Child and **A**dolescent **N**eeds and **S**trengths: **E**arly **C**hildhood

CANS: EC Supplemental Guide

A Support for the CANS (Early Childhood) Information Integration Tool for Young Children Ages Birth to Five

SET is part of the System of Care Initiative, within the Allegheny County Department of Human Services, Office of Behavioral Health

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Section One: Child Strengths

This section focuses on the attributes, traits, talents and skills of the child that can be useful in developing a strength-based treatment plan. Within a systems of care approach identifying strengths is considered an essential part of the process (Miles, P., Burns, E.J., Osher, T.W., Walker, J.S., 2006). A focus on strengths that both the child and the family have to offer allows for a climate of hope and optimism and has been proven to engage families at a higher level. Strength-based assessment has been defined as, "the measurement of those emotional and behavioral skills, competencies, and characteristics that create a sense of personal accomplishment; contribute to satisfying relationships with family members, peers, and adults; enhance one's ability to deal with adversity and stress; and promote one's personal, social, and academic development" (Epstein & Sharma, 1998, p.3). The benefits of a strength-based assessment include involving parents and children in a service planning experience that builds on what a child and family are doing well, facilitates positive expectations for the child, and empowers family members to take responsibility for the decisions that will affect their child (Johnson & Friedman, 1991; Saleebey, 1992).

When assessing strengths it is useful to first determine if the strength is present and then make the assessment to what degree it is present. If a strength is described and/or observed as being fully developed and it does not appear that any interventions need to occur to make this area stronger it is most likely a "O" or centerpiece strength. If a strength is well developed but could be developed more fully; then the appropriate ranking is a "1". A "2" is indicated by an area that needs to be developed and a "3" is an area in which there is not a strength present.

1. Family Relationships

The family that the child resides within 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. The items further in the assessment, Parent Child Interaction and Attachment, are closely related but there are differentiations. 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. 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.

Table 1. **Observations of Positive/Negative Parent and Sibling Relationships**

Positive Parent/Child Relationships	**Negative Parent/Child Relationships**	**Positive Sibling Relationships**	**Negative 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 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 Expectation to Have Needs 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	• 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

As indicated earlier the assessment of items takes place within the activities of questioning parents and children (as appropriate to age), observation of the child, observation of the parent, observation of the child/parent dyad, and analysis of information received from chart review and others providing information. Others may include extended family, teachers, clinicians, referral source or alternate caregivers. Along with the suggested questions listed in the manual 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 Table 1 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. 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. 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 the developmental considerations. As an infant grows older they move from fleeting eye contact and frequent distractions in this task 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, or at worst does the parent or child report physical or sexual abuse.

The following grid may be of assistance in making determination of the appropriate rating of this item:

Check	Family Relationships
0	Strong: The relationship between the child and family members is **consistently** positive in nature and serves to support the child's development.
1	Good: The relationship between the child and family members is overall positive but there are times when it is strained or needs improvement in some way.
2	Potential: The relationship between the child and family members is positive at times but is in need of improvement in order for it to be the basis of a strength-based plan.
3	Not Present: The relationship between the child and family members is not an area of strength.

2. Extended Family Relationships

Extended family relationships can be of tremendous value to a child because of the support that this gives their primary caregiver as well as the child's own valuable experience of a synchronous and positive relationship with another adult figure. The level of support given to caregivers is critical to consider because this 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). When making determinations regarding the quality of these types of supports the following considerations should be made: Is the support requested or are the extended family members intrusive or insistent, does the support build up the parents' sense of competence or undermine the evolving identity and abilities as a parent, does the support sabotage the parents decisions or wishes in any way, does the support serve to complement or build up the parent/child relationship rather than compete with it. See Table 2.

Table 2.

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 in making the determination of the benefit of these 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
- The child's experiences with extended family member do not contradict rules, values or expectations that caregiver considers important
- The experiences with the extended family member are consistent and predictable

When considering the appropriate rating for this item it may be helpful to use the above assessment recommendations and the following grid to assist in the determination.

Check	Extended Family Relationships
0	Strong: 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	Good: 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	Potential: 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	Not Present: 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.

3. Interpersonal

The infant or child's capacity to relate to others in a positive manner is a capacity that can be of great benefit in numerous ways. Children that are perceived by others as pleasant to associate with usually are blessed with 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. The National Research Council and Institute of Medicine authored a book, *From Neurons to Neighborhoods:*

the Science of Early Childhood Development in 2000 and included as one of their core concepts the notion 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 in stating that "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 (p. 54). Not only do youth that are inept 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.

Table 3.

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

See the following grid for scoring guidance.

Check	Interpersonal
0	Strong: The child consistently demonstrates strong interpersonal skills. The child has well developed skills in initiating and maintaining relationships with others.
1	Good: The child demonstrates good interpersonal skills much of the time. The child may need support and encouragement to demonstrate these skills.
2	Potential: The child has some interpersonal skills that could be developed more fully. The child may respond to well known adults but not initiate such actions.
3	Not Present: The child does not demonstrate interpersonal strengths.

4. Relationship Permanence

This item refers to the presence or absence of ongoing relationships with biological parents and significant others such as family, friends and community members. Due to the primary importance that both the maternal and paternal relationship holds for children this item reflects an appreciation of this concept. The paternal relationship is often characterized as less involved in care-giving than the maternal relationship and more playful and physical in nature. These experiences have been studied to promote assertiveness and participation in organized physical activities (Palm, 1997). The maternal relationship is characterized as more nurturing and promotes increased socialization. Due to the importance of both parenting experiences this item conceptualizes the ideal experience for children as experiencing an ongoing relationship with both biological parents. This item does not consider the quality of these relationships. The following grid may be of assistance in considering the appropriate rating.

Check	Relationship Permanence
0	Strong: The child has experienced very stable relationships with both parents and significant others such as friends and community members.
1	Good: The child has experienced stable relationships although there may be some concern about disruption in the near future or a relationship with only one parent has been stable.
2	Potential: The child has experienced some instability due to such factors as divorce, death, removal or moving.
3	Not Present: The child does not have any stability in relationships such as a child in congregate care or a child that has experienced numerous moves throughout his lifetime.

5. Curiosity

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.

Table 4. Developmental Benefits of Curiosity in Children

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

To determine the level of curiosity present in a child it is important to note again that this characteristic is considered by some temperament researchers as reflective of temperament. This means that the characteristic is considered a stable and persistent component of personality that while it can be mediated by environmental factors is the child's overall tendency. Assessment occurs by discussion with the caregiver(s) and child depending on age as well as observation of behavior. The following list of observations or descriptions of behavior will assist in identifying curiosity as an area of strength.

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

Infants

- 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

Toddlers

- 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

Preschoolers/School Age Children

- 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
- Can Relate Others Likes and Dislikes

The following grid offers scoring guidance.

Check	Curiosity
0	Strong: The child consistently demonstrates curiosity and takes action to explore their environment.
1	Good: The child demonstrates curiosity much of the time and will take action to explore their environment some of the time.
2	Potential: The child with encouragement will explore and demonstrate interest in novelty or change.
3	Not Present: The child does not demonstrate curiosity or exploration of his/her environment.

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6. Playfulness

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.

Table 5. Developmental Benefits Facilitated By Play

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 Spacial 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.

Adapted from *The American Academy of Child and Adolescent Psychiatry Practice Parameters for the Psychiatric Assessment of Infants and Toddlers (1997).*

Check	Playfulness
0	Strong: The child consistently demonstrates the ability to make use of play to further their development. Their play is consistently developmentally appropriate, spontaneous, self-initiated and enjoyable.
1	Good: The child demonstrates play that is developmentally appropriate, self-initiated, spontaneous and enjoyable much of the time. Child needs some assistance making full use of play.
2	Potential: The child demonstrates the ability to enjoy play and use it to support their development some of the time or with the support of a caregiver. Even with this in place there does not appear to be investment and enjoyment in the child.
3	Not Present: The child does not demonstrate the ability to play in a developmentally appropriate or quality manner.

7. **Creativity/Imagination** (for toddlers and preschool/school age children only)

Toddlers, Preschoolers and School Age Children may exhibit the characteristic of creativity/imagination in varying ways and to different degrees. Creativity reflects the ability to think "out of the box". Children that demonstrate this ability are able to accept explanations, solutions and alternatives to problems. This allows them to accept changes more easily and therefore cope with challenging situations more successfully. This will also result in expanding play sequences as well as developing opportunities to play when other children would be limited in this capacity. When a child is rigid in their thinking this makes them more challenging to discipline, socialize and interact with. Rigid thinking is as frustrating for the individual as the parent/caregiver due to the

inability to control changes and life events. Creativity/Imagination is often manifested in artistic, musical and literary abilities as well as skills in the dramatic arts. This again, demonstrates a child's interest to think broadly and express their ideas, feelings and experiences. The emotional benefit is often anxiety reducing and compliments verbal methods of processing feelings. Some children that are challenged in their ability to process their feelings verbally can compensate for this through using creative means.

Manifestations of Creativity in Toddlers and Preschoolers/School Age Children

Toddlers

- Explores Art and Music
- Pretends with Objects
- Develops Pretend Play without Objects
- Develops Pretend Play with Other Inanimate Objects (ie. Dolls)
- Tells Stories
- Has Imaginary Friends
- Develops Ability to Use Objects in Alternative Ways (block can be a phone)

Preschoolers/School Age

- Finds Enjoyment in Drawing and Creating
- Offers Interpretations of Artwork Reflecting Feelings and Experiences
- Can Play Independently for Extended Periods of Time
- Enjoys Music and Sings Songs about Life Experiences
- Enjoys Dress Up Activities
- Tells Detailed Stories
- Greater Capacity for the Abstract

Check	Creativity
0	Strong: The child consistently demonstrates a significant level of creativity. This appears interwoven into their normal routines and chosen activities.
1	Good: The child demonstrates a moderate level of creativity 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	Potential: The child shows a mild level of ability in this area. Parents and caregivers need to be the primary support in this area.
3	Not Present: The child does not demonstrate creativity.

8. Special Skills/Talents (for toddlers and preschool/school-age children only)

The presence of special skills or talents has been a characteristic of resilient children noted in several longitudinal studies (Werner, 1990). A child that demonstrates capacity in this area can focus their time, attention and skills in a manner that is both enjoyable and supportive of their growth and development. A child that spends time demonstrating a special skill is often encouraged by both peers and adults in a way that develops self concept and self esteem. A talent that is truly of benefit to a child is enjoyable and not imposed on them by adults. A child should demonstrate their own initiative to participate in this activity. This is manifested by the child initiating the activity, conversing about the activity and planning for continuation of the activity. This certainly can be supported by the adults in their life but to fully be of use to the child it should be their own investment. As Howard Gardner has described the concept of multiple intelligences this can be used to identify areas in which a child may have special skills or talent.

Linguistic Intelligence "Word Smart"	Skills in speaking, writing, understanding meaning of words, debating, and explaining concepts or their point of view. May be interested in drama, journaling, or writing stories.
Musical Intelligence	Skills in playing instruments, recognizing songs and patterns/rhythms, or singing.
Interpersonal Intelligence	Skills in listening, responding with empathy, awareness of other's feelings, awareness of social cues, forming relationships with peers and adults.
Intrapersonal Intelligence	Skills in being aware of own feelings, strengths and weaknesses. Develops within a caring, nurturing relationship with caregivers.
Visual Spatial Intelligence	Skills in puzzle building, legos, construction toys, copying designs, sense of direction.
Logical/Mathematical Intelligence	Skills in sorting and classifying, sequencing, understanding number concepts, understanding shapes.
Bodily/Kinesthetic Intelligence	Skills in physical coordination, sports, hands on tasks, crafts, and expressing feelings through the body.

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Check	Special Skills/Talents
0	Strong: The child consistently demonstrates a significant level of ability and interest in a special skill or talent that is supportive of their growth and development. This can be used to mediate challenges in other areas.
1	Good: The child demonstrates a moderate level of ability and interest in a special skill or talent that is supportive of their growth and development. It has strong potential but could be further developed.
2	Potential: The child shows a mild level of ability in a special skill or talent. Parents and caregivers may be more invested in this that the child or it needs considerable development to make it a centerpiece strength.
3	Not Present: The child does not demonstrate a special skill or talent.

9. Adaptability

A child's ability to adjust to changes in their routine or environment, known as adaptability, is considered one of the original nine temperament characteristics as defined by Chess and Thomas (1959). Temperament characteristics are defined by Chess and Thomas as "the style in which a person does what he or she does" Children that are adaptable are flexible, tolerant of changes and transitions, not bothered intrusions and "go with the flow". The characteristic of adaptability is protective for children for a number of reasons. Children that are exposed to high-risk environments are often challenged with multiple stressors, caregivers, and changes in their routine. The ability to cope with such affords them a greater amount of energy to focus on growth and development. Children that are less adaptable often evoke negative reactions from caregivers, authority figures as well as peers due to their increased neediness and changes in behavior. Parents that experience their children as flexible and less demanding overall tend to be more responsive and consistent in their reactions. Parents who are experiencing their own stressors, health or mental health problems typically have less patience to offer their children and are easily overwhelmed.

Manifestations of Adaptability in Infants and Toddlers

- Easily Falls Asleep and Remains Asleep
- Changes in Routine Minimally Disrupts Sleep
- Accepts New Foods Easily
- Eats a Variety of Foods
- Accepts Diapering, Dressing and Bathing Tasks Without Resistance
- Accepts Changes in Day Care Providers or Introduction of Additional Children
- Accepts Separations

Manifestations of Adaptability in Preschoolers/School Age Children

- Transitions from Wake to Sleep State Easily
- Sleep Cycle Remains Unaffected by Changes
- Eats a Variety of Foods and Will Try New Foods
- Accepts Control from Caregivers/Teachers
- Is Not Excessively Needy
- Follows Instructions Easily
- Can "Switch Gears" Easily
- Makes Friends Easily
- Tries New Activities

Check	Adaptability
0	Strong: The child consistently has a strong ability to adjust to changes and transitions. This supports further growth and development and be incorporated into a service plan as a centerpiece strength.
1	Good: The 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	Potential: The child shows a mild level of ability in this area. Parents and caregivers need to be the primary support in this area.
3	Not Present: The child does not demonstrate adaptability.

10. Persistence

Persistence refers to the ability to continue an activity that is difficult or unappealing. A persistent child is one that is very focused and motivated. Persistence is another one of the original temperament characteristics described by Thomas and Chess. This characteristic supports the acquisition of new developmental abilities. In children that are challenged by health or developmental disabilities this characteristic can prove to be essential to their well-being. Children that manifest this characteristic show the ability to face challenges physically and emotionally in a more competent fashion.

Manifestations of Persistence in Infants/Toddlers

- Attempts Tasks Related to Motor Development Over and Over Until Mastery Occurs
- Will Persist in Attempting Tasks Independent of Parents
- Plays Alone Well
- Does not Cry or Whine Easily
- Good Attention Span
- Sleeps Well

Manifestations of Persistence in Preschool/School Age Children

- Attempts Difficult Tasks
- Keeps Focused and On Track
- Motivated Internally
- Appears Stubborn
- Slow to Disengage from Activity or Task
- Does Not Quit Team Sports or Play
- Identified as a Perfectionist
- Accepts Challenges

Check	Persistence
0	Strong: 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	Good: The child demonstrates some ability to continue an activity that is challenging. Adults can a assist a child to continue a task or activity.
2	Potential: 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	Not Present: The child does not demonstrate persistence.

11. **Self Esteem/Self Confidence** (for toddlers and preschool/school-age only)

Self Esteem/Self Confidence refers to the child's belief that they are worthwhile, competent and able to succeed. It is hard to imagine how this would not be considered an essential characteristic for a child to have. A child is constantly exposed to new tasks, changes and challenges that are tolerated by this core belief. A child that does not reflect a strong sense of self is handicapped in numerous ways. Children will not typically attempt or sustain in new activities or tasks nor will they achieve to the same capacity without self esteem. Self esteem often is further developed as a child experiences making friends, achieves developmental milestones, and learns new skills, experiences love and support, experiences encouragement for effort, and feels valued. A positive self esteem is associated with positive mental health, academic achievement, good behavior and frustration tolerance. Poor self esteem is more often associated with negative behavior, frustration intolerance, poor academic achievement, social withdrawal and poor peer relations.

Manifestations of Strong Self Esteem

- Child Accepts Compliments
- Child Points Out Successes
- Child Tries Difficult Tasks
- Child Socializes Well with Peers
- Child Accepts Correction
- Child Gives Others Compliments

Check	Self Esteem
0	Strong: The child consistently demonstrates a significant level of self esteem/self confidence. This consistently supports the child in their development and functioning.
1	Good: The child demonstrates a moderate level of self esteem/self confidence that is of benefit to the child. This area could be further developed to consider it a centerpiece strength.
2	Potential: The child shows a mild level of ability in this area. Parents and caregivers are the main supporters of the child in this area and the child needs continued development for this to be a significant strength.
3	Not Present: The child does not demonstrate self esteem/self confidence.

Section Two: Functioning

This section focuses primarily on the various developmental domains and functioning of the child in a variety of settings including the home, school and community.

12. Motor

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. The following reference is from Landy, S. (2002). *Pathways to competence: Encouraging healthy social and emotional development in young children* (pp. 12-27). Baltimore: Paul H. Brookes Publishing Co.

By 3 Months (Gross Motor)

- 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

By 3 Months (Fine Motor)

- 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 (Gross Motor)

- 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

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By 7 Months (Fine Motor)

- 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 (Gross Motor)

- 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

By 14 Months (Fine Motor)

- 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 (Gross Motor)

- 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

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By 2 years (Fine Motor)

- Copies circles and lines
- Stacks six blocks
- Puts pieces in puzzles
- Nest objects
- Puts tiny object in small container
- Folds paper in half
- Strings beads
- Opens doors by turning doorknob
- Enjoys pouring and filling

By 4 Years (Gross Motor)

- Throws ball overhand
- Skips Walks on tiptoes
- Stands on one foot
- Balances on walking board or plank
- Walks in straight line
- Enjoys throwing and catching games
- Jumps over object 5 or 6 inches high
- Pedals and steers a tricycle or other wheeled object
- Climbs stairs using alternating feet
- Climbs on playground equipment

By 4 Years (Fine Motor)

- Can screw things on such as lids on jars
- Builds tower of 10 or more blocks
- Inserts pieces in puzzle
- Threads wooden beads on a string
- Cuts with scissors
- Paints with large brush
- Manipulates clay
- Draws person with three parts
- Folds paper
- Copies shapes and letters

By 6 Years and Early School Age (Gross Motor)

- Enjoys running, jumping, climbing and throwing
- Skips with rope
- Skips with alternating feet
- Hops distance of 50 feet
- Climbs, slides, swings
- Is learning to swim

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- Swings a bat
- Is learning to ride a bike and kick a ball

By 6 Years and Early School Age (Fine Motor)

- Can draw a person
- Uses scissors skillfully
- Folds and cuts out simple shapes
- Can write letters
- Holds brush or pencil between thumb and forefinger
- Likes to paint
- Favors right or left hand consistently
- Traces around hand or other objects
- Cuts and pastes
- Prints name

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 typically coordination 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. See the following scoring grid.

Check	Motor
0	No action needed: No evidence of fine or gross motor problems.
1	Let's watch/monitor: There is either a history of fine or gross motor problems or slow development in either or both areas.
2	Help is needed: The child has delays in either or both fine and gross motor development or challenges in the aspects of motor development related to strength, coordination, tone, or motor planning.
3	Help is needed now/immediately: The child has significant challenges in either fine or gross motor development or the related areas of strength, coordination, tone or motor planning.

13. Sensory

This area refers to a child's ability to fully utilize the senses of sight, taste, touch, sound and smell as well as their ability to monitor their reactivity to these experiences. According to Stanley Greenspan (1985) one of the child's major tasks during the first three months of life is to learn to take in sensory information while remaining calm and organized. When this is poorly developed an infant or young child can do little more than attempt to cope with the sensory experience. This results in an interference in other areas of development as well as in their capacity to develop and make use of social relationships. This often causes parents to feel poorly able to meet the needs of their child and in some cases results in a disturbance in the attachment relationship. In the DC 0-3R there are descriptors of how children with sensory processing challenges may react to these types of experiences.

In the assessment of the infant's ability to react to sound it is helpful to be aware of how this develops. An infant from 0-1 month will begin to evidence an awareness of sounds that is seen in their pausing their breathing, a startle reaction, change in expression, their body tensing, or eyes widening. These are more primitive reactions and further develop as an infant matures. Into the second and third months of life, an infant shows the capacity to respond to a voice and then search with their eyes for sounds. By the end of the first year they should be able to localize sounds that are hidden, come from below them and later from above them. It is helpful to use these benchmarks when asking parents to tell you how they determine if their child is able to hear normally. In addition, asking parents if there has been hearing tests is important and will offer helpful information. In the assessment of the infant's ability to react to visual experiences the developmental sequence of this activity is again useful in being familiar with. The infant's abilities in this area are not fully developed for quite sometime after birth. Initially, within the first month, it is considered on track for an infant to respond to a brightly colored object approximately 8-10 inches away from them. Their response may only be brief, lasting 2-3 seconds. As their vision further develops the infant is later able to follow a person moving toward them and then an object moving in the midline or from side to side. By the end of three months, an

infant should be able to follow an object downward and then upward. It is helpful to also ask parents if any vision screenings have occurred. The following listings will give some guidance regarding sensory reactivity as described in the *Diagnostic Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood: Revised Edition*, Zero to Three (2005).

Indications of Overreactivity to Sensory Stimulation

- Fearfulness
- Crying
- "Freezing"
- Trying to get away from stimulus
- Increased distractibility
- Aggression
- Excessive Startle reaction
- Motoric agitation
- Restricted tolerance for variety in food textures, tastes and smells

Indications of Underreactivity to Sensory Stimulation

- Lack of response
- Ignores social interactions or encouragement
- Withdrawal from stimuli
- Inattentiveness
- Fatigability
- Apathetic appearance

Check	Sensory
0	No action needed: No evidence of sensory problems.
1	Let's watch/monitor: There is either a history of sensory problems or suboptimal functioning in this area.
2	Help is needed: The child has challenges in either sensory abilities or processing.
3	Help is needed now/immediately: The child has significant challenges in either sensory abilities or sensory processing.

14. Developmental/Intellectual

This area of development is important to assess due to its impact on all other areas of development. A child that is impaired in their cognitive functioning will demonstrate

limitations in other areas of development especially their language development and self-help skills. This is an area in which early intervention is critical.

The following reference is from Landy, S. (2002). *Pathways to competence: Encouraging healthy social and emotional development in young children* (pp. 12-27). Baltimore: Paul H. Brookes Publishing Co.

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

By 6 Years and Early School Age

- Knows colors, shapes, and sizes
- Writes numbers up to 5
- Understands number concepts
- Begins to understand concept of conservation (e.g., that short and wide and tall and narrow may hold same amount)
- Enjoys games with rules
- Understands *left* and *right*
- Compares *bigger* and *smaller, part* and *whole*
- Understands *today*, *tomorrow,* and *yesterday*
- Recognizes seasons and major holidays

Check	Developmental/Intellectual
0	No action needed: No evidence of developmental/intellectual problems.
1	Let's watch/monitor: There is either a history of developmental/intellectual problems or slow development in this area.
2	Help is needed: The child does not meet developmental milestones related to development/intellectual functioning.
3	Help is needed now/immediately: The child has significant challenges in developmental/intellectual functioning.

15. Communication

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.

The following reference is from Landy, S. (2002). *Pathways to competence: Encouraging healthy social and emotional development in young children* (pp. 12-27). Baltimore: Paul H. Brookes Publishing Co.

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

By 6 Years and Early School Age

- Has vocabulary of 10,000 -14,000 words
- Constantly asks questions
- Uses fluent speech that is grammatically correct
- Knows birthday and name and address
- Memorizes songs and television jingles
- Uses plurals, tenses, and questions
- May recognize more words
- Likes "bathroom talk"
- Likes telling jokes and riddles

Check	Communication
0	No action needed: No evidence of receptive or expressive language problems.
1	Let's watch/monitor: There is either a history of receptive or expressive language problems or slow development in either or both areas.
2	Help is needed: The child has delays in either or both receptive or expressive language development.
3	Help is needed now/immediately: The child has significant challenges in either receptive or expressive language development.

16. Medical/Physical

This area encompasses both any medical conditions as well as the child's general physical 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 not causing problems in their functioning. A child's nutritional and physical condition should be considered in this rating as well. A child may not have a medical condition but appears tired, reports feeling badly or misses school frequently. This would be considered in this item as well. See the following grid for assistance in rating.

Check	Medical/Physical
0	No action needed: No evidence of medical or physical problems.
1	Let's watch/monitor: There is either a history of medical or physical problems or some medical issues that require medical treatment. These issues do not interfere with functioning.
2	Help is needed: The child has a medical or physical challenge that requires ongoing medical intervention and is interfering with functioning.
3	Help is needed now/immediately: The child has significant challenges either medically or physically that may be life threatening or seriously impairing functioning.

17. Family

This item assesses how the family as a whole interacts and supports one another. In assessing this item we are not focused solely on the interaction of the child with members of the family but as the family as a whole. The family functioning is critical to the experience of the child due to the potential impact this has on the child. A family environment that is stressful and characterized by poor relationships can produce high levels of the stress hormone, cortisol in a child. The ongoing presence of cortisol in the bloodstream can have lasting effects such as hypervigilance, increased sensitivity to others, and what some refer to as "addiction to chaos". This "addiction" is manifested in children creating chaos and not feeling comfortable with routine or novelty. The family relationships also become a guide for a child in determining how relationships should work. A child that is exposed to negative relationships begins to believe that these characteristics are normal and may begin to imitate these characteristics. A family that is supportive of one another lays the foundation for a child to experience success in other relationships, support for school success, positive self-esteem and skills in developing empathy and caring. It is helpful to observe and question the types of activities the family is involved in, 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.

Check	Family
0	No action needed: No evidence of family functioning problems.
1	Let's watch/monitor: There is either a history of family functioning problems or indications that functioning is not optimal.
2	Help is needed: The family functioning is in need of help. Some or all of the members do not feel supported or comfortable within the family system.
3	Help is needed now/immediately: The family functioning is in need of significant help in that one or all of the family members may feel unsafe or endangered emotionally or physically.

18. Social/Emotional

This item is important to assess due to how significantly it relates to all other areas of development. A child that is struggling in their capacity to relate to their parents, caregivers and peers will also struggle in their ability to find support for the other areas of development. The importance of the parent/child relationship and the child's capacity to socialize and regulate their emotions 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.

The following reference is from Landy, S. (2002). *Pathways to competence: Encouraging healthy social and emotional development in young children* (pp. 12-27). Baltimore: Paul H. Brookes Publishing Co.

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 Peekaboo
- 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 her or she cannot meet standards
- Labels of 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

By 6 Years or Early School Age

- Still has difficulty with mixed emotions
- Shows some understanding of pride, gratitude, shame, worry and jealousy
- Shows pride in work
- Uses private speech to calm down
- Is anxious to please and follow the rules
- Can be upset by something that is "not right"
- Hates to be corrected
- May develop fears of such things as the dark, storms and dogs
- Usually plays with same-sex children and gender specific toys
- Understands views of others and shows prosocial behavior
- Sharing with others is common
- Has a best friend
- Engages in complex social pretend play

Check	Social/Emotional
0	No action needed: No evidence of social or emotional problems.
1	Let's watch/monitor: There is either a history of social or emotional problems or suboptimal functioning in one or both areas.
2	Help is needed: The child does not meet developmental milestones related to social or emotional functioning and experiences problems in functioning in one or both areas.
3	Help is needed now/immediately: The child has significant challenges in either social or emotional functioning that causes significant impairment in functioning in one or more life domains.

19. Self Care/Daily Living Skills

Self Care/Daily Living Skills refers to a number of tasks that reflect a child's growing ability to take care of their own physical needs and to become responsible for dressing, doing household chores, eating, toileting, and preparing for sleeping. Self Care/Daily Living Skills are often reflective of cognitive ability. This is important to assess and monitor due to the limitations that this places on children when it is suboptimal. Children are at times excluded from some environments if skills in this area are not present. This area if underdeveloped causes challenges in parenting that are often overwhelming.

The following reference is from Landy, S. (2002). *Pathways to competence: Encouraging healthy social and emotional development in young children* (pp. 12-27). Baltimore: Paul H. Brookes Publishing Co.

By 3 Months

- Explores environment by looking around
- Opens mouth to touch of nipple or bottle
- Sucks well
- Enjoys being bathed

By 7 Months

- Places hands on bottle or breast during feeding
- Enjoys making things happen such as squeezing a toy to make a noise
- Can pick up objects

By 14 Months

- Sips from a cup with assistance
- May begin to use a spoon
- Can ask for a drink by pointing or gesturing
- Can feed self with finger foods
- Interested in pulling off clothes
- Removes food from spoon with tongue

By 2 Years

- Uses cup with minimal spilling
- Puts on shoes, socks and shorts
- Can use spoon to feed him or herself
- May tell parent when "wet" and may begin to indicate need to use potty
- Cooperates in dressing
- Unbuttons large buttons; unzips large zippers

By 4 Years

- Can dress and undress fully
- Can do up buttons
- Can feed self with little spilling
- Can pour from jug into cup
- Is toilet trained, may stay dry at night
- Uses fork effectively

By 6 Years and Early School Age

- Combs/brushes hair
- Blows nose independently
- Washes face and hands
- Hangs up clothes
- Cuts with knife
- Takes care of toileting tasks independently
- Ties own shoes

The development of taking responsibility for household tasks is also related to development and typical milestones may include the following:

By One Year: A one year old may show interest in imitating household tasks such as sweeping, dusting or vacuuming but is far from able to complete these task alone.

By Two Years: A child of this age is will often assist in simple clean up tasks as long as the task is modeled for them and they can physically accomplish the task. Their attention span is limited at this age and there will be a need for consistent support and direction.

By Three Years: A child will be able to complete simple chores such as setting a table, feeding a pet, or cleaning spills independently if supervised by an adult.

By Four Years: A child will be able to complete many simple chores that start to involve more than one step such as sorting and folding clothes. They can understand and adhere to routine and daily tasks with support and reminding.

By Five Years and Early School Age: A child will begin to follow through with simple routines without ongoing monitoring by an adult.

Check	Self Care/Daily Living Skills
0	No action needed: No evidence of self care/daily living skills.
1	Let's watch/monitor: There is either a history of self care/daily living skill problems or slow development in this area.
2	Help is needed: The child does not meet developmental milestones related to self care/daily living skills and experiences problems in functioning in this area.
3	Help is needed now/immediately: The child has significant challenges in self care/daily living and is in need of intensive or immediate help in this area.

20. Parent/Child Interaction

The way in which a parent/child dyad interacts is a critical area to assess and intervene in if necessary. Perhaps, there is nothing that has more impact on a child than the way that their parent interacts with them. The parent/child interaction that is supportive allows for the child to focus fully on growth and development. It is the foundation for the development of all other social relationships and guides and supports all areas of development. This concept is outlined in the book, *Infant Mental Health Services: Supporting Competencies/Reducing Risks* by Deborah Weatherson and Betty Tableman as one of the basic principles of the infant mental health perspective in the statement that "an impaired or dyssynchronous relationship, or disruption through an extended separation can compromise physical and emotional well-being, impair the ability to trust and relate to others, promote withdrawn or impulsive acting out behavior, delay language development, and constrain the capacity to explore and to learn." The following list will highlight important areas to consider in observing parent/child interaction.

Assessment of the Parent/Child Interaction

- What is the predominant emotional tone of the interaction

- Does the parent/child demonstrate good eye contact and communication
- What is the balance of positive to negative interactions
- What are the typical routines and activities of the parent/child
- Does the dyad seem comfortable and interested in one another
- Do the interactions seem smooth and synchronous
- Does the dyad respond to each other's cues
- Does the parent allow the child to lead play interactions
- Does the parent and child demonstrate nurturing touch and behaviors toward one another
- How does the child respond to limit setting
- Does the dyad demonstrate appropriate boundaries and expectations of one another
- Does the parent comfort the child when the child is hurt or upset
- Can the parent accept the child's display of feelings even negative ones
- Does the parent support the child in exploration

Check	Parent/Child Interaction
0	No action needed: No evidence of problems in the parent/child interaction.
1	Let's watch/monitor: There is either a history of problems or suboptimal functioning in parent/child interaction. There may be inconsistent or indications that interaction is not optimal that has not yet resulted in problems.
2	Help is needed: The parent/child dyad interacts in a way that is problematic and has led to interference with the child's growth and development.
3	Help is needed now/immediately: The parent/child dyad is having significant problems that can be characterized as abusive or neglectful.

21. Early Care/Education Settings

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. Many child advocates such as Stanley Greenspan have devoted a great deal of time promoting these concepts. 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 ways that the parent or child can indicate that the child's uniqueness is being accepted and embraced.

Indicators of an Appropriate Early Care/Education Setting

- 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

This item also considers the presence of problems within these environments in terms of attendance, academic performance and support and behavioral response to these environments. If any of these areas are problematic than the item would be rated a "2".

Check	Early Care/Education Settings
0	No action needed: No evidence problems within an early care/day care environment.
1	Let's watch/monitor: 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	Help is needed: The child demonstrates problems related to their social or emotional functioning, attendance, or behavior in an early care/education setting.
3	Help is needed now/immediately: The child has significant challenges within an early care/education setting such that harm to the child is imminent or present.

22. Social Behavior

Social behavior refers to the child's behavior within a social setting that may or may not need sanctioning on an adult's part. A child that is unable to function appropriately in a social setting often will be kept from participating in these types of activities. This may interferes with the child's opportunity to further develop in this area. Parents often relate concerns for allowing children to be in problematic social situations as harm to others, possible harm to self, lack of willingness or energy to adequately supervise and support the child's challenges, and embarrassment of parents regarding behavior. In assessing whether or not there are challenges in this area the following considerations should be made: what is the parent's understanding of age appropriate behavior, what types of behaviors are present and how long lasting are they, can the child discontinue behaviors considered inappropriate with adult intervention, do the behaviors threaten either the child or others, does the child's behaviors result in parent's avoiding certain situations and does the child enjoy social situations.

Typically Developing Patterns of Social Behavior

- Infants will demonstrate voluntary efforts to initiate action with others and sustain interaction with them. Infants will change interaction patterns based on facial expressions.
- Toddlers will use the reactions of their primary caregivers to guide their own reactions (social referencing). Toddlers can comply with simple directions and restrictions.
- Preschoolers will generally cooperate with caregivers and need less ongoing support and guidance to maintain control in social setting. They are able to remember rules and have internalized basic standards of behavior.
- Early School age children are able to regulate their actions through discussion. They have internalized standards of behavior and rely less on others to enforce basic standards. They are capable of judging their own behavior and behavior others.

Check	Social Behavior
0	No action needed: No evidence of problems in social behavior.
1	Let's watch/monitor: There is either a history of problems in social behavior or issues developing that need monitoring.
2	Help is needed: The child is displaying problems in social behavior that result in the need for adult sanctioning and/or avoidance of these situations.
3	Help is needed now/immediately: The child has such significant challenges in social behavior that the family and child is in need of intensive assistance in this area due to threat to the child's development and family functioning.

Section Three: Challenges

This section of the CANS focuses on identifying your child's social/emotional or behavioral challenges. Again, please think about *the last month (30 days)* when describing your child's needs or behaviors. Please let us know the areas in which you would like help or support.

23. Attachment

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. Levy (1998) summarizes these benefits as promoting positive development in self esteem, independence and autonomy, impulse control, conscience development, long-term friendships, prosocial coping skills, relationships with caregivers and adults, trust, intimacy and affection, empathy, compassion, behavioral and academic performance and the ability to form secure attachment with their own children when they become adults.

Signs of Attachment Disturbance in Young Children

- 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

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24. Failure to Thrive

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, 1993). 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

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

Adapted from *Infant Mental Health: A Psychotherapeutic Model of Intervention* by Michael Trout

Check	Failure to Thrive
0	No action needed: No evidence of problems weight gain or growth.
1	Let's watch/monitor: There is either a history of failure to thrive or slow growth or weight gain.
2	Help is needed: The child is determined to have inadequate growth or weight

	gain.
3	Help is needed now/immediately: The child has such significant challenges in either growth or weight gain that the child's health may be at risk.

25. Anxiety

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 worse 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)* states that all of the following criteria must be present to consider an anxiety disorder been 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

Clinical Manifestations of Anxiety

- 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 complaints

Check	Anxiety
0	No action needed: No evidence of anxiety.
1	Let's watch/monitor: There is either a history of anxiety or some indication that anxiety may be emerging.
2	Help is needed: The child evidences signs of anxiety.
3	Help is needed now/immediately: The child has significant challenges in the management of anxiety such that a threat to their development and well-being is present.

26. Adjustment to Trauma

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

- 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 this to their benefit in the face of trauma. If a child is challenged in this capacity a 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 it's ability to alter fundamental neuro-chemical processes which in turn affect the growth, structure and functioning in the brain. 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 this is not present. A child may need the opportunity to process what occurred with an adult and 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. The *Diagnostic Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood: Revised Edition (DC: 0-3R)* 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 reenactment.

Check	Adjustment to Trauma
0	No action needed: No evidence of adjustment to trauma.
1	Let's watch/monitor: The child has experienced a traumatic event and is not demonstrating symptoms or there are mild changes in a child's behavior that are controlled by caregivers.
2	Help is needed: The child evidences signs of adjustment problems associated with traumatic life events. Adjustment is interfering with child's functioning in at least one life domain. Infants may have developmental regression, and eating or sleeping disturbance. Older children may have all of the above as well as behavioral symptoms, tantrums and withdrawn behavior.
3	Help is needed now/immediately: The child has significant challenges in adjusting to trauma and it may be nearly impossible to function in any life area.

27. Oppositional Behavior (preschoolers/school-age only)

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 is not a factor in the rating. Although a child may be experiencing ineffective parenting to explain oppositional behavior, it is still 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 to adult requests
- Temper tantrums
- Often loses temper
- Often argues with adults
- Is often angry or vindictive
- Blames others for mistakes
- Annoys or provokes others

Check	Oppositional Behavior
0	No action needed: No evidence of oppositional behavior.
1	Let's watch/monitor: There is either a history of oppositional behavior or mild concerns in this area that have not yet interfered with functioning.
2	Help is needed: There is clear evidence of oppositional behavior towards authority figures, behavior is persistent and caregiver's attempts to change behavior have not been successful.
3	Help is needed now/immediately: The child has significant challenges in this area that is characterized as a dangerous level of oppositional 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.

28. Aggression (toddlers and preschoolers/school-age only)

Aggression is often the reason parents seek assistance for young children and therefore this item was included in the early childhood versions. In research conducted by Carolyn Webster-Stratton (2003) it was determined that the need to intervene early with childhood aggressive problems is critical. She concluded that "by intervening early, the trajectory of early conduct problems leading to adolescent delinquency and adult antisocial behaviour may be corrected". 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 item.

Check	Aggressive Behavior
0	No action needed: No evidence of aggressive behavior.
1	Let's watch/monitor: There is either a history of aggressive behavior or mild concerns in this area that have not yet interfered with functioning.
2	Help is needed: There is clear evidence of aggressive behavior towards others, behavior is persistent and caregiver's attempts to change behavior have not been successful.
3	Help is needed now/immediately: 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.

29. Depression

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. 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. 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*. 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: 1. The disturbed affect and pattern of behavior should represent a change from the child's baseline mood and behavior. 2. The depressed mood or anhedonia 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. 3. Symptoms should be pervasive, occurring in more than one activity or setting and in more than one relationship. 4. Symptoms should be causing the child clear distress, impairing functioning or impeding development. 5. Disturbances are not due to a general medical condition or the direct effect of a medication or substance.

Manifestations 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 adults' 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.

Check	Depression
0	No action needed: No evidence of depression.
1	Let's watch/monitor: There is either a history of depression or some indication that depression may be emerging.
2	Help is needed: The child evidences signs of depression.
3	Help is needed now/immediately: The child has significant challenges in the management of depression such that a threat to their development and well being is present.

30. Atypical Behaviors

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 have related to pervasive developmental disorders. Early intervention to assess the etiology of these symptoms is critical.

Check	Atypical Behaviors
0	No action needed: No evidence of atypical behaviors.
1	Let's watch/monitor: There is either a history or reports of atypical behaviors that have not been observed by parents.
2	Help is needed: The child evidences signs of atypical behaviors.
3	Help is needed now/immediately: The child is noted to have atypical behaviors that are consistently present and interfere with the infant/child's functioning on a regular basis.

31. Sleep

Sleep is one of the primary reasons families seek intervention. This is often due to the impact that this has on parents, and siblings. The bed-time routine, and actual amount of time spent asleep may be of concern to parents. Infants typically sleep 14-18 hours a day. Sleep does not have a regular circadian rhythm 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 to occur intermittently. They are often present when a child is attempting to master developmental tasks. In assessing sleep concerns that 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?

Check	Sleep
0	No action needed: No evidence of sleep problems.
1	Let's watch/monitor: There is either a history of sleep problems or some indication that sleep is of concern.
2	Help is needed: There is clear evidence that sleep issues are present.
3	Help is needed now/immediately: The child has significant challenges in their sleeping routine such that it is causing interference with their growth and development.

32. Impulsivity/Hyperactivity

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 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. ADHD is considered appropriate as a diagnosis according to DSM IV-TR 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".

Check	Impulsivity/Hyperactivity
0	No action needed: No evidence of impulsive or hyperactive behavior.
1	Let's watch/monitor: There is either a history of impulsive or hyperactive behavior or a mild degree of difficulty that can be managed.
2	Help is needed: There is clear evidence that the child demonstrates impulsive or hyperactive behavior that interferes with functioning.
3	Help is needed now/immediately: The child has significant challenges in impulsive or hyperactive behavior which is detrimental to the child's health and development.

33. Attention

Attention is something that develops with age and should be considered problematic only within the framework of the child's developmental capacities. Attention is considered problematic when an infant or child cannot focus long enough to complete a task or activity. Ways in which this may be presented includes distractibility, shifting from activity to activity, not finishing tasks or rapidly shifting attention. An infant may not be able to focus for more than 5-6 seconds on a person, toy or interaction. Young children may appear to not play for periods of time that would seem normal for age, often show confusion about what is occurring, miss parts of conversations or pieces of information, and may not attend to self-care tasks.

Check	Attention
0	No action needed: No evidence of attention problems.
1	Let's watch/monitor: There is either a history of attention problems or suboptimal functioning in this area.
2	Help is needed: There is clear evidence that the child demonstrates attention

	problems that interferes with functioning.
3	Help is needed now/immediately: The child has significant challenges in attention that is causing delay or problems in development.

34. Current Environmental Stressors

This item appreciates the stress and potential risk that a child may be exposed to when community and living situations are not idea. Such situations include the presence of domestic violence, violence within the community, or unsafe school situations. All of these areas if present can be impacted or families can be assisted in problem solving ways to lessen the risk for children.

Check	Current Environmental Stressors
0	No action needed: No evidence of current environmental stressors.
1	Let's watch/monitor: There is either a history of environmental stressors or concern that these situations may emerge.
2	Help is needed: There is clear evidence that the child is exposed to current environmental stressors.
3	Help is needed now/immediately: The child is exposed to environmental stressors and is showing negative effects due to such.

Section Four: Care Intensity and Organization

This section of the CANS: EC focuses on the various types of assistance that may be needed in order to care for a child and family.

35. Service Intensity

When families experience children with specialized needs there are definitely varying degrees of support that is necessary in providing for these needs. Some families may need to provide medical care or support to their child along with transportation to a multitude of services. This item appreciates the level of strain and stress this can place on a family. Asking parents the level of treatment support or intervention the parent needs to ensure occurs in order to meet their child's needs will help determine how much support the parent may need. The amount of social support to the parent has been shown to be a critical factor in the experience of the child.

36. Funding/Eligibility

It is critical for parents and children to have access to insurance or funding of services in order for services to occur. If this is a need for the family it will need to be addressed as soon as possible. Along with this is the importance of children not being excluded from services due to eligibility criteria.

37. Transportation

Caregivers need transportation for a multitude of reasons. Families need the ability to obtain for instance, needed food, clothing, household necessities and support their children's ability to attend activities. If transportation is problematic, families may also be limited in their ability to access needed services for their child. In assessing this item it is important to not just determine if the family has transportation or can access transportation but if it is reliable, consistently available and if there are financial barriers to using the transportation.

38. Service Permanence

One of the frequent complaints that children and families have regarding services is the lack of service permanence in their experience. This refers to the lack of consistency in service providers or the experience of losing a needed service. It is often a challenge for families to establish trust and a working relationship with service providers. The assessment of service permanence therefore is critical to assess to ensure that services

are positive and that unnecessary changes do not occur. Families should be asked to reflect on the continuity, consistency of providers and if change has occurred what the time frames have been.

39. Service Coordination

One of the important aspects of systems of care principles is the need to assist the family in coordinating and integrating services to ensure a quality experience. This eliminates or assists in the duplication of services. Often times, families may be experiencing multiple service providers addressing the same or similar issues and perhaps in various ways. Especially when families are told conflicting recommendations and strategies this leaves the child and family confused and less likely to demonstrate progress. There often are fragmented delivery systems that do not provide the child and family with complimentary and synergistic efforts. This item rates the child and family's experience when a variety of needs and services are in place.

40. Service Access/Availability

When services are determined as being needed by either the family or professionals it only becomes a help to the family if the services are accessible and available. Families may experience barriers to entering into services or finding the types of services their child needs. In assessing this item considering the caregiver's experience regarding perceived or real barriers is important as well. Even if a parent perceives that a service is not available to them or that it is not what the child needs there is a problem.

41. Cultural Appropriateness of Services

Every family experiences culture in unique ways. It is important to think broadly about a family's cultural orientation not just in terms of ethnicity but also the region of the country the family comes from, socio-economic status, and how child rearing practices and beliefs are practiced. It is important for families to be offered services that are culturally sensitive and appreciative of individual differences.

Section Five: Caregiver Strengths and Needs

This section of the CANS: EC focuses on identifying your strengths and needs as the child's parent/primary caregiver. Please let us know the positive things that can be used to help build a brighter future for your child and family, as well as any areas where you would like some help.

42. Supervision

One of the core components of the parenting role is the ability to provide for the safety and security of children. Often, if this is a weakness for the parent, the child may be or has been at risk and at worse removed from their parent's care. The provision of this role for the child not only ensures the well-being of the child but supports the child in seeing the care-giving relationship as responsive to their needs. A child that is not ensured of a safe environment often develops an overall level of anxiety and insecurity about the world. In considering how well developed this area is for a parent it is helpful to listen to scenarios regarding their care-giving routine, observe the interaction and take into account reports from schools or other service providers. It is important to remember as well that the various developmental stages tax parents in terms of supervision in different ways. Some of the developmental stages require a greater level of supervision in terms of constant watching and being with a child. Other stages require knowing how to balance the child's need for exploration with their need to be restricted. Some of the important factors to consider in assessing this item are:

- How does a parent perceive their child's needs in terms of supervision?
- Has there ever been any concern regarding their supervision?
- Does this parent seem to understand their child's developmental abilities in a way that is reflected in their supervision?
- Does this parent show any ability to predict or recognize potential safety hazards?
- What interferes with a parent's capacity to provide good supervision? i.e. poor health, depression, lack of knowledge

43. Involvement with Care

This item refers to the parent's capacity to identify, advocate for and participate in the care of their child. This may be difficult to assess if the parent is new to the examiner and there is not a history to refer to. In this case, discussing the parent's values regarding their role in service provision, their comfort level in sharing viewpoints, their ability to assert themselves and their past experiences in other or similar situations will assist in the rating. This is an important component of care due to the importance of the parent being a full partner in the care of their child. It is the goal of all service

provision for the parent to be able to better meet the needs of their child in an ongoing way.

44. Knowledge

This area refers to the parent's understanding of the child's needs and abilities. This also includes their understanding of service provision, their role in the services, and how to navigate the system. The question to ask parent's in the assessment of this item is, "Is there any information that you could have regarding your child that could improve your ability to parent?" It is important not to assume that high functioning parents do not have a need for more knowledge.

45. Organization

This item refers to the parent's ability to manage the demands of maintaining and coordinating the household, keeping appointments, managing time and demands, responding to the needs of the children and knowing where needed items are kept. This directly affects the experience of the child especially as they grow into preschool and school age years and have increasing needs that may tax a parent's skills in this area. In assessing this item it is again helpful to ask the parent to relate scenarios related to this skill and reflect on their ability in this area. This also may be evaluated based on one's own experiences with this parent. A parent that demonstrates this capacity contributes to a child's security and sense of trust that needs will be met.

46. Financial Resources

This item reflects whether or not the parent is able to rely on financial resources to support the needs of their child. This does not suggest that the family that is limited in their income does not have strength in this area as they may demonstrate a strong ability to conserve their spending and stretch their resources. A family that overspends and is left with the inability to meet the financial needs of the child and family would not rate highly in this area. The focus is whether or not the family has the resources to meet the needs of the child and how well this is managed.

47. Social Resources

This item refers to the caregiver's need for support from a network of friends, community members or family members that are not paid and will be available to them. The family of young children may need this more than any other service that can be made available to them. This item looks at the presence of this being available to the caregiver and does not focus on the child's experience of these supports.

48. Housing

The importance of having stable and appropriate housing is critical in both the parent's and child's experience. There is perhaps no other environment that young children may spend more time in and the need for this to be safe and secure is significant for children. Children that do not experience this develop higher levels of anxiety and less trust in the fact that their needs will be attended to. The child that experiences multiple moves also may have challenges in developing a routine and feeling the benefits of predictability. Families may be asked to discuss their experiences in moving and any possible need for this in the future to assess this item.

49. Cultural Diversity

A family that is able to report routines, practices, beliefs and shared values that are reflective of culture often find comfort in this. This item appreciates how a family identity that is unique and rooted in their cultural orientation often brings a sense of pride and connectedness that is supportive to the system. In assessing this item it is important to ask families if they feel that their family's belief systems and shared values are reflective of a larger cultural orientation and how this is helpful or not helpful to them.

50. Spirituality

Spirituality should be considered as something that if it is present it can be a significant help to a family but if not present should not be considered a need. Many families attest to the fact that having a belief in a higher power contributes to resiliency and stress reduction. This is especially true when tragedy takes place or situations that seem difficult to comprehend or make sense of.

51. Employment

The benefits of a parent being employed often exceed what is considered as the obvious one, financial gain. Parents often see employment as a vehicle for obtaining benefits such as insurance and this is often one of the primary needs for the family. Employment may also serve as a stress reliever and social support to the parent. Parents describe feeling a need to "be around adults" and without employment may not have this opportunity on a regular basis. In the consideration of whether or not this a strength of parents several factors should be determined: Is the parent employed? Does the employment satisfy the parent? Is the parent in a position that matches their strengths and abilities? Does the situation seem stable and consistent?

52. Education

Education offers families greater opportunities in the job market and therefore can contribute to the reduction of other risk factors. In addition, to education making financial stability easier to attain it also is associated with job satisfaction. Parents that are less stressed and happy with their employment opportunities are better able to meet the needs of the children. Education is also associated with better developed abilities to obtain resources and understand the needs of their children.

53. Language

A parent's ability to communicate with others is necessary and important to assess. Parents that experience challenges in this area are in need of support to understand their child's needs, support their child and ask pertinent questions. It is important to consider both a parent's ability to express themselves and understand what is being said and their ability to read.

54. Physical Health

Parents that experience stable health and are in good physical condition are afforded many benefits that parents that are challenged in this area are not. A parent that struggles with poor health or physical condition is often less able to provide support and care to their child and to attend fully to their emotional needs. The parent with health conditions may be so overwhelmed with their own needs that it is a challenge to address their child's needs. In assessing this item it is important to understand that the presence of a chronic health condition that is well managed does not automatically suggest a low rating in this area. The parent in the same vein may be in poor physical condition without a major health condition and be compromised in their abilities to meet the child's needs. Knowing how the parent functions in this capacity allows the service provider/s to better align the parent with resources or supports.

55. Behavioral Health

Infants and young children are primarily in need of parents that are emotionally available, reciprocal in their interactions and capable of providing for their needs. When a parent is challenged with difficult symptoms associate with mental health challenges all of these needs may be poorly or intermittently met. Much research has taken place regarding how depression in parents affects children. Carter, Osofsky & Hahn (1991) substantiate the disturbances in infant patterns of regulating affect when experiencing parental depression. In addition, Murray and Cooper (1997) report that two negative interaction patterns, withdrawn-hostile and hostile-intrusive, have been observed in their research with depressed mothers. These two patterns have been demonstrated to

interfere with the cognitive and emotional development of their infants. Anxiety or trauma related challenges in parents also have the potential to cause a number of difficulties for children. Children with parents that are anxious can experience anxiety themselves due to their response to the social cues of their parents or the interference with the care-giving routine.

56. Substance Use

It is important to note that what typically puts infants at greater risk related to substance abusing parents is the exposure to the multiple risks that usually are associated with substance abuse. Due to the effects of substance abuse, parents often experience poverty, disorganized and chaotic lifestyles, stress, 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).

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