your child's routine?
- How does your child control his activity level?
- Does your child surprise you with the level of intensity and responses to emotions?
- How does your child respond to excessive stimulation such as noise, light, touch, crowds?
- Do others have concerns about your child's ability to control their emotions or behavior?

Failure to Thrive

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

Ratings	Failure to Thrive Anchor Definitions
0	No evidence
1	The infant/child may have experienced past problems with growth and ability to gain weight and is currently not experiencing problems. The infant/child may presently be experiencing slow development in this area.
2	The infant or child is experiencing problems in their ability to maintain weight or growth. The infant or child may be below the 5th percentile for age and sex, may weigh less than 80% of their ideal weight for age, have depressed weight for height, have a rate of weight gain that causes a decrease in two or more major percentile lines over time, (75th to 25th)
3	The infant/child has one or more of all of the above and is currently at serious medical risk.

Failure to thrive is considered a condition in which an infant or child has weight below the 5th percentile on NCHS growth charts or has a decrease across two percentiles in growth or weight (Zeanah, 2000). This is critical to monitor due to the possible problems that may be associated with this condition such as possible developmental disorders such as oral motor problems, sensory processing disorders, relationship problems, self-regulation problems or difficult temperament issues.

Failure to thrive has also been associated with later cognitive challenges, school problems, attachment difficulties, self-regulation challenges, inability to delay gratification and various health concerns. Relationship disturbances are also present in failure to thrive infants as they grow older which are seen in their frequent lack of confidence in others, poor self-esteem, and inability to trust the attachment relationship. The feeding experience for infants also serves additional functions other than caloric intake. It is through this experience that an infant develops a sense of security and source of emotional comfort. It is also an organizing and integrating event in the infant's day.

There have been numerous causes for failure to thrive listed in literature some of which are lack of caloric intake due to lack of information on part of parent, lack of caloric intake due to parental neglect, lack of caloric intake due to food refusal, nutritional absorption problems, inappropriate feeding practices, or relationship based problems that manifest in feeding challenges. Some of the characteristics of the infant/toddler that can be associated with failure to thrive are listed below.

Possible Characteristics of Infants/Toddlers with Failure to Thrive

Adapted from Trout (1987)

- Extreme watchfulness
- Bizarre eating patterns (excessive intake, hoarding food, refusing food)
- Protruding abdomen
- Noted Improvement in weight gain during hospitalizations
- Poor cuddling or social responsiveness

Depression

This item refers to any symptoms of depression which may include sadness, irritable mood most of the day nearly every day, changes in eating and sleeping, and diminished interest in playing or activities that were once of interest. A rating of '2' could be a two year old who is often irritable, does not enjoy playing with toys as s/he used to, is clingy to his/her caregiver, and is having sleep issues.

Ratings	Depression Anchor Definitions
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.
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.

An infant or young child that is attempting to cope with feelings of sadness or depression is compromised in their ability to attend to the tasks of development. Many clinicians and caregivers do not believe that an infant can experience depression despite the fact that researchers and clinicians began documenting this condition in the early 1940's when Anna Freud and Dorothy Burlingham recorded the reactions of young children removed from their parents during World War II. The two researchers documented a distinct grief reaction that started with protest, continued to despair and finally the children appeared disconnected, withdrawn, developmentally delayed and almost resolved to their fate (Freud & Burlingham, 1944).

A child that is traumatized in any way may first develop a traumatic response that can develop into depression and meet criteria for a depressive disorder. There are children in which it is difficult to identify a specific trauma although they appear depressed. A child may experience depression that is not reactive in nature. At times it is a challenge for the caregiver to identify or even believe a specific environmental condition may contribute to depression in young children. These factors may include a chaotic home environment, poor or limited interaction from caregivers, or preoccupation of caregiver with their own stressors (Luby, Stalets & Belden, 2007).

The assessment of depression in young children should meet the criteria outlined in the *Diagnostic Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood: Revised Edition (DC: 0-3R, Zero to Three, 2005)*. Both the *DC 0-3R* and the *DSM IV-R* consider the symptoms of depression to include depressed/irritable mood, diminished interest or pleasure, weight loss/gain, insomnia/hypersomnia, psychomotor agitation/retardation, fatigue or energy loss, feelings of worthlessness, diminished ability to think/concentrate, or recurrent thoughts of death or suicidal ideation. Clinical observations and manifestations of these symptoms are listed in the chart below. In

addition the *DC 0-3 R* states that all of the following general characteristics must be present to diagnosis a child with Major Depression:

- The disturbed affect and pattern of behavior should represent a change from the child's usual mood and behavior.
- The depressed mood or anhedonia (lack of pleasure) must be persistent and, at least some of the time, uncoupled from sad or upsetting experiences. Persistent is defined as present most of the day, more days than not, over a period of at least 2 weeks.
- Symptoms should be pervasive, occurring in more than one activity or setting and in more than one relationship.
- Symptoms should be causing the child clear distress, impairing functioning or impeding development.
- Disturbances are not due to a general medical condition or the direct effect of a medication or substance.

Evidence of Depressive Symptoms in Young Children

- Depressed or Irritable mood may be displayed by little variation in emotional expression, few smiles, infrequent laughter, cries easily and frequently. The infant or toddler may display poor coping skills and difficulty recovering from frustration.
- Diminished pleasure or interest in activities may be displayed by little interest in play and poor response to adult's encouragement to play. The child may appear unhappy or withdrawn during play.
- When assessing the presence of appetite or sleep disturbance there should be a change from a previously established pattern that is now the consistent experience for the child. Due to the dynamic nature of the child's development this may be difficult to assess so weight changes or fatigue may help guide the rating to this.
- Diminished ability to think or concentrate may be illustrated in giving up easily on completing tasks in play, poor ability to sustain attention despite strong motive to do so, and poor persistence in general.

Depression Discussion Points:

Infants

- How would you describe your infant's mood throughout the day?
- Have there been changes in this?
- Does your infant appear happy at times?

- Is it difficult to get your infant to respond to you or others?
- Have there been situations that have been stressful for your infant?
- Does your infant's development seem to be on track to you?
- Has there been a change in your infant's skills or abilities?

Toddlers

- How is your toddler's mood throughout the day?
- Does your toddler recover from upsetting situations or seem hard to console?
- Is your toddler easy to interact with?
- Does it take a lot to get your toddler to respond to you or others?
- Does your toddler seem to enjoy playtime?
- Has there been a change in your toddler's skills or abilities?

Preschoolers

- How would you describe your child's mood most of the time?
- Is it difficult to engage your child in play?
- Have there been changes in how your child relates to you and others?
- If this has been a problem, what have you done to help the situation?
- Has anything helped?

Anxiety

This item refers to the presence of worries or fears.

Ratings	Anxiety Anchor Definitions
0	No evidence
1	History or suspicion of anxiety problems or mild to moderate anxiety associated with a recent negative life event.
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.

A child that is preoccupied with worries or fears may experience significant challenges in their ability to relate to others, accept support and nurturing from others and focus on growth and development. Beyond this, a caregiver that is attempting to assist a child that is anxious is also challenged in their task of being responsive and supportive to their child. This experience may interfere with the attachment relationship making the parent feel inadequate in meeting their child's needs. In the worst case scenario, a parent may reject or withdraw from their child to protect themselves from the negative feelings of perceived rejection.

Anxiety in adults is often described as debilitating and "the worst possible feeling". It is no different in infants and young children and can stalemate development and result in regression. The challenge in assessing anxiety in young children first becomes the determination of the presence of clinically significant anxiety versus temperament characteristics or otherwise normative anxiety. Important considerations in this determination become how persistent is the problem, and to what degree does it interfere with functioning.

The Diagnostic Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood: Revised Edition (DC: 0-3R, Zero to Three, 2005) states that all of the following criteria must be present to consider an anxiety disorder substantiated:

- The anxiety or fear causes the child distress or leads the child to avoid activities or settings associated with the anxiety or fear
- Occurs during two or more everyday activities or within two or more relationships (pervasive)
- Is uncontrollable at least some of the time
- Impairs the child's functioning related to expected development
- The anxiety or fear is persistent

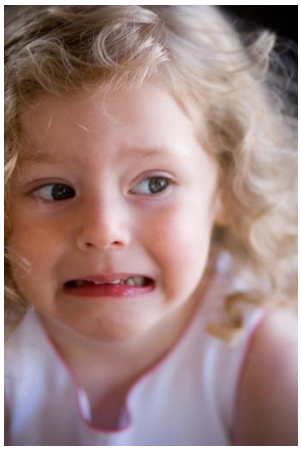
Evidence of Anxiety in Young Children

- Excessive distress when separated from caregiver may be seen as excessive crying, inability to be consoled, inability to be distracted, self injurious behavior and statements of worry or fear
- Persistent and excessive worry regarding separation from caregiver may be seen in scanning the environment, clingy behavior, statements regarding possibility of something bad happening, lack of exploratory behavior
- Frequent startle reactions, hypervigilance
- Nightmares, poor ability to go to sleep and stay asleep
- Somatic (physical) complaints

Anxiety Discussion Points:

Infants

- Does your infant show fear or worry in situations that you wouldn't expect?
- How easily can you comfort your infant when he/she is upset?
- Are there situations you try to avoid because of how your infant reacts?
- How can you tell that your infant is worried or upset?



Toddlers

- Does your child ever appear nervous or worried?
- Does this keep your child from interacting with others or following normal routines?
- What things have you tried to help your child cope with fears or worries*?*

Preschoolers

- What words or actions tell you that your child is upset or worried?
- Are there certain times that your child seems worried?
- Has this affected your child's activities or routines?
- What things have you tried to help your child cope with fears or worries*?*

Atypical Behaviors

This item rates whether the child repeats certain actions over and over again, or demonstrates behaviors that are unusual or difficult to understand.

Ratings	Anchor Definitions
0	No evidence of atypical behaviors.
1	There is either a history or reports of atypical behaviors that have not been observed by parents.
2	The child evidences signs of atypical behaviors.
3	The child is noted to have atypical behaviors that are consistently present and interfere with the infant/child's functioning on a regular basis.

This item rates the presence of such things as head banging, eye blinking, eating unusual things, smelling objects, spinning, twirling, hand flapping, finger-flicking, toe walking, staring at lights, or making sounds over and over again. This is important in early childhood to assess due to the possible indication that this may be related to pervasive developmental disorders. Early intervention to assess the etiology of these symptoms is critical.

Atypical Behavior Discussion Points:

Infants:

- Do you notice any behaviors that are of concern in your infant?
- Do these behaviors become worse when your infant is tired or hungry?

Toddlers:

- Have you or anyone else noticed any behaviors that are of concern in your toddler?
- If behaviors like these are present, have they changed in any way over time?
- Do these behaviors increase or get worse at certain times?

Preschoolers:

- Have you or anyone else noticed any behaviors that are of concern in your child?
- If behaviors like these are present, can you tell me when they began and if things have changed in any way over time?
- Have you found anything that has helped with these behaviors?

Impulsivity/Hyperactivity

This item refers to the child's level of difficulty controlling activity level or actions. The child should be 3 years of age or older to rate this item.

Ratings	Impulsivity/Hyperactivity Anchor Definitions
0	No evidence
1	Some problems with impulsive, distractible or hyperactive behavior that places the Child at risk of future functioning difficulties.
2	Clear evidence of problems with impulsive, distractible, or hyperactive behavior that interferers with the Child's ability to function in at least one life domain.
3	Clear evidence of a dangerous level of impulsive behavior that can place the Child at risk of physical harm.

This item refers to both a child's ability to control impulses as well as his/her activity level. Both of these areas need to be considered as problematic, rated a '2', only when it impairs functioning, is observed in more than one setting and is outside the realm of what is considered normal for the child's age and development. Both of these behaviors may result in disruptions in relationships and interference with the development of new skills if problematic. A '3' on this item is reserved for those whose impulsive behavior has placed them in physical danger during the period of the rating.

Attention Deficit Hyperactivity Disorder(ADHD) is considered appropriate as a diagnosis according to DSM IV-TR (APA, 2000, pp. 84 -85) if "6 or more of the following symptoms of hyperactivity or impulsivity have persisted for at least 6 months: often fidgets with hands or feet or squirms in seat, often leaves seat in classroom or other situations, often

runs about or climbs excessively in situations in which it is inappropriate, often has difficulty playing or engaging in leisure activities quietly, is often on the go, often talks excessively, often blurts out answers, often has difficulty awaiting turns, and often intrudes on others." Symptoms of inattention may or may not be present.

Impulsivity/Hyperactivity Discussion Points:

Toddlers, 3 year olds:

- Describe your child's activity level.
- Do you or others have any concerns in this area?
- Have you needed to find ways to prevent your child from getting hurt due to his/her activity level?
- Does your toddler run and climb excessively?
- Do you or others have trouble controlling your toddler's activity?
- Does your toddler require more supervision than others his/her age?

Preschoolers:

- Describe your child's activity level.
- Do you or others have any concerns in this area?
- Have you needed to find ways to prevent your child from getting hurt due to his/her activity level?
- Does your child need a high level of supervision due to his/her activity level?
- Does your child have trouble taking turns?
- Does s/he blurt out answers in day care or preschool?
- Does your child seem to continue doing things you don't want him/her to do, even though he/she has been taught not to do these things?
- Does your child have difficulty sitting still during mealtimes or activities like "circle time" in day care or preschool?

OPPOSITIONAL BEHAVIOR

This item refers to the child's difficulty in controlling actions with authority figures. The child should be 3 years of age or older to rate this item.

Ratings	Oppositional Behavior Anchor Definitions
0	No evidence
1	History or recent onset (past 6 weeks) of defiance towards authority figures.
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.
3	Clear evidence of a dangerous level of oppositional behavior involving the threat of physical harm to others.

Oppositional behavior is a significant concern for parents, teachers and caregivers. It is one of the most common reasons for referral for a mental health assessment. Behavioral difficulties may range from significant to mild and may interfere with a child's functioning in varying ways. In determining how to rate this item it is important to remember that etiology or cause is not a factor in the rating. Although a child may be experiencing ineffective parenting to explain oppositional behavior, oppositional behavioral may still be present. Oppositional behavior refers to reactions towards adults, not peers.

Characteristics of Oppositional Behavior in Preschoolers

Presence of "hostile defiance" rather than attempts to negotiate or avoid punishment Consistent pattern of refusal to comply with adult requests	Temper tantrums Often loses temper Often argues with adults Is often angry or vindictive Blames others for mistakes Annoys or provokes others

Oppositional Behavior Discussion Points:

- Can you describe any concerns you may have with your child's behavior?
- Do any adults that interact with your child have concerns in this area?
- How does your child react to being told what to do?
- Does your child usually follow the rules?
- Does your child become angry easily or often when interacting with authority figures?
- How do you correct your child if he/she is acting inappropriately towards authority figures?
- If this is an issue, has anything helped in this area?

Adjustment to Trauma

Adjustment to Trauma refers to the presence of symptoms related to a traumatic event.

Ratings	Anchor Definitions
0	No evidence
1	History or suspicion of problems associated with traumatic life event(s).
2	Clear evidence of adjustment problems associated with traumatic life event(s). Adjustment is interfering with Child's functioning in at least one life domain.
3	Clear evidence of symptoms of Post Traumatic Stress disorder, which may include flashbacks, nightmares, significant anxiety, and intrusive thoughts of trauma experience.

Trauma is an experience that can have serious implications for children of all ages. A child may experience developmental arrest, developmental regression, depression, anxiety, cognitive disturbances and, perhaps most significantly, impairment in their ability to use

the attachment relationship. More specifically, research has indicated that a child may develop abnormal patterns in their feeling expression, unusual or deviant patterns of behavior, distractibility, inattention, disturbances in eating and elimination patterns, poor sleep, delays in motor and language acquisition (Scheeringa & Gaensbauer, 2000).

A child may develop very distorted views about their safety, the safety of others and view others as threatening and harmful to their own well-being. It is also true that children respond to trauma in a very individualized fashion and the duration of these reactions may range from short term to long lasting. A number of factors that may affect the way a child responds to trauma are listed below.

Factors Affecting Response to Trauma

Adapted from Cornett (2011)

- Temperamental Variations
- Age and Developmental Stage
- Parental Response and Ability to Support the Child
- Presence of Environmental Supports
- Intellectual Ability
- Degree of Structure and Predictability Within the Home
- Presence of Age Appropriate Explanations Regarding Trauma
- Ability of the Child to Integrate the Traumatic Experience
- Parental Ability to Predict Child's Need for Support in the Presence of Traumatic Reminders and Ability to Demonstrate Support to Child
- Degree of Perceived Threat or Harm to Child and/or Significant Others

All of the above factors can impact the child's ability to cope with trauma. In considering temperamental variables it is important to be aware of first what the child's temperament consists of and how these variables are received and supported within the home. A child that is adaptable and comfortable with change will use these strengths to their benefit in the face of trauma. If a child is challenged in this capacity, a support parent that is aware and able to assist the child in this area can make a significant difference for a child.

The child's developmental status is significant as well. If a child is focused on attempting to master major developmental tasks, their emotional reservoir may be more easily drained. A child's age is also an important factor. Children that are preverbal may incorporate memories in a manner that is harder to access and process. The ability to use cognitive appraisal and restructuring to mediate anxiety is a particular advantage and may not be available to a younger child. Of all age groups, children under the age of 5 are the least resilient when it comes to trauma.

Early childhood trauma can have the greatest impact due to its ability to alter fundamental neuro-chemical processes which, in turn, adversely affect the growth, structure and functioning in the brain (Blaustein & Kinniburgh, 2010).

If the child has a caregiver that can provide a basic feeling for the child of being safe and providing a predictable routine, a child will stabilize much faster than if a feeling of safety and a routine are not present. A child may need the opportunity to process what occurred with an adult to gain an understanding that will also help with feelings of anxiety. A child's magical thinking or errors in cognition may contribute to less managed anxiety. The type of trauma needs to be understood as well. There are various types of trauma such as medical, disasters such as flooding or tornados, abuse, neglect, separation from caregivers, exposure to domestic violence or violence in the community.

Young children and youth exposed to single or ongoing incidents of abuse may experience trauma symptoms, poor functioning and increased risks related to the trauma, often differing from post trauma stress (Kisiel, Fehrenbach, Small & Lyons 2009). The exposure of young children to trauma, especially interpersonal violence, is associated with substantial decreases in IQ and reading achievement (DeLaney-Black, 2002), poor school attendance and academic performance (Hurt, 2001). Abused youth have poorer social functioning than non-abused youth, less pro-social and more aggressive, disruptive and withdrawn behavior (Alink, Cicchetti, Kim & Rogosch, 2012), resulting in increased cortisol and stress symptoms. Exposure to interpersonal violence, especially multiple types of abuse, increase the likelihood that the child will experience subsequent behavioral health symptoms, including depression, substance abuse, PTSD and risk behaviors (Crisler, 2012).

The *Diagnostic Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood: Revised Edition (DC: 0-3R, Zero to Three, 2005)* indicates that the criteria for Traumatic Stress Disorder includes a response to a traumatic event that includes:

1. Symptoms of re-experiencing the trauma in the form of post traumatic play, repeated statements or questions about the trauma, nightmares, distress at exposure or dissociation.
2. A Numbing of responsiveness which may include restricted range of affect, social withdrawal, regression, or constricted play.
3. Increased arousal which may include night terrors, night waking, attentional difficulties, or startle response.
4. Signs of fear or aggression that began after the trauma such as separation anxiety, fear of dark, aggression towards peers or animals, sudden new fears or enactment.

Experiencing multiple, chronic interpersonal traumas, often referred to as complex trauma exposure, can impact several areas of mental health need and functioning (Ford, Connor & Hawke, 2009). Different levels of trauma related impairments are found among children who have experienced abuse or neglect and multiple placements. Falling short of classical post traumatic stress criteria, trauma related symptoms often have functional consequences which may be resolved with early identification and effective intervention (Kisiel, Fehrenbach, Small & Lyons, 2009).

Rating the CANS Birth to 5: As the Adjustment to Trauma item is a "screening" item, for youth with a history of trauma (including neglect or abuse, significant loss or placement disruptions, rate the item, "1". If there is evidence that the child is experiencing trauma related needs which impact function, rate the item '2'. A rating of '3' is consistent with PTSD.

A rating of a "1" or greater would result in the need for further specification of these needs through the completion of the Trauma Module. The trauma module was taken from the Trauma Experiences and Adjustment version of the CANS which was developed in collaboration with several sites of the **National Child Traumatic Stress Network** (NCTSN). The module includes specification of traumatic experiences that can be associated with PTSD. In addition, specific trauma stress symptoms are described. A child or youth may experience trauma which are not listed, such as death or loss. For children with a history of trauma or loss, consider this detailed information in determining the overall rating for **Adjustment to Trauma.**

Rating Adjustment to Trauma on the CANS

'0' - No evidence of trauma or related needs.

'1' - A history of trauma, including neglect, abuse, or interpersonal violence ("keep an eye on it", assess further)

'2' - Trauma related needs, including complex trauma exposure, that fall short of PTSD

'3' - Consistent with Post Traumatic Stress

The first item on the Trauma Module is "Sexual Abuse". If the child scores a 1, 2 or 3 on this item *on the module*, the additional items of "Emotional Closeness", 'Frequency of Abuse", 'Duration, Physical Force and Reaction to Disclosure" at the end of the module must be completed. If information is limited, some sexual abuse items could be rated '1', indicating need for further assessment.

Adjustment to Trauma Discussion Points:

Infants:

- Do you have any concerns that your infant has had or seen a traumatic situation?
- Has your infant heard gun shots or seen other violent acts in the community?
- Has your infant seen violence on TV or in movies?
- Has your infant experienced the death or loss of someone in the family (loss could be due to hospitalization, incarceration or divorce)?
- Has your infant ever been separated from you for a significant period of time?
- Does your infant appears to be "on guard" or worried at times?
- Have there been any changes in the way your infant acts or responds to you or others?
- Have you noticed any changes in your infant's development since he/she experienced the stressful event?
- Is your infant more easily upset or noticeably quieter since experiencing the stressful event?

Toddlers and Preschoolers:

- Do you have any concerns that your child has experienced or witnessed a traumatic situation?
- Has your child heard gun shots or seen other violent acts in the community?
- Has your child experienced the death or loss of someone in the family (loss could be due to hospitalization, incarceration or divorce)?
- Has your child experienced separations from caregivers?
- Has your child had nightmares or night fears, or changed his/her behavior after a difficult situation?
- Do certain situations make your child uncomfortable or react in a way that is unusual for him/her?
- Have you had to make changes in your child's normal routines due to his/her reactions or fears?

RISK FACTOR DOMAIN

Birth Weight

This item rates the child's birth weight as compared to optimal development.

Ratings	Anchor Definitions
0	Child is within normal range for weight and has been since birth. A child with a birth weight of 2500 grams (5.5.pounds) or greater would be rated here.
1	Child was born under weight but is now within normal range or child is slightly beneath normal range. A child with a birth weight of between 1500 grams (3.3 pounds) and 2499 grams would be rated here.
2	Child is considerably under weight to the point of presenting a developmental risk to the child. A child with a birth weight of 1000 grams (2.2 pounds) to 1499 grams would be rated here.
3	Child is extremely under weight to the point that the child's life is threatened. A child with a birth weight of less than 1000 grams (2.2 pounds) would be rated here.

Birth Weight Discussion Point:

- What was your child's birth weight? How has your child's weight gain been since birth?

PICA

Pica refers to the child eating dangerous or unusual materials. The child must be older than 18 months to rate this item.

Ratings	Anchor Definitions
0	There is no evidence that the child eats unusual or dangerous materials.
1	Child has a history of eating unusual or dangerous materials but has not done so in the last 30 days.
2	Child has eaten unusual or dangerous materials consistent with a diagnosis of Pica in last 30 days.
3	Child has become physically ill during the last 30 days by eating dangerous materials.

Prenatal Care

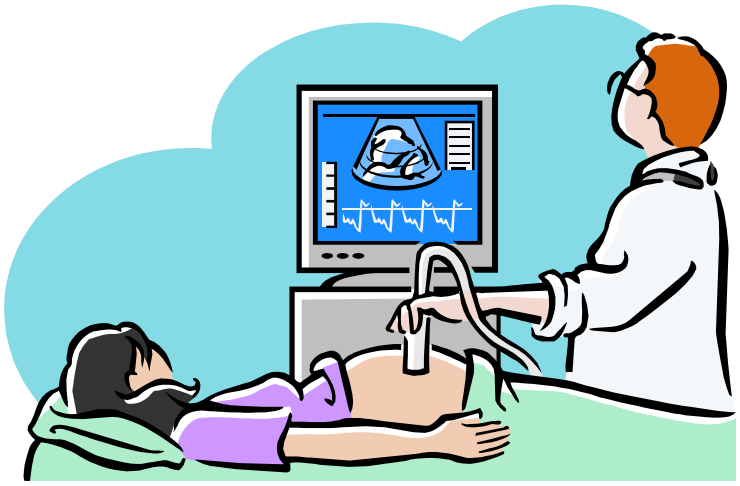
This item refers to the health care pre-birth circumstances experienced by the child in utero.

Ratings	Anchor Definitions
0	Child's biological mother received adequate prenatal care that began in the first trimester. Child's mother did not experience any pregnancy-related illnesses.
1	Child's biological mother had some short comings in prenatal care, or had a mild form of pregnancy-related illness.
2	Child's biological mother received poor prenatal care, initiated only in the last trimester, or had a moderate form of a pregnancy-related illness.
3	Child's biological mother had no prenatal care or had a severe pregnancy-related illness.

A child whose mother had 6 or fewer planned visits to a physician (her care must have begun in the first or early in the second trimester), had a mild or well-controlled form of pregnancy-related illness such as gestational diabetes, or who had an uncomplicated high-risk pregnancy, would be rated as a '1'. A child whose mother had 4 or fewer planned visits to a physician or who experienced a high-risk pregnancy with some complications would be rated as '2'. A mother who had toxemia/pre-eclampsia would be rated a '3'.

Prenatal Care Discussion Points:

- When did you first receive health care for your pregnancy? Did you receive health care throughout your pregnancy?



Labor and Delivery

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

Ratings	Anchor Definitions
0	Child and biological mother had normal labor and delivery. A child who received an Apgar score of 7-10 at birth would be rated here.
1	Child or mother had some mild problems during delivery, but child does not appear affected by problems. An emergency C-Section or a delivery-related physical injury (e.g. shoulder displacement) to the child would be rated here.
2	Child or mother had problems during delivery that resulted in temporary functional difficulties for the child or mother. Extended fetal distress, postpartum hemorrhage, or uterine rupture would be rated here. A child who received an Apgar score of 4-7, or who needed some resuscitative measures at birth, would be rated here.
3	Child had severe problems during delivery that have resulted in long term implications for development (e.g. extensive oxygen deprivation, brain damage). A child who received an Apgar score of 3 or lower, or who needed immediate or extensive resuscitative measures at birth, would be rated here.

Labor & Delivery Discussion Points:

- Describe your labor and delivery experience.
- Describe any difficulties with either you or your child during labor and delivery?

Substance Exposure

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

Ratings	Anchor Definitions
0	Child had no in utero exposure to alcohol or drugs, and there is no current exposure in the home.
1	Child had either mild in utero exposure (e.g. mother ingested alcohol or tobacco in small amounts fewer than four times during pregnancy) or there is current alcohol and/or drug use in the home.
2	Child was exposed to significant alcohol or drugs in utero. Any ingestion of illegal drugs during pregnancy or significant use of alcohol or tobacco would be rated here.
3	Child was exposed to alcohol or drugs in utero and continues to be exposed in the home. Any child who evidenced symptoms of substance withdrawal at birth (e.g. crankiness, feeding problems, tremors, weak and continual crying) would be rated here.

While exposure to substance abuse is a known risk, the associated stressors that often accompany substance abusing parents heighten the concerns. Due to the effects of

substance abuse, parents often experience poverty, disorganized and chaotic lifestyles, stress, and exposure to violence (Lester and Tronick, 1994). Due to the critical importance of forming a secure attachment relationship within the first few years of life, a young child with substance abusing parents may be at considerable risk. In addition, it has also been determined that when the combination of prenatal drug exposure and ongoing substance use in parents occurs a child is at high risk for learning and behavior problems (Lester & Tronick, 1994; Kaplan-Sanoff, 1996).

Substance Exposure Discussion Points:

- Does your child have a history of being exposed to substances prenatally?
- Are there any concerns that your child is exposed to substances within the home?

Parent/Sibling Problems

This item refers to how the child's caregiver(s) and other siblings have done/are doing in their respective development and behavioral health.

Ratings	Parent/Sibling Problems Anchor Definitions
0	The child's parents have no developmental disabilities. The child has no siblings or existing siblings are not experiencing any developmental or behavioral problems.
1	The child's parents have no developmental disabilities. The child has siblings who are experiencing some mild developmental or behavioral problems (e.g. Attention Deficit Hyperactivity, Oppositional Defiant, or Conduct Disorders). It may be that the child has at least one healthy sibling.
2	The child's parents have no developmental disabilities. The child has a sibling who is experiencing a significant developmental or behavioral problem (e.g. a severe version of any of the disorders cited above, or any developmental disorder).
3	One or both of the child's parents have been diagnosed with a developmental disability, or the child has multiple siblings who are experiencing significant developmental or behavioral problems.

Discussion Points:

- Are there any developmental or behavioral health problems in parents or siblings?
- Have there been any concerns in the past with parents or siblings? If so, describe the concerns.

Maternal Availability

This item addresses the primary caretaker's emotional and physical availability to the child in the weeks immediately following the birth. Rate maternal availability from birth to 12 weeks post partum.

Ratings	Maternal Availability Anchor Definitions
0	The child's mother/primary caretaker was emotionally and physically available to the child in the weeks following the birth.
1	The primary caretaker experienced some minor or transient stressors which made her slightly less available to the child.
2	The primary caregiver experienced a moderate level of stress sufficient to make him/her significantly less emotionally and physically available to the child in the weeks following the birth.
3	The primary caregiver was unavailable to the child to such an extent that the child's emotional or physical well being was severely compromised.

One of the factors that contribute to early childhood emotional disorders is a parent's not being emotionally available to read and respond to infant's cues. Parents may be compromised by limited parenting skills, a lack of social support, physical or mental health issues, substance abuse or interpersonal or external stressors (e.g. poverty or domestic violence).

Abuse or Neglect

This item includes current abuse or neglect, rated '3'; no current abuse or neglect, but parent has history of this behavior without treatment, rated '2', or history of prior abuse or neglect with parental treatment and no evidence of current abuse or neglect, rated '1'.

	ABUSE/NEGLECT *Please rate the highest level from the* ***past 30 days***
0	No evidence nor does the caregiver have any history of abuse/neglect.
1	No evidence of abuse/neglect, parent has received treatment to address this behavior.
2	No evidence of abuse or neglect. Parent has history of this behavior without treatment.
3	Evidence of current abuse/neglect.

CHILD RISK BEHAVIOR DOMAIN

Self Harm

This item refers to repetitive behaviors that result in physical injury to the child, e.g. head banging.

Ratings	Self Harm Anchor Definitions
0	There is no evidence of self-harm behaviors.
1	There is a history, suspicion, or mild level of self-harm behavior.
2	There is a moderate level of self-harm behavior such as head banging that cannot be impacted by caregiver and interferes with child's functioning.
3	There is a severe level of self-harm behavior that puts the child's safety and well being at risk.

Aggressive Behavior

This item rates whether there have been times when the child hurt or threatened to hurt another child or adult.

Ratings	Aggressive Behavior Anchor Definitions
0	No evidence of aggressive behavior.
1	There is either a history of aggressive behavior or mild concerns in this area that have not yet interfered with functioning.
2	There is clear evidence of aggressive behavior towards others, behavior is persistent and caregiver's attempts to change behavior have not been successful.
3	The child has significant challenges in this area that is characterized as a dangerous level of aggressive behavior that involves the threat of harm to others or problems in more than one life domain that significantly threatens the child's growth and development.

Aggression is a common reason that parents seek assistance for young children. Early intervention with childhood aggressive problems is critical (Webster-Stratton, 2003). She concluded that effective early intervention could correct the negative trajectory of early conduct problems which could lead to delinquency and antisocial behavior.

Aggressive behavior in young children is often associated with other risk factors such as parental stress, parental drug abuse, maternal depression, and single parenthood. The more risk factors that are associated with the aggressive behavior, the more likely the behavior will persist and develop into more serious conduct problems (Webster-Stratton, 2003). Important considerations in the assessment of this item include the severity of the aggression, pervasiveness of behavior, ability to use caregiver support to discontinue

behavior and frequency of the behavior. Although aggression may be present for a variety of reasons including parenting concerns, modeling of inappropriate behavior, poor impulse control, regulatory and sensory concerns or depression, the etiology is not of concern in rating the CANS Aggressive Behavior Item.

Aggression Discussion Points:

Toddlers:

- Have there been situations in which others have been hurt by your child?
- Can you describe the situation? What were the results of this situation?
- Were there things that you or others did that made the situation better?
- How do you correct your toddler if s/he is being verbally or physically aggressive towards another person?
- Have other caregivers ever been uncomfortable caring for your toddler because of your child's aggressive behavior?

Preschoolers:

- Have there been situations in which others have been hurt by your child?
- If so, can you describe the situation?
- What were the results of this situation?
- Were there things that you or others did that made the situation better?
- What does your child say about this problem?
- Have there been any changes to your child's activities or routines because of this?
- Has your child been asked not to return to a childcare or school setting because of aggressive behavior?

Social Behavior (Intentional Misbehavior)

This item refers to obnoxious behaviors that force adults to sanction the child. The key to rating social behavior is to understand if the child is intentionally trying to force discipline or consequences. These behaviors occur in such a way that the child is intentionally seeking negative attention, acting out, or the behavior could be seen as a cry for help. *A child must be at least 3 years old before this item would be rated.*

Ratings	Anchor Definitions
0	No evidence of problematic social behavior. Child does not engage in behavior that forces adults to sanction him/her.
1	Mild level of problematic social behavior. 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 problematic social behavior. 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).

The key to rating this behavior is to understand if the child is intentionally trying to force discipline or consequences. These behaviors occur in such a way that the child is intentionally seeking sanctions and negative attention, acting out, or the behavior could also be seen as a cry for help. A rating of '2' could be a child who, several times per week, is intentionally getting into trouble at preschool in order to have his/her caregiver pick him/her up early.

Intentional Misbehavior Discussion Points:

- Does your child ever intentionally do or say things to upset adults?
- Does your child seem to purposely get in trouble by making you or other adults angry with him/her?

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