

# CHILD AND ADOLESCENT NEEDS AND STRENGTHS (CANS)

## The Montana CANS Comprehensive Version:

*A comprehensive information integration and communication tool  
for children and adolescents*

*CANS Developed by John S. Lyons, PhD*

*Customized for Montana Department of Public Health and Human Services by:*



**MJ Henry & Associates, Inc.**

**CANS BINDER**  
**Table of Contents**

**CANS Certification Training Power Point ..... 3**

**Children’s Mental Health CANS and MCS CANS Website ..... 96**

**Montana CANS Practice Reference Sheet ..... 98**

**Field Rating Sheet..... 99**

**Reference Guide ..... 106**

**Montana CANS System PowerPoint..... 192**

**CANS Certification ..... 199**

**MCS Reports ..... 202**

**CANS Recertification ..... 209**

**Montana CANS Videos (Therap Montana) ..... 210**

## A SHARED VISION

A collaborative relationship between youth, caregivers and provider(s) to develop a shared understanding of identified problems and its sources, assets, a shared goal and a set of actions to achieve that goal.



Children's Mental Health Bureau



# Child and Adolescent Needs and Strengths

## *CANS Certification Training*



# AGENDA

- Welcome and Introduction
- CANS as a Practice Framework
- Communimetrics and TCOM
- Montana Comprehensive CANS
  - National Child Traumatic Stress Network (NCTSN) CANS-Comprehensive
- A “Dry Run”
- Certification

# LEARNING OBJECTIVES

- Explore the practice framework and characteristics of CANS.
- Learn about the Montana CANS-Comprehensive.
- Achieve proficiency in rating CANS items.
- Discuss how CANS can be used to improve practice.

# KEY ASSUMPTIONS

1  
Providers want to do what is best for children, youth, and families. This can sometimes be challenging given the constraints of daily work.

2  
Working in collaboration with other committed professionals is vital to success.

3  
Communication is critical to our work.

4  
Creating and communicating a shared vision will keep focus on the child and family.

5  
***Transformation is possible and essential.***



# MARKETPLACE: *HIERARCHY OF OFFERINGS*

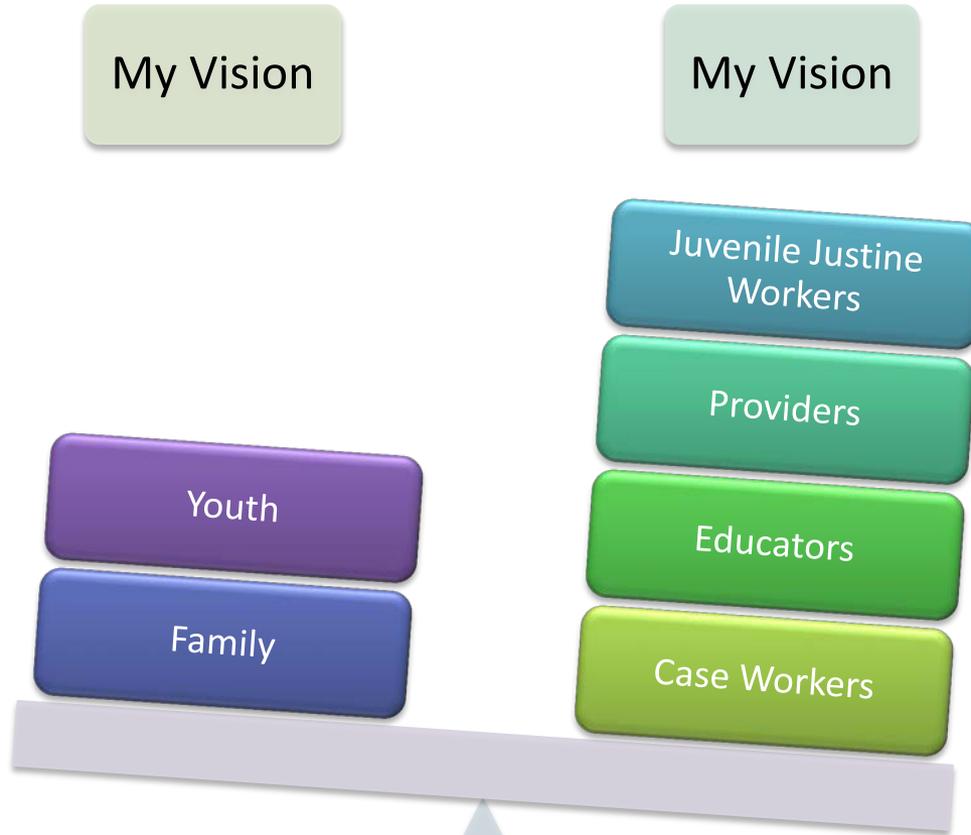
- I. Commodities: Raw materials
- II. Products: Mass produced from raw materials
- III. Services: Hiring someone to apply a product
- IV. Experiences: Memories
- V. Transformations: Opportunities for change as a person or family

Pine & Gilmore, 1999

# TRADITIONAL CHILD-SERVING SYSTEMS

- Service-oriented *not* transformational
  - Manage services not transformations
- Management *requires* measurement
- Transformation *requires* measurement
- Multiple professionals with differing agendas
- Practitioner assumes responsibility for youth and family planning
- Conflict arises when competing agendas or visions are at play

# MULTIPLE VISIONS



BACK



# KEY PRINCIPLES TO MANAGE CONFLICT

- Identify the shared vision.
- Communicate about the shared vision.
- CANS can focus and manage the shared vision.

# A SHARED VISION

A collaborative relationship between youth, caregivers and provider(s) to develop a shared understanding of identified problems and its sources, assets, a shared goal and a set of actions to achieve that goal.

# SHARED VISION

Our Vision

Professionals

Professionals

Youth

Youth

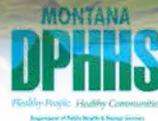
Family

Family



*Benefits and Evidence*

# **YOUTH & FAMILY-CENTERED PRACTICE**



Children's Mental Health Bureau



# BENEFITS OF YOUTH & FAMILY-CENTERED PRACTICE

- Parents and youth gain a greater sense of control
- Acknowledges and appreciates individual and family differences
- Shared goal development and planning
  - Parents and youth as experts – immersed in family culture
- Builds skills and knowledge to anticipate and prepare for future challenges

Prizant, 2008

# WHAT DOES RESEARCH TELL US?

- Involving family and youth in the goal-setting positively influences a family's satisfaction with care and enhances outcomes.
- Clear goals enhance motivation and lead to more positive outcomes (Locke & Latham, 1990).
- Specific, functional goals lead to the best outcomes (Ponte-Allan & Giles, 1999).
- Feedback about performance is necessary.
- Personal satisfaction comes with successful performance (Theodorakis, et al., 1996)

# USING STRUCTURED ASSESSMENTS IN CHILD AND FAMILY TEAMS

- Creates a shared vision which can transition into a plan
- Provides direction to all parties
- Requires substantiated decision-making
- Sets the stage for understanding outcomes and effective resource management
- Drafted in preparation for the team meeting and finalized with input of all participants including youth and family

# THREE TYPES OF ASSESSMENTS

- Youth and family self report
- Provider report
- Collaborative completion – CANS
  - Collaborative completion of CANS leads to creating a shared vision which leads to collaborative planning.
  - Collaboration leads to better outcomes system-wide.

# WE HAVE TO UNDERSTAND...TO HELP

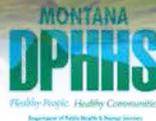
“We have to understand the individual, their family, their culture, the context within which they’re doing their behaviors, and thinking and making decisions. And when we do, we will be better at helping them express their full potential.”

Bruce Perry, MD PhD

9-2013 (Nebraska Conference)

# *A Communication Framework*

# **CANS**



Children's Mental Health Bureau



# WHAT IS CANS?



- Tool to communicate the needs and strengths of children, youth, and families
- An information integration tool designed to support individual case planning and the planning and evaluation of service systems
- Does not replace clinical diagnostics

***Communitrics: Numbers exist to add stories together***



# KEY FEATURES OF THE CANS

- It focuses on **what** is happening and **not why**.
  - This is important so that everyone keeps a focus on *what* is happening because we can't always know *why* it is happening.
  - Focusing on the *why* can create feelings of embarrassment or blame for youth and families, which is not helpful to anyone.
- It always takes into account a youth's development and his or her culture to provide the most accurate information for planning.
- Youth and families should see a draft copy of the CANS and inform the ratings before it is finalized.

# WHY IS MT CMHB USING CANS?



- CANS is a **youth and family friendly** tool that makes youth and family the center of the work.
- It is a **comprehensive** tool that captures a youth's current needs and strengths with simple, straightforward language.
- It gives youth and families an opportunity to be **full partners** in the work.

# WHY IS MT CMHB USING CANS?

- It is purposefully **direct and clear**. It has simple ratings per item so that all important people in the youth's life can understand and communicate about his or her needs and strengths.
- It **helps** youth and families understand the recommendations that providers make for treatment.



# CANS: *SIX GUIDING PRINCIPLES*

**1** Items are included because each one may impact service planning.

**2** Item rating levels translate immediately into action.

**3** Focus on the child's needs not interventions that could mask a need.

**4** Consider development and culture before translating into action levels.

**5** It is about the 'what' not about the 'why.'

**6** The 30-day window reminds us to keep assessments relevant and 'fresh.'

# ITS ABOUT THE CHILD NOT THE SERVICE

## 3 Focus on the child's needs not interventions that could mask a need.

**Actionable needs (2 or 3)** can be conceptualized as

- Background or Pathway needs
- Treatment target needs
- Functional outcomes

# PRIORITIZING AND PLANNING NEEDS

- Background or Pathway Needs
  - Needs that are likely not addressable but are a lens for interventions
- Treatment Target Needs
  - the focus of intervention
- Anticipated Functional Outcome Needs:
  - expected to respond as a result of effectively targeting the treatment needs

# EXAMPLE: SARA, 11 YRS OLD

- Background or Pathway Needs
  - Sexual Abuse
  - Physical Abuse
  - Intellectual
- Treatment Target Needs
  - Anxiety
  - Depression
  - Adjustment to Trauma
- Functional Outcome Needs
  - School attendance
  - Danger to others
  - Social functioning
  - Relationship permanence

# CONSIDER CULTURE

- Engaging children, youth and families in the CANS process should always be culturally sensitive
- Translating CANS language for families based on their given culture, language, and understanding is critical
- Cultural humility: appreciating what you don't know and being willing to learn

# CANS: A PRACTICE FRAMEWORK

Use CANS to :

- Create a common starting point for case discussions
- Facilitate discussions with caregivers and collateral contacts
- Inform planning based upon identified needs and strengths
- Base intervention/treatment modalities on the item ratings
- Support intervention or planning decisions
- Monitor progress

# Rating Items per Domain

## **THREE RATINGS SCALES**



# TRAUMA RATING SCALE

## ANCHORS:

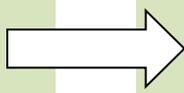
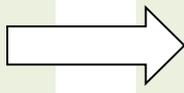
## FREQUENCY AND SEVERITY:

0	NONE	→	No evidence of any trauma
1	MILD	→	Single incident or suspicion
2	MODERATE	→	Multiple incidents or moderate degree
3	SEVERE	→	Repeated and severe

# STRENGTHS RATING SCALE

## ANCHORS:

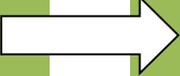
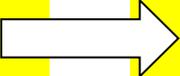
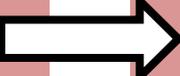
## ACTION LEVELS:

<b>0</b>	<b>Significant strength</b>		<b>Can be used as a centerpiece for strength-based plan</b>
<b>1</b>	<b>Strength exists</b>		<b>Can be useful in the plan</b>
<b>2</b>	<b>Potential strength</b>		<b>Requires significant strength building in order to be used in the plan</b>
<b>3</b>	<b>No strength identified at this time</b>		<b>Efforts are required to identify strengths in order to be used in the plan</b>

# NEEDS RATING SCALE

## ANCHORS:

## ACTION LEVELS:

<b>0</b>	<b>No evidence</b>		<b>No evidence or no reason to believe that the rated item requires any action</b>
<b>1</b>	<b>History, mild degree of dimension</b>		<b>Need for watchful waiting, monitoring, or possibly preventative action</b>
<b>2</b>	<b>Moderate degree of dimension</b>		<b>Need for action; some strategy is needed to address the problem/need</b>
<b>3</b>	<b>Severe or profound degree of dimension</b>		<b>Need for immediate or intensive action; this level indicates an immediate safety concern or priority for intervention</b>

# STRATEGIES FOR DECIDING RATINGS

- Use the anchor definitions for each item.
- When between ratings, consider action level. ASK:
  - What would I do about it?
  - Would it be in the treatment/service plan?

## NEEDS:

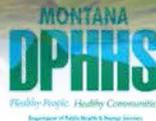
- 0 = No need to act
- 1 = Watch/wait/prevent
- 2 = **Action needed**
- 3 = **Immediate/intensive action needed**

## STRENGTHS:

- 0 = **Centerpiece**
- 1 = **Part of the plan**
- 2 = Strength building
- 3 = Identify strength

# Montana Comprehensive

# CANS



# MONTANA COMPREHENSIVE CANS



- Comprehensive age range 0-21 years
- Nine domains with two specific to age or relevancy
- Dedicated Traumatic/Adverse Childhood Experiences domain
  - Allows for identification and severity of an array of traumatic experiences
  - Ensures that planning and practice with children, families, and team acknowledges and incorporates the influence of trauma
  - Captures data about prevalence of trauma for the population → inform policy and practice

TRAUMA ITEMS: BASED ON THE NATIONAL CHILD TRAUMATIC STRESS NETWORK (NCTSN)  
CANS-COMPREHENSIVE © Praed Foundation



# CANS: *DOMAINS*

- Traumatic/Adverse Childhood Experiences
- Child Strengths
- Life Domain Functioning
- Cultural Considerations
- Child Behavioral/Emotional Needs
- Child Risk Behaviors
- Children Under Five (*Optional*)
- Transition to Adulthood (*Optional*)
- Caregivers Resources and Needs

# MT CANS REFERENCE GUIDE

- It is the resource used to appreciate what each item and individual rating means.
- Should be referenced whenever completing a CANS.
  - Don't assume a CANS item meaning. Always check.
- CANS should be completed on paper using the MT field rating sheet before entered into data system.
  - Narrative text boxes per domain – required – take notes on paper of key information informing ratings.
- Have a CANS Reference Guide available whenever discussing CANS with team members, including youth and family.

# PRACTICE/RATING CONSIDERATIONS

- Help decide how to rate an item
- Clarify potential impact on child's functioning
- Consider what action might be required
- Highlights intersection of item and CANS characteristics

# CANS DATA COLLECTION: *THE WORK OF A BIOGRAPHER*

- Use multiple sources of evidence
  - Biopsychosocial with youth and family
  - Case records
  - Referral reports
  - Discharge reports
  - Providers
  - Team members
  - Other
- Investigate specific areas with limited evidence
- Assess one's own personal and professional bias
- Edit and update the youth and family CANS as you obtain more information and evidence.

# QUESTIONS TO CONSIDER

- What do we know about:
  - Family?
  - Friends?
  - Community connections?
  - Interests & strengths?
- What do we know about the family culture?
- What are the caregivers' needs?
- What are trauma experiences?
- What are her behavioral needs?
- What are her risk behaviors?

# *Rating the items per domain*

## **3 SCALES**

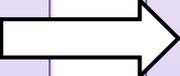
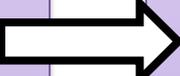


# TRAUMA RATING SCALE

*Lifetime of experiences – not a 30 day window*

## ANCHORS:

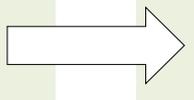
## FREQUENCY AND SEVERITY:

<b>0</b>	<b>None</b>		<b>No evidence of any trauma</b>
<b>1</b>	<b>Mild</b>		<b>Single incident or suspicion</b>
<b>2</b>	<b>Moderate</b>		<b>Multiple incidents or moderate degree</b>
<b>3</b>	<b>Severe</b>		<b>Repeated and severe</b>

# STRENGTHS RATING SCALE

## ANCHORS:

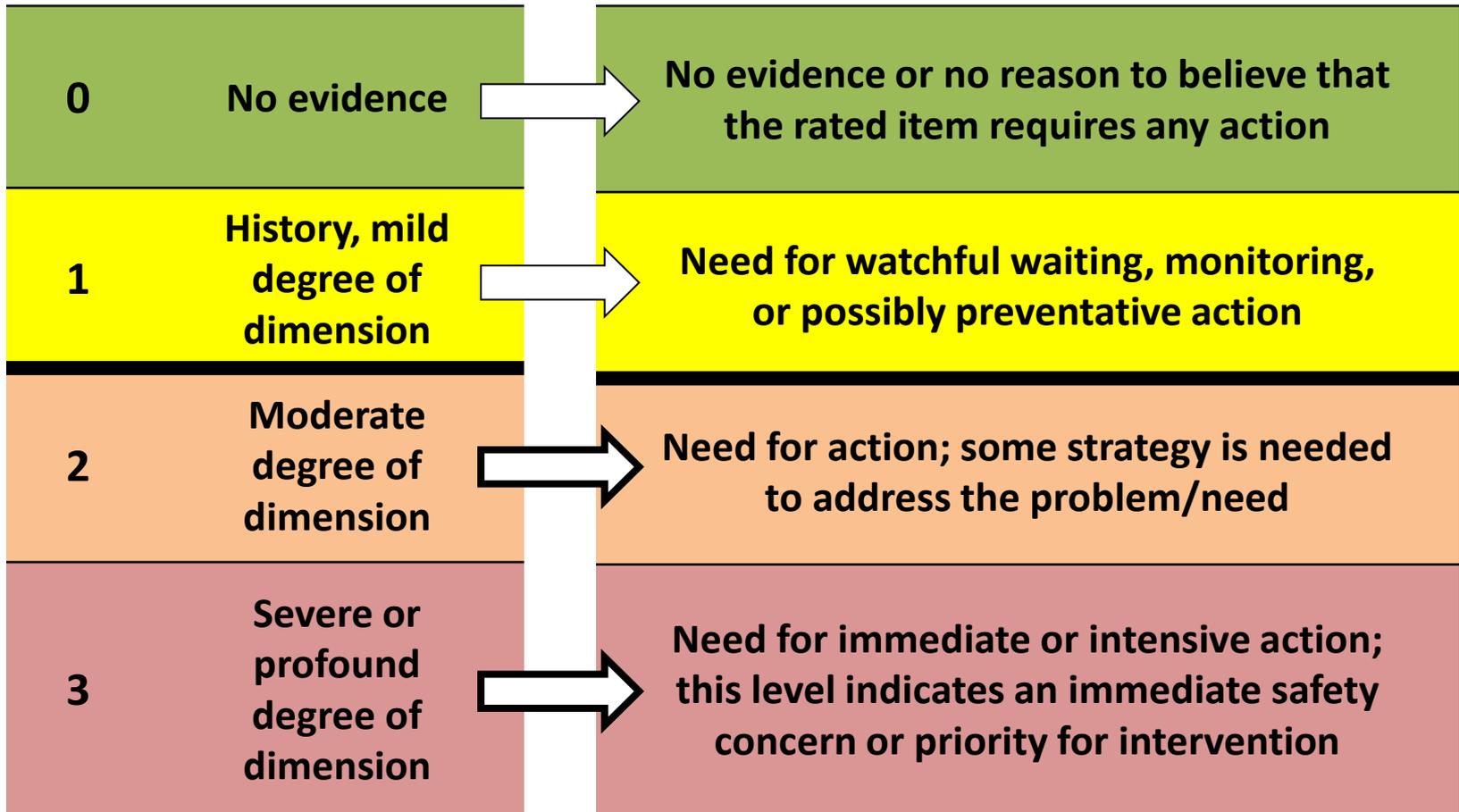
## ACTION LEVELS:

<b>0</b>	<b>Significant strength</b>		<b>Can be used as a centerpiece for strength-based plan</b>
<b>1</b>	<b>Strength exists</b>		<b>Can be useful in plan</b>
<b>2</b>	<b>Potential strength</b>		<b>Requires significant strength building in order to be used in plan</b>
<b>3</b>	<b>No strength identified at this time</b>		<b>Efforts are required to identify strengths in order to be used in plan</b>

# NEEDS RATING SCALE

## ANCHORS:

## ACTION LEVELS:



# WHAT DO THE RATINGS MEAN?

**0** = represents **best possible** functioning

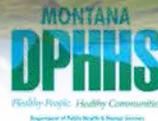
**1** = functioning is ok but should keep an eye on it

**2** = action is needed or moderate degree of  
functioning impacted

**3** = immediate or intensive action is needed or  
severe degree of functioning impacted

# *DOMAINS & ITEMS*

# **MONTANA CANS**



Children's Mental Health Bureau



# TRAUMA RATING SCALE

## ANCHORS:

## FREQUENCY AND SEVERITY:

0	NONE	→	No evidence of any trauma
1	MILD	→	Single incident or suspicion
2	MODERATE	→	Multiple incidents or moderate degree
3	SEVERE	→	Repeated and severe

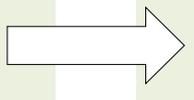
# TRAUMATIC/ADVERSE CHILDHOOD EXPERIENCES

- Sexual Abuse
- Physical Abuse
- Emotional Abuse
- Neglect
- Medical Trauma
- Family Violence
- Community Violence
- School Violence
- Natural or Man-made Disasters
- War
- Terrorism
- Witness to Criminal Activity
- Parental Criminal Behavior
- Disruption in Caregiving

# STRENGTHS RATING SCALE

## ANCHORS:

## ACTION LEVELS:

<b>0</b>	<b>Significant strength</b>		<b>Can be used as a centerpiece for strength-based plan</b>
<b>1</b>	<b>Strength exists</b>		<b>Can be useful in plan</b>
<b>2</b>	<b>Potential strength</b>		<b>Requires significant strength building in order to be used in plan</b>
<b>3</b>	<b>No strength identified at this time</b>		<b>Efforts are required to identify strengths in order to be used in plan</b>

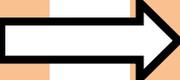
# STRENGTHS ITEMS

- Family
- Interpersonal
- Educational Setting
- Vocational
- Coping and Savoring Skills
- Talents/Interests
- Spiritual/Religious
- Community Life
- Relationship Permanency
- Resilience
- Optimism
- Youth Involvement
- Use of Free Time
- Peer Influences

# NEEDS RATING SCALE

## ANCHORS:

## ACTION LEVELS:

<b>0</b>	<b>No evidence</b>		<b>No evidence or no reason to believe that the rated item requires any action</b>
<b>1</b>	<b>History, mild degree of dimension</b>		<b>Need for watchful waiting, monitoring, or possibly preventative action</b>
<b>2</b>	<b>Moderate degree of dimension</b>		<b>Need for action; some strategy is needed to address the problem/need</b>
<b>3</b>	<b>Severe or profound degree of dimension</b>		<b>Need for immediate or intensive action; this level indicates an immediate safety concern or priority for intervention</b>

# LIFE DOMAIN FUNCTIONING

- Family
- Living Situation
- Social Functioning
- Developmental
- Recreational
- Legal
- Medical
- Physical
- Sleep
- Sexual Development
- Activities in Daily Living
- School Behavior
- School Achievement
- School Attendance

# CULTURAL CONSIDERATIONS

- Language
- Identity
- Ritual
- Cultural Stress

# CHILD BEHAVIORAL/EMOTIONAL NEEDS

- Adjustment to Trauma
- Affective/Physiological Regulation
- Psychosis
- Attention/Concentration
- Impulsivity
- Depression
- Anxiety
- Oppositional
- Conduct
- Substance Use
- Attachment
- Eating Disturbance
- Behavioral Regression
- Somatization
- Anger Control
- Mood Disturbance

# CHILD RISK BEHAVIORS

- Suicide Risk
- Self-Mutilation
- Other Self-Harm
- Danger to Others
- Sexual Aggression
- Runaway
- Delinquency
- Judgment
- Fire-Setting
- Intentional Misbehavior
- Sexually-Reactive Behavior
- Bullying
- Victimization

# RATINGS OF CHILDREN 5 YEARS AND YOUNGER: *OPTIONAL OF IF RELEVANT TO CHILD OF ANY AGE*

- Motor
- Sensory
- Communication
- Failure to Thrive
- Feeding/Elimination
- Birth Weight
- Prenatal Care
- Substance Exposure
- Labor and Delivery
- Parent/Sibling Problems
- Maternal Availability
- Curiosity
- Playfulness
- Temperament
- Day Care Preschool

# TRANSITION TO ADULTHOOD: *OPTIONAL*

*14 ½ YEARS OR IF RELEVANT TO CHILD OF ANY AGE*

- Independent Living Skills
- Transportation
- Parenting Roles
- Intimate Relationships
- Medication Compliance
- Education Attainment
- Job Functioning
- Transition to Adult Services

# CAREGIVER RESOURCES AND NEEDS

- Physical
- Mental Health
- Substance Use
- Developmental
- Supervision
- Involvement
- Knowledge
- Organization
- Social Resources
- Residential Stability
- Safety
- Marital/Partner Violence
- Post-traumatic Reactions
- Financial Resources
- Family Stress
- Accessibility to Child Care
- Transportation

# TIPS FOR VIGNETTES

- Look for evidence
- Consider anchor definitions
- Life Domain Functioning: Rate the Needs (“worst”)
- Child Strengths: Rate the Strengths (“best”)
- Caregiver: Rate the worst and who impacts child most
- No evidence for Needs: Rate 0
- No evidence for Strengths: Rate 3
- Transition to Adulthood Items for ages 14 ½ years
- Children under five years

# PRACTICE *VIGNETTE*



# PRACTICE POINTS

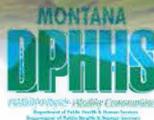
- You already have solid clinical skills
- CANS is not a checklist
- Will not be able to rate every item after first visit
- Instrument to a begin a conversation
- Must be reviewed with family
- Should be shared with team
- Should be updated regularly/when you have new Information

# SUMMARY

- Must have evidence
- Always consider action level
- Include/share with everyone involved
- Remember development and culture
- Its about the 'what' not the 'why'
- Timeframes are important

# EXPERIENCES AND RESPONSES

## *Trauma*



Children's Mental Health Bureau

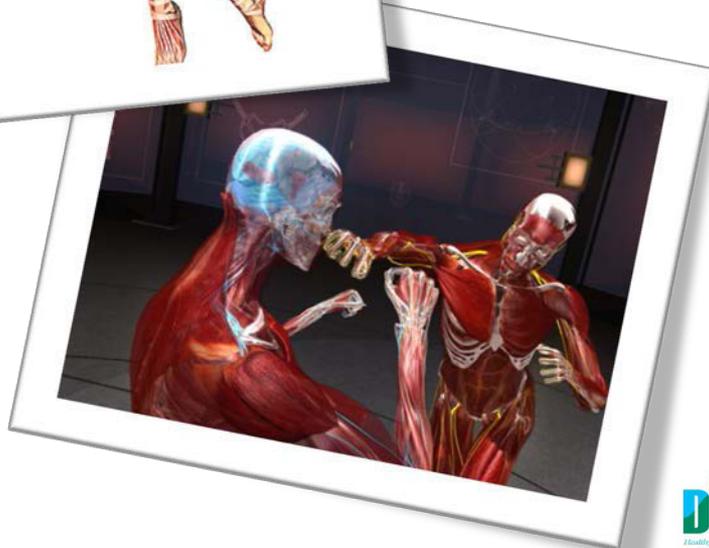


# TRAUMA: PROFESSIONAL PSYCHOLOGY DEFINITION<sup>1</sup>

- Experience
  - Direct personal experience of an event that involves actual or threatened death or serious injury, or threat to personal integrity
  - Witnessing an event that involves death, injury, or threat to the physical integrity of another person
  - Learning about unexpected violent death, serious harm, or threat of death or injury experienced by a family member or close person
- Response
  - Must include intense fear, helplessness, horror, or disorganized or agitated behavior

<sup>1</sup> American Psychiatric Association (1994) , Diagnostic and Statistical Manual of Mental Disorders, 4<sup>th</sup> Edition

# ADAPTIVE RESPONSE TO TRAUMA



- Brain mediates neurobiological, neuroendocrine, and neuropsychological responses
- Two primary responses
  1. Hyperarousal: *fight or flight*
    - Increased heart rate, breathing, movement
    - Tune out non-critical info (non-verbal cues are key)

# CHILDREN AND FIGHT OR FLIGHT

*Is this an option for a child  
and/or adolescent?*



# ADAPTIVE RESPONSE TO TRAUMA

2. Dissociation: *freeze or surrender*
  - Withdraw inward, avoidant, psychological fleeing
  - Daydreaming, fantasy world
- Response influences the way a person thinks, feels or acts



# ADAPTIVE RESPONSE TO TRAUMA

- Children will most often employ a combination.
  - Hyperarousal
  - Dissociation
- The primary response during the traumatic event(s) will usually predict long-term symptoms.
- **Disorder** : when responses are active post-trauma and begins to interfere with a person's functioning

# FOR CONSIDERATION

- **Individual adaptive responses will vary.**
- The nature of an event can determine which response pattern is most adaptive.
- Traumatic events of the same nature can induce different adaptive responses in the same child at different times during the child's development.

# COMPLEX TRAUMA

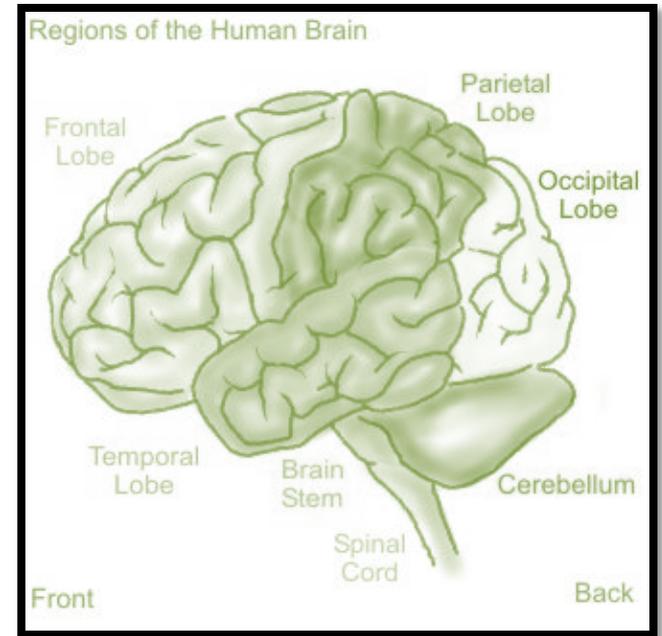
- Complex trauma impacts attachment, affective and behavioral regulation, cognition, biology, and self concept<sup>2</sup>.
  - Changes the physiological and psychological functioning of the brain and nervous system
- Caregiver-induced trauma is more potentially damaging psychologically than any other social or physical stressor<sup>3</sup>.

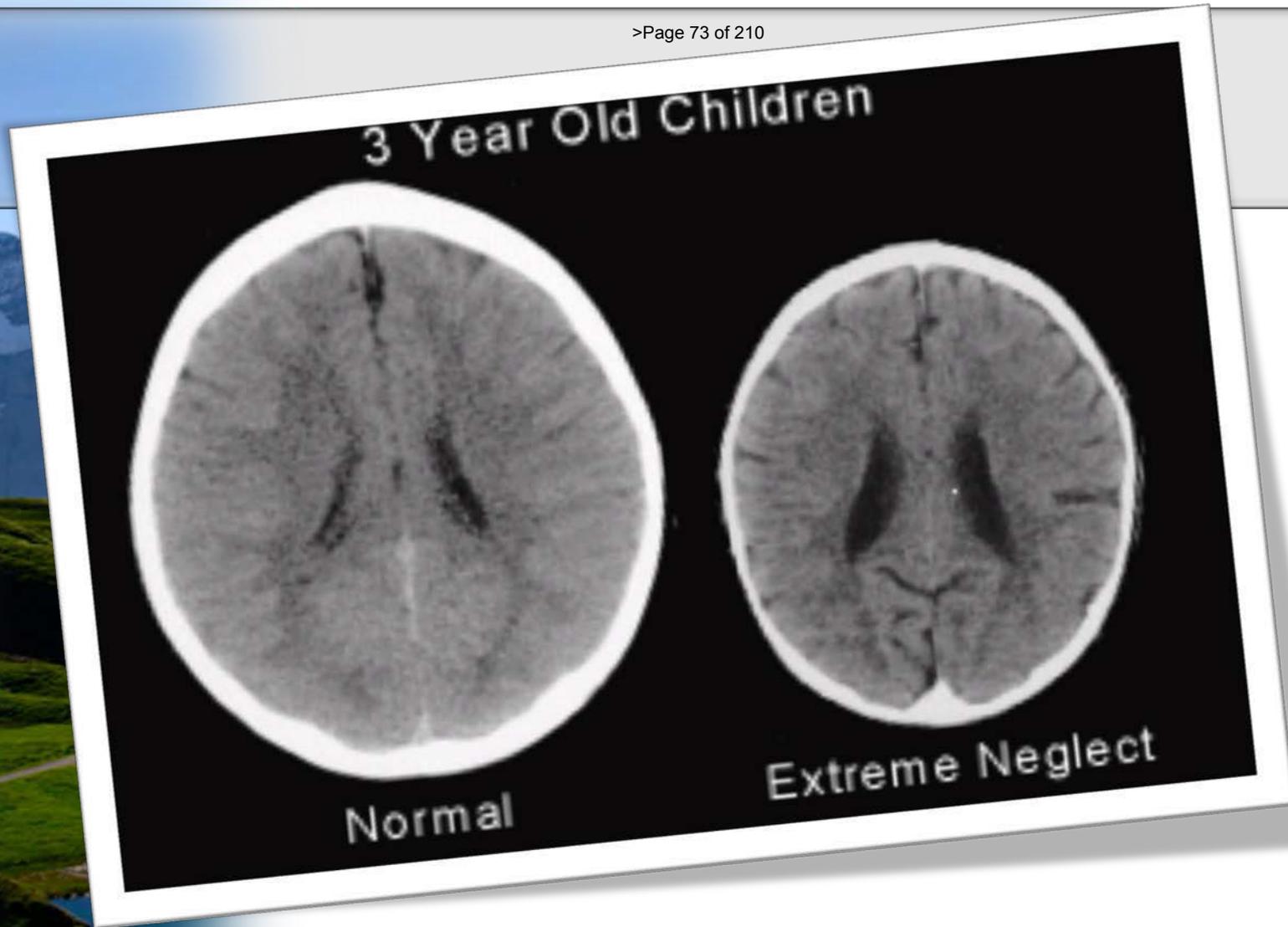
<sup>2</sup> Denise Lacher, Family Attachment and Counseling Center of Minnesota

<sup>3</sup> Bruce Perry, *The Child Trauma Academy*

# ABUSE AND TRAUMA: *EFFECTS ON BRAIN DEVELOPMENT*

- Chronic stress, abuse, and neglect
  - Overdevelop regions of the brain effecting fear and anxiety
  - Underdevelopment of frontal lobe (learning/decision-making)
  - Patterns of intense, unstable relationships and interactions
  - Rational thoughts vs. overwhelming emotion
- Difficulty interpreting and identifying emotional responses
- Problems with trust, autonomy, initiative, self-care





Perry, Bruce – The Child Trauma Academy – [www.childtrauma.org](http://www.childtrauma.org).



Children's Mental Health Bureau  
Children's Mental Health Bureau



# LONG TERM RISKS AND ISSUES

- Post-Traumatic Stress Disorder
- Potential emotional and adjustment issues
  - Self-stimulation behaviors
  - Eating disorders
  - Interaction problems
  - Behavior issues
  - Attachment (**etiology not diagnosis**)
  - Tantrums
- Sensory integration or processing dysfunction

# POST-TRAUMATIC STRESS DISORDER

- Neuropsychiatric disorder
- Trauma must be extreme
- Experience may be live or vicarious
- Person most likely has an occurrence of re-experiencing, avoiding, numbing, and increased arousal

# POST-TRAUMATIC STRESS DISORDER

## PTSD often misdiagnosed as:

- Acute stress disorder
- Adjustment disorders
- Panic disorder
- Generalized anxiety disorder
- Major Depressive Disorder
- Substance use disorders
- Dissociative disorders
- Conduct disorder
- Borderline or other personality disorder
- Schizophrenia or other psychotic disorder
- Factitious disorder
- Attention Deficit Hyperactivity Disorder

# CONSIDERATION FOR ASSESSMENT

- Development and pre-service history
- Developmentally expected behaviors
- Family culture
- Interpersonal and relationship skill-building

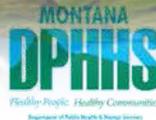
# HOPE



*...the single best predictor of positive outcome for children surviving a traumatic event is the ability of parents and other significant adults to cope with the trauma.*

# *Total Clinical Outcomes Management*

# TCOM



Children's Mental Health Bureau



# TOTAL CLINICAL OUTCOMES MANAGEMENT

- **Total:** It is embedded in all activities with families as full partners.
- **Clinical:** Focus is on child and family health, well-being, and functioning.
- **Outcomes:** The measures are relevant to decisions about approach or proposed impact of interventions.
- **Management:** Information is used in all aspects of managing the system.
  - Individual and family planning
  - Supervision
  - Program operations
  - System operations

# TCOM FUNDAMENTAL TENET: *SHARED VISION*

- A required focus of a *shared vision* of the children and families receiving services
- For effective services within complex systems the following are a MUST:
  1. Collaboration of multiple partners often with different mandates, agendas, priorities, and perspectives
  2. Communication facilitation among all partners, including youth and families
  3. Shared commitment to serving children and families despite differences
  4. Collective *accountability* to the child and family

# TCOM

## Grid of Activities

Family and Youth



Program



System



Decision Support

Service planning  
Effective practices  
Evidence Based  
Practices

Eligibility  
Step-down

Resource Management  
Right-sizing



Outcome Monitoring

Service Transitions &  
Celebrations

Evaluation

Provider Profiles  
Performance/  
Contracting



Quality Improvement

Case Management  
Integrated Care  
Supervision

CQI/QA  
Accreditation  
Program Redesign

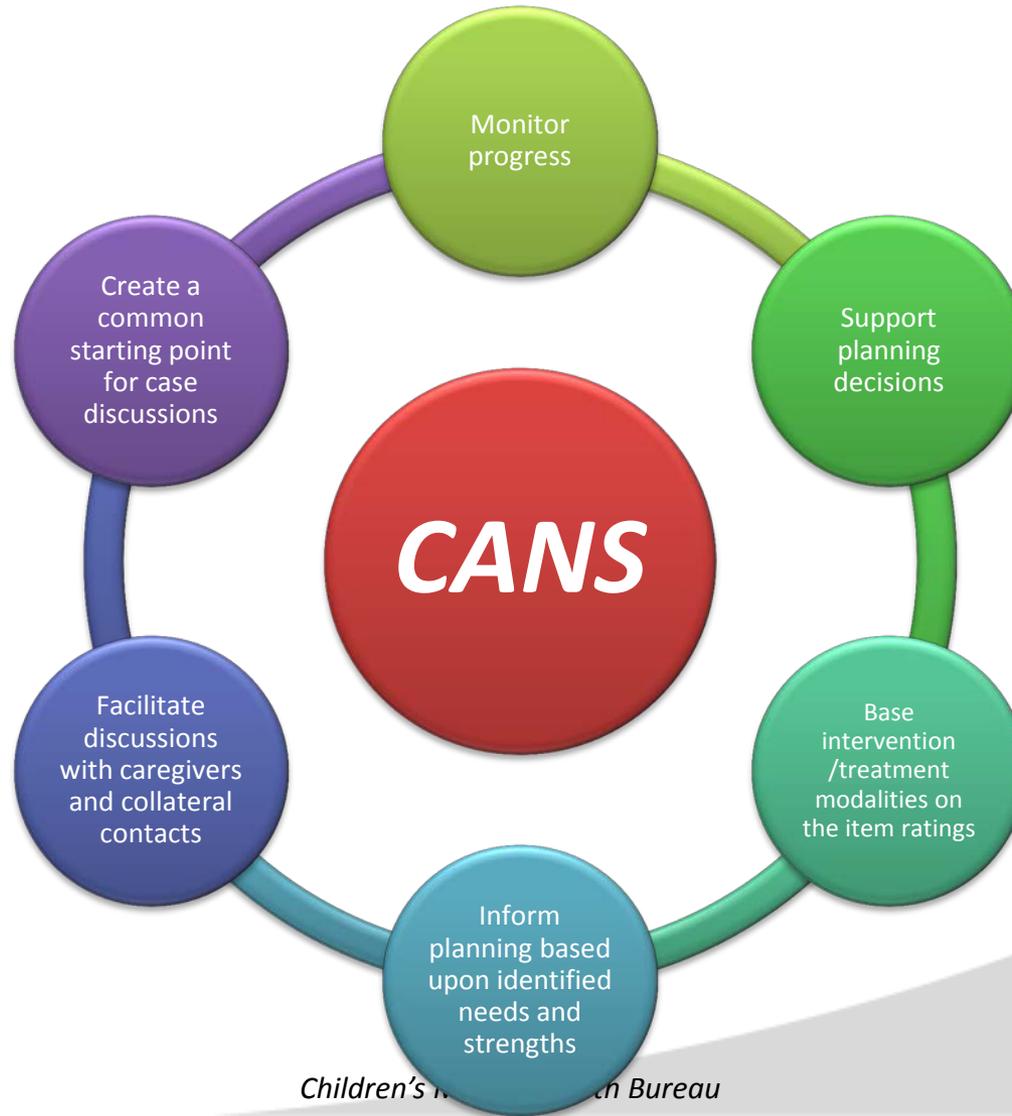
Transformation  
Business Model  
Design

# CANS: *MEASURING OUTCOMES*

Use CANS to :

- Celebrate successes with child and family
- Identify actionable needs and inform service planning
- Supervise cases
- Inform program services and improvements
- Inform resource need and allocation

# CAN(S) THIS BE ACHIEVED?



# USING CANS IN A TEAM CAN...

- Reduce Gossip
- Clarify Perspectives
- Create agenda
- Streamline process
- Increase accountability

# IMPACT OF TCOM APPROACHES

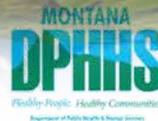
- Reduction by  $\frac{1}{3}$  of children and youth placed in residential treatment in child welfare in Illinois
- Improvement in psychiatric hospital decision-making and elimination of racial disparities
- Identification of need for intensive community services in New York State
- Expansion of TFC capacity and subsequent reduction in use of congregate care in Philadelphia
- Expansion Transitional Living Program capacity in Illinois
- Improved outcomes in Residential Treatment

# CANS: A COMMUNIMETRIC MEASURE

- Psychometric → Communimetric
  - Fewer items required, shorter measure
  - Immediate results, no need for scoring
- Decision support focused
  - Levels of need translate directly into action levels.
  - Measures are reliable at the item level.
  - Tool must be meaningful to the service delivery process.
  - All partners involved in communication process should be involved in design of measure.
  - The value of the measure should be evaluated by its communication utility.
- Common language for multidisciplinary settings

# Becoming CANS Certified

## ONLINE CERTIFICATION EXAM



Children's Mental Health Bureau



# CERTIFICATION

- Read a short vignette
- Rate the vignette
- Remember the vignette tips
- Do not read into the vignette
- Only rate information based on evidence
- Do not ‘make a movie’ of the child/youth
- “smell the flowers; blow out the candles”

# ONLINE CANS CERTIFICATION SITE

**Montana CANS certification is done through the Praed Foundation CANS training website at [www.canstraining.com](http://www.canstraining.com)**

- To become certified to use the tool you must read a 1-page fictional vignette and rate items on the Montana CANS.
- You must score at least a .70 to pass certification.
- The certification is valid for one year and to continue using the CANS tool you must recertify annually.

# ONLINE CANS CERTIFICATION SITE

- The cost to become certified and have access to the CANS training website is \$10 per year and is the responsibility of the individual provider. Providers should check with their specific agency to determine if the cost of the CANS site access is reimbursable.
- Once registered, you can visit [www.canstraining.com](http://www.canstraining.com) at any time to refresh your CANS information or take a practice vignette to refresh ratings a CANS. We encourage you to take full advantage of the site.

# HELPFUL TIPS

**Use your Montana CANS Reference Guide for the test and in practice.**

**Refer to the item- and rating-specific definitions to ensure reliable ratings.**

- |   |   |
|---|---|
| <ul style="list-style-type: none"><li>• Read vignette assumptions.</li></ul>                                  | <ul style="list-style-type: none"><li>• Look for evidence to support item ratings.</li></ul>  |
| <ul style="list-style-type: none"><li>• Consider anchor definitions</li></ul>                                 | <ul style="list-style-type: none"><li>• What level of action would you take based on evidence and rating definitions</li></ul>          |
| <ul style="list-style-type: none"><li>• Child Strengths: Rate the Strengths - “best”</li></ul>                | <ul style="list-style-type: none"><li>• Life Functioning Domain: Rate the Needs - “worst”</li></ul>                                     |
| <ul style="list-style-type: none"><li>• No evidence for Strengths: Rate 3</li></ul>                           | <ul style="list-style-type: none"><li>• No evidence for Needs: Rate 0</li></ul>   |
| <ul style="list-style-type: none"><li>• Caregiver Domain: Rate the worst and who impacts child most</li></ul> | <ul style="list-style-type: none"><li>• Refer to your CANS reference manual often to ensure evidence support rating per item.</li></ul> |

# ADDITIONAL DISCUSSION OR QUESTIONS?



Children's Mental Health Bureau



# WHERE CAN YOU GET MORE INFO?

*Visit:*

<http://dphhs.mt.gov/dsd/CMB>

CANS Hotline 406-444-7394

**Children's Mental Health Bureau**

**Trainers**

Libby Carter, 406-254-7305, [ecarter@mt.gov](mailto:ecarter@mt.gov)

Dan Carlson-Thompson, 406-444-1460 [Dcarlson-Thompson@mt.gov](mailto:Dcarlson-Thompson@mt.gov)

**Montana CANS System**

Robin Albee, 406-444-2727, [ralbee@mt.gov](mailto:ralbee@mt.gov)

Jamie Olsen, 406-444-7392, [jgainesolsen@mt.gov](mailto:jgainesolsen@mt.gov)



# SELECTED REFERENCES

- Bohman, M., & Sigvardsson, S. (1990) Outcome in adoption: Lessons from longitudinal studies. IN D. M. Brodzinsky & M. D. Schechter (Eds.), *The psychology of adoption* (pp. 93-106). New York: Oxford University Press.
- Brodzinsky, D. M. (1993). Long-term outcome in adoption. *The Future of Children*, 3 (1), 153-166.
- Brodzinsky, D.M., Smith, D. W., & Brodzinsky, A. B. (1998). *Children's Adjustment to adoption: Developmental and clinical issues*. Thousand Oaks, CA: Sage.
- Davis, M., & VanderStoep, A. (1993). The Transition to Adulthood for Youth Who Have Serious Emotional Disturbance: Developmental Transition and Young Adult Outcomes. *The Journal of Mental Health Administration*, 24, (4), 400-427.
- James, B. (1989). *Treating Traumatized Children: New Insights and Creative Interventions*. Lexington, MA: Lexington Books.
- Henry, M. J. & Pollack, D. (2008). *Adoption in the United States: A reference for families, professionals, and students*. Chicago, IL: Lyceum Books.
- Herman, J. (1992). *Trauma and Recovery*. New York, NY: Basic Books.
- Lyons, J.S. (2009). *Communitics: A theory of measurement for human service enterprises*. New York: Springer.
- Perry, Bruce – The Child Trauma Academy – [www.childtrauma.org](http://www.childtrauma.org).
- Perry, B., & Szalavitz, M. (2006). *The Boy Who Was Raised As A Dog*. New York, NY: Basic Books.
- Strauch, B. (2003). *The Primal Teen: What the New Discoveries About the Teenage Brain Tells Us About Our Kids*. New York: Doubleday.

Screen shot of <http://dphhs.mt.gov/dsd/CMB/CANS.aspx>

## Child and Adolescent Needs and Strength Assessment

### Montana CANS

- [Clicker Request Form](#)
- [Therap Access to CANS videos](#)
- [List of Current Trainers and Agencies with Employees Certified in CANS](#)
- [Montana CANS - A Summary For Youth and Families](#)
- [Can a Youth/Parent/legal Guardian opt-out of the CANS assessment?](#)
- [Montana CANS Field Rating Sheet](#)
- [Montana CANS Overview Presentation](#)
- [Montana CANS Practice Reference](#)
- [Montana CANS Preparing for Recertification](#)
- [Montana CANS Reference Guide](#)
- [Instructions for Completing the CANS certification on the Praed Foundation Website](#)
- [CANS Introduction CSCT Template for Caregivers](#)
- [Generic CANS Introduction Letter](#)
- [MT CANS Summary Handout Educators Version](#)
- [MT CANS Summary Handout Partners Version](#)
- [MT CANS Overview Presentation-Educators](#)
- [How to Navigate the Praed canstraining.com website](#)

For more information, contact the CANS Hotline 406-444-7394

- **Robin Albee, [ralbee@mt.gov](mailto:ralbee@mt.gov) 406-444-2727**
- **Jamie Gaines Olsen, [jgainesolsen@mt.gov](mailto:jgainesolsen@mt.gov) 406-444-7392**

For more information about the MT CANS please e-mail us at: [HHSDSDMTCANSInformation@mt.gov](mailto:HHSDSDMTCANSInformation@mt.gov)

<http://dphhs.mt.gov/dsd/CMB/MCS-Information>

# Montana CANS System (MCS)

[Montana CANS System \(MCS\) Hierarchy](#)

[MCS Live Entry](#)

[Creating an E-Pass Account](#)

[How To Get Started in Montana CANS System \(MCS\)](#)

[Montana CANS System \(MCS\) User Guide](#)

[MCS Report User Guide](#)

[Montana CANS System Electronic Database](#)

[MCS Helpful Hints](#)

[MCS Provider Administration Enrollment](#)

[Montana CANS System \(MCS\) training WebEx](#)

**For more information contact the CANS Hotline 406-444-7394**

- **Robin Albee, [ralbee@mt.gov](mailto:ralbee@mt.gov) 406-444-2727**
- **Jamie Gaines Olsen, [jgainesolsen@mt.gov](mailto:jgainesolsen@mt.gov) 406-444-7392**
- **Fax 406-444-5913**

## CANS: Information Integration and Communication

CANS is designed as a practice framework for communicating about a shared vision and using information as an integrated story to inform planning, support decisions, and monitor outcomes. It provides a common language for multidisciplinary settings for consensus building, and it is action-oriented and focused on both the planning process and outcomes. CANS is intended to be used in a collaborative process with youth, families, and other team members.

### Guiding Principles

1. Each CANS item is included because each one may impact service planning.
2. Item rating levels translate immediately into action.
3. Focus on the child's needs, not interventions that could mask a need.
4. Consider development and culture before translating into action levels.
5. It is about the 'what,' not about the 'why.'
6. Use a 30-day window for rating to keep the assessment current and meaningful.

### CANS Ratings: Action Levels

The way the CANS works is that each item suggests different pathways for service or treatment planning. There are four levels of each item with anchored definitions; however, these definitions are designed to translate into the following action levels (separate for needs and strengths).

**THE ITEMS ON THE CANS SHOULD BE RATED IN THE CONTEXT OF WHAT IS NORMATIVE FOR A CHILD'S OR YOUTH'S AGE/DEVELOPMENTAL STAGE AND CULTURE.**

For Needs Domains		For Strengths Domain	
0	No evidence of a need / no need for action	0	Centerpiece strength of treatment planning
1	Watchful waiting / prevention / mild need	1	Useful strength in treatment planning
2	Action needed / moderate need	2	Strength has been identified in this area but needs more development to be useful in treatment planning
3	Immediate / Intensive action / severe need	3	No strength is identified in this area or there is no information

For initial assessments, a 0 (Needs) or a 3 (Strengths) for items where there is no information or evidence is the best rating. During the natural course of the engagement and relationship building, the initial 'no evidence' ratings should be updated to reflect the current information known. If there are no current concerns of adverse impact of functioning for a particular item, the 0 ratings in the Needs Domain reflects the best possible functioning.

### REMINDER: Before rating, be sure to consider the following factors.

- *Do you have evidence of a need or strength?*
- *What current services are already in place?*
- *Is it impacting the child/youth's functioning? If so, how severely?*
- *Respect and consider the child or family's culture – Culture is broadly defined from the experience of the individuals, family, and group.*
- *What are some typical developmental needs or behaviors?*
- *Stay focused on the 'what,' not the 'why.'*

Child/Youth's Name: \_\_\_\_\_

Date: \_\_\_\_\_

For use with MJ Henry & Associates, Inc. customized version of  
**MONTANA CANS COMPREHENSIVE REFERENCE GUIDE**

**Traumatic/Adverse Childhood Experiences Domain**

**Key for Traumatic/Adverse Childhood Experiences Domain:**

- 0 = No evidence of any trauma of this type.
- 1 = A single incident or suspicion of this trauma or ACE.
- 2 = Child/youth has experienced multiple incidents or moderate degree of this trauma or ACE.
- 3 = Child/youth experienced repeated and severe incidents of trauma or ACE.

	0	1	2	3	N/A
1. Sexual Abuse	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
2. Physical Abuse	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
3. Emotional Abuse	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
4. Neglect	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
5. Medical Trauma	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
6. Witness Family Violence	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
7. Community Violence	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	

	0	1	2	3	N/A
8. School Violence	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
9. Natural/Manmade Disasters	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
10. War	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
11. Terrorism	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
12. Witness to Criminal Activity	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
13. Parental Criminal Behavior	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
14. Disruption in Caregiving	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	

**Comments and supporting information for ratings:**

## Child Strengths Domain

**Key for Strengths Domain:**

- 0 = Centerpiece strength
- 1 = Useful strength
- 2 = Identified strength
- 3 = Not yet identified strength / No information about a strength in this area

	0	1	2	3	N/A
15. Family	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
16. Interpersonal	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
17. Educational	<input type="radio"/>				
18. Vocational	<input type="radio"/>				
19. Coping/Savoring Skills	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
20. Optimism	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
21. Talents/Interests	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	

	0	1	2	3	N/A
22. Spiritual/Religious	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
23. Community Life	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
24. Relationship Permanence	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
25. Resilience	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
26. Involvement with Care	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
27. Use of Free Time	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
28. Peer Influences	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	

**Comments and supporting information for ratings:**

**Key for Needs Domains:**

- 0 = No evidence or no reason to believe that the rated item requires any action.
- 1 = A need for watchful waiting, monitoring, or possibly preventive action.
- 2 = A need for action. Some strategy is needed to address the problem/need.
- 3 = A need for immediate or intensive action. This level indicates an immediate safety concern or a priority for intervention.

## Life Functioning Domain

	0	1	2	3	N/A		0	1	2	3	N/A
29. Family	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>		36. Physical	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
30. Living Situation	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>		37. Sleep	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
31. Social Functioning	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>		38. Sexual Development	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
32. Developmental/Intellectual	<input type="radio"/>	39. Activities in Daily Living	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>					
33. Recreational	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>		40. School Behavior	<input type="radio"/>				
34. Legal	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>		41. School Achievement	<input type="radio"/>				
35. Medical	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>		42. School Attendance	<input type="radio"/>				

Comments and supporting information for ratings:

## Cultural Considerations Domain

	0	1	2	3	N/A
43. Language	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
44. Identity	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
45. Ritual	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
46. Culture Stress	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	

Comments and supporting information for ratings:

## Child Behavioral/Emotional Needs Domain

	0	1	2	3	N/A		0	1	2	3	N/A
47. Adjustment to Trauma	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>		55. Conduct	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
48. Emotional/Physical Reg.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>		56. Substance Abuse	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
49. Psychosis	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>		57. Attachment Difficulties	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
50. Attention/Concentration	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>		58. Eating Disturbances	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
51. Impulsivity	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>		59. Behavioral Regressions	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
52. Depression	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>		60. Somatization	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
53. Anxiety	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>		61. Anger Control	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
54. Oppositional Behavior	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>		62. Mood Disturbance	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	

**Comments and supporting information for ratings:**

## Child Risk Behaviors Domain

	0	1	2	3	N/A		0	1	2	3	N/A
63. Suicide Watch	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>		70. Judgment	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
64. Self-Mutilation	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>		71. Fire-Setting	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
65. Other Self-Harm	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>		72. Intentional Misbehavior	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
66. Danger to Others	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>		73. Sexually-Reactive Behaviors	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
67. Sexual Aggression	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>		74. Bullying	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
68. Runaway	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>		75. Victimization	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
69. Delinquency	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>							

**Comments and supporting information for ratings:**

## Items for Children Five Years Old and Younger

*The following items are designed primarily for any child who is five years old or younger or developmentally disabled (DD); however, these items should also be rated for any child/youth if it is felt that there were significant early childhood events in the child's/youth's developmental history (e.g., substance exposure). Please rate the child/youth on all items. Mark N/A if the item is not relevant or applicable to the child/youth, or if early developmental history is unknown. Historical information should be captured as a '1' for youth older than 5 years of age.*

**Historical information is critical when planning for youth and families.**

	0	1	2	3	N/A
76. Motor	<input type="radio"/>				
77. Sensory	<input type="radio"/>				
78. Communication	<input type="radio"/>				
79. Failure to Thrive	<input type="radio"/>				
80. Feeding/Elimination	<input type="radio"/>				
81. Birth Weight	<input type="radio"/>				
82. Prenatal Care	<input type="radio"/>				
83. Substance Exposure	<input type="radio"/>				

	0	1	2	3	N/A
84. Labor and Delivery	<input type="radio"/>				
85. Parent or Sibling Problems	<input type="radio"/>				
86. Maternal Availability	<input type="radio"/>				
87. Curiosity	<input type="radio"/>				
88. Playfulness	<input type="radio"/>				
89. Temperament	<input type="radio"/>				
90. Day Care/Preschool	<input type="radio"/>				

**Comments and supporting information for ratings:**

## Transition to Adulthood Domain

*The following items are designed primarily for youth 14 years, 6 months of age and older; however, these items should also be rated for any child/youth if it is felt that transition issues apply (e.g., youth less than 14 years, 6 months old in a parenting role). Please rate child/youth on all items. Mark N/A if item is not relevant or applicable to child/youth.*

	0	1	2	3	N/A		0	1	2	3	N/A
91. Independent Living Skills	<input type="radio"/>	95. Medication Compliance	<input type="radio"/>								
92. Transportation	<input type="radio"/>	96. Educational Attainment	<input type="radio"/>								
93. Parenting Roles	<input type="radio"/>	97. Job Functioning	<input type="radio"/>								
94. Intimate Relationships	<input type="radio"/>	98. Transition to Adult Services	<input type="radio"/>								

**Comments and supporting information for ratings:**

## Caregiver Resources and Needs Domain

**PLEASE NOTE: Rate the caregiver who has the highest needs and may impact child's functioning negatively. Use a 30-day window to rate caregivers.**

TITLE/ROLE of CAREGIVER #1 (Relationship to Child): \_\_\_\_\_

	0	1	2	3	N/A		0	1	2	3	N/A
99. Physical Health	<input type="radio"/>	108. Residential Stability	<input type="radio"/>								
100. Mental Health	<input type="radio"/>	109. Safety	<input type="radio"/>								
101. Substance Use	<input type="radio"/>	110. Marital/Partner Violence	<input type="radio"/>								
102. Developmental	<input type="radio"/>	111. Post-Traumatic Reactions	<input type="radio"/>								
103. Supervision	<input type="radio"/>	112. Financial Resources	<input type="radio"/>								
104. Involvement with Care	<input type="radio"/>	113. Family Stress	<input type="radio"/>								
105. Knowledge	<input type="radio"/>	114. Accessibility to Child Care	<input type="radio"/>								
106. Organization	<input type="radio"/>	115. Transportation	<input type="radio"/>								
107. Social Resources	<input type="radio"/>										

TITLE/ROLE of CAREGIVER #2 (Relationship to Child): \_\_\_\_\_

	0	1	2	3	N/A
99. Physical Health	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
100. Mental Health	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
101. Substance Use	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
102. Developmental	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
103. Supervision	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
104. Involvement with Care	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
105. Knowledge	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
106. Organization	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
107. Social Resources	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	

	0	1	2	3	N/A
108. Residential Stability	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
109. Safety	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
110. Marital/Partner Violence	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
111. Post-Traumatic Reactions	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
112. Financial Resources	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
113. Family Stress	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
114. Accessibility to Child Care	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
115. Transportation	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	

**Comments and supporting information for ratings:**

Certified CANS Assessor Name: \_\_\_\_\_

Signature \_\_\_\_\_

# CHILD AND ADOLESCENT NEEDS AND STRENGTHS (CANS)

**The Montana CANS Comprehensive Version:**

*A comprehensive information integration and communication tool  
for children and adolescents*

## *Reference Guide*

*CANS Developed by John S. Lyons, PhD*

*Customized for Montana Department of Public Health and Human Services by:*



**MJ Henry & Associates, Inc.**

## Praed Foundation – Copyright 2010

A large number of individuals have participated in the mass collaboration to develop and refine various versions of the Child and Adolescent Needs and Strengths information integration tool. These include CANS for various child-serving areas such as mental health, developmental disabilities, juvenile justice, child welfare, and the National Child Traumatic Stress Network (NCTSN) CANS-Comprehensive. The CANS information integration tool is designed to support individual case planning and the planning and evaluation of service systems. The CANS-Comprehensive is an open domain tool for use in service delivery systems that address the mental health of children, adolescents, and their families. The copyright is held by the Praed Foundation to ensure that it remains free to use for those who are trained and certified in CANS. For more information about CANS and its history, please contact:

### John S. Lyons, Ph.D.

University of Ottawa  
145 Jean-Jacques-Lussier (352)  
Ottawa ON K1N 6N5 Canada  
Phone: (613) 864-4940  
jlyons@uottawa.ca

### Praed Foundation

550 N Kingsbury St. #101  
Chicago, IL 60654  
praedfoundation@yahoo.com  
www.praedfoundation.org

Beginning December 1, 2011, Montana identified the Child and Adolescent Needs and Strengths (CANS) as the functional assessment tool that state agencies and providers will use to communicate youth and family needs and strengths. This effort is intended to support Montana youth's and families' resilience in their challenges with mental illness. Many assisted with the process of identifying, customizing, and adopting the CANS for Montana. Among those are Montana providers of Children's Mental Health Services and System of Care Planning Committee (SOC) members, which include representatives from:

- Juvenile Justice
- Child and Family Services
- Developmental Disabilities
- Department of Corrections
- Board of Crime Control
- Office of Public Instruction (OPI)
- Early Childhood Services Bureau
- Addictive and Mental Disorders Division
- Utilization management contractor Magellan Medicaid Administration
- Children's Mental Health Bureau staff
- CANS consultant, MJ Henry & Associates, Inc.
- DPHHS administration

In consultation with MJ Henry & Associates, Inc., the Montana Children's Mental Health Bureau and its key stakeholders have customized a comprehensive CANS, including information about trauma experiences, for children and youth, birth through twenty-one years of age, receiving mental health services throughout Montana. Through the promotion of strong, collaborative working relationships among state agencies, providers, and other community stakeholders, the Children's Mental Health Bureau (CMHB) of Montana is committed to strength-based, culturally-informed service delivery that allows children, youth, and families to be served in the least restrictive environments, with the most effective interventions. The CANS offers partners across systems an easy-to-use tool with a straightforward, common language to communicate information about child and youth needs and strengths, as well as to inform treatment decisions.



# TABLE OF CONTENTS

***CANS Action Levels..... 7***

***Exposure to Potentially Traumatic/Adverse Childhood Experiences Domain..... 8***

- 1. SEXUAL ABUSE.....8
- 2. PHYSICAL ABUSE.....9
- 3. EMOTIONAL ABUSE.....9
- 4. NEGLECT.....10
- 5. MEDICAL TRAUMA.....11
- 6. WITNESS TO FAMILY VIOLENCE.....11
- 7. COMMUNITY VIOLENCE.....12
- 8. SCHOOL VIOLENCE.....12
- 9. NATURAL OR MAN-MADE DISASTERS.....13
- 10. WAR.....14
- 11. TERRORISM.....14
- 12. WITNESS / VICTIM TO CRIMINAL ACTIVITY.....15
- 13. PARENTAL CRIMINAL BEHAVIOR (Birth parents and legal guardians only).....16
- 14. DISRUPTION IN CAREGIVING / ATTACHMENT LOSSES.....16

***Child Strengths Domain ..... 18***

- 15. FAMILY.....18
- 16. INTERPERSONAL.....19
- 17. EDUCATIONAL SETTING.....19
- 18. VOCATIONAL.....20
- 19. COPING AND SAVORING SKILLS.....21
- 20. OPTIMISM.....21
- 21. TALENTS / INTERESTS.....22
- 22. SPIRITUAL / RELIGIOUS.....22
- 23. COMMUNITY LIFE.....23
- 24. RELATIONSHIP PERMANENCE.....23
- 25. RESILIENCE.....24
- 26. YOUTH INVOLVEMENT WITH CARE.....24
- 27. USE OF FREE TIME.....25



28. PEER INFLUENCES.....25

***Life Functioning Domain..... 27***

29. FAMILY.....27

30. LIVING SITUATION .....28

31. SOCIAL FUNCTIONING .....28

32. DEVELOPMENTAL / INTELLECTUAL .....29

33. RECREATIONAL.....29

34. LEGAL.....30

35. MEDICAL.....30

36. PHYSICAL .....31

37. SLEEP .....31

38. SEXUAL DEVELOPMENT.....32

39. ACTIVITIES IN DAILY LIVING.....33

40. SCHOOL BEHAVIOR.....33

41. SCHOOL ACHIEVEMENT.....34

42. SCHOOL ATTENDANCE .....35

***Cultural Considerations Domain..... 36***

43. LANGUAGE .....36

44. IDENTITY .....37

45. RITUAL .....37

46. CULTURE STRESS .....38

***Child Behavioral / Emotional Needs Domain ..... 39***

47. ADJUSTMENT TO TRAUMA.....39

48. EMOTIONAL AND / OR PHYSICAL REGULATION .....40

49. PSYCHOSIS .....41

50. ATTENTION / CONCENTRATION .....42

51. IMPULSIVITY .....43

52. DEPRESSION .....43

53. ANXIETY .....44

54. OPPOSITIONAL BEHAVIOR (Compliance with authority) .....45

55. CONDUCT .....45

56. SUBSTANCE ABUSE.....46



57. ATTACHMENT DIFFICULTIES.....47

58. EATING DISTURBANCES.....48

59. BEHAVIORAL REGRESSIONS.....48

60. SOMATIZATION .....49

61. ANGER CONTROL.....50

62. MOOD DISTURBANCE.....50

***Child Risk Behaviors Domain..... 52***

63. SUICIDE WATCH.....52

64. SELF-MUTILATION .....53

65. OTHER SELF-HARM .....53

66. DANGER TO OTHERS .....54

67. SEXUAL AGGRESSION .....54

68. RUNAWAY .....55

69. DELINQUENCY .....55

70. JUDGMENT .....56

71. FIRE-SETTING.....56

72. INTENTIONAL MISBEHAVIOR.....57

73. SEXUALLY-REACTIVE BEHAVIORS .....57

74. BULLYING.....58

75. VICTIMIZATION.....59

***Items for Children Five Years Old and Younger..... 60***

76. MOTOR.....60

77. SENSORY.....61

78. COMMUNICATION .....61

79. FAILURE TO THRIVE .....62

80. FEEDING / ELIMINATION .....62

81. BIRTH WEIGHT.....63

82. PRENATAL CARE .....64

83. SUBSTANCE EXPOSURE .....64

84. LABOR AND DELIVERY .....65

85. PARENT OR SIBLING PROBLEMS.....66

86. MATERNAL AVAILABILITY .....66



87. CURIOSITY.....67

88. PLAYFULNESS.....68

89. TEMPERAMENT .....68

90. DAY CARE / PRESCHOOL.....69

***Transition to Adulthood ..... 70***

91. INDEPENDENT LIVING SKILLS .....70

92. TRANSPORTATION.....71

93. PARENTING ROLES.....71

94. INTIMATE RELATIONSHIPS .....72

95. MEDICATION COMPLIANCE.....73

96. EDUCATIONAL ATTAINMENT .....74

97. JOB FUNCTIONING .....74

98. TRANSITION TO ADULT SERVICES SYSTEM.....75

***Caregiver Resources and Needs..... 76***

99. PHYSICAL HEALTH.....76

100. MENTAL HEALTH .....77

101. SUBSTANCE USE .....77

102. DEVELOPMENTAL .....78

103. SUPERVISION .....78

104. INVOLVEMENT WITH CARE .....79

105. KNOWLEDGE .....80

106. ORGANIZATION .....80

107. SOCIAL RESOURCES .....81

108. RESIDENTIAL STABILITY .....82

109. SAFETY .....82

110. MARITAL / PARTNER VIOLENCE .....83

111. CAREGIVER POST-TRAUMATIC REACTIONS.....84

112. FINANCIAL RESOURCES .....84

113. FAMILY STRESS .....85

114. ACCESSIBILITY TO CHILD CARE RESOURCES AND/OR RESPITE .....85

115. TRANSPORTATION.....86



## **CANS Action Levels**

The way the CANS works is that each item suggests different pathways for service or treatment planning. There are four levels of each item with anchored definitions; however, these definitions are designed to translate into the following action levels (separate for needs and strengths).

### **For Potentially Traumatic/Adverse Childhood Experiences Domain:**

***These items are rated based on LIFETIME exposure of trauma or adverse childhood experiences and should be considered as a lens for planning.***

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

### **For Needs Domains (Life Functioning, Cultural Considerations, Child Behavioral/ Emotional Needs, Child Risk Behavior, Children Five and Younger, Transition to Adulthood, Caregiver Domain):**

- 0 – No evidence of a need / no need for action
- 1 – Watchful waiting / prevention / mild need
- 2 – Action needed / moderate need
- 3 – Immediate / Intensive action / severe need

### **For Strength Domain:**

- 0 – Centerpiece strength
- 1 – Useful strength
- 2 – Strength has been identified in this area but it must be built
- 3 – No strength is identified in this area / no information

***NOTE: CANS items should be rated in the context of what is normative for an individual's age/developmental stage and with respect to his or her culture.***

## Exposure to Potentially Traumatic/Adverse Childhood Experiences Domain

**These items are rated based on LIFETIME exposure of trauma or adverse childhood experiences.**

For this domain, the following ratings and action levels are used:

- 0 = There is no evidence of any trauma of this type.
- 1 = A single incident of trauma occurred, or suspicion exists of this trauma type.
- 2 = Child has experienced multiple incidents or moderate degree of this trauma type.
- 3 = Describes repeated and severe incidents of trauma.

### 1. SEXUAL ABUSE

This item describes the child’s or youth’s experience of sexual abuse.

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

### RATING AND PRACTICE CONSIDERATIONS (*Sexual Abuse*)

- How old was the child/youth at age of abuse?
- Is the abuse ongoing?
- Who inflicted the abuse?
- What is the nature of the abuse?
- Has it been investigated? Supported?
- Does the abuser have access to the child/youth?

## 2. PHYSICAL ABUSE

This item describes the child’s/youth’s experience of physical abuse.

RATING	DEFINITION
0	No evidence that child/youth has experienced physical abuse.
1	Suspicion that child/youth has experienced physical abuse, but no confirming evidence. Spanking without physical harm or threat of harm also qualifies.
2	Child/youth has experienced a moderate level of physical abuse and/or repeated forms of physical punishment (e.g., hitting, punching).
3	Child/youth has experienced severe and repeated physical abuse with intent to do harm and that causes sufficient physical harm to necessitate hospital treatment.

### RATING AND PRACTICE CONSIDERATIONS

- How old was the child/youth at age of abuse?
- Is the abuse ongoing?
- Who inflicted the abuse?
- Has it been investigated? Supported?
- Does the abuser have access to the child/youth?

## 3. EMOTIONAL ABUSE

This item describes the degree of severity of emotional abuse, including verbal and nonverbal forms.

RATING	DEFINITION
0	No evidence that child/youth has experienced emotional abuse.
1	Child/youth has experienced mild emotional abuse. For instance, child/youth may experience some insults or is occasionally referred to in a derogatory manner by caregivers.



<b>2</b>	Child/youth has experienced moderate degree of emotional abuse. For instance, child/youth may be consistently denied emotional attention from caregivers, insulted or humiliated on an ongoing basis, or intentionally isolated from others.
<b>3</b>	Child/youth has experienced significant or severe emotional abuse over an extended period of time (at least one year). For instance, child/youth is completely ignored by caregivers or threatened/terrorized by others.

**RATING AND PRACTICE CONSIDERATIONS (*Emotional Abuse*)**

- How old was the child/youth at age of abuse?
- Is the abuse ongoing?
- Who inflicted the abuse?
- Has it been investigated? Supported?
- Does the abuser have access to the child/youth?

**4. NEGLECT**

This item describes the severity of neglect.

RATING	DEFINITION
<b>0</b>	No evidence that child/youth has experienced neglect.
<b>1</b>	Child/youth has experienced minor or occasional neglect. Child/youth may have been left at home alone for a short period of time with no adult supervision or there may be occasional failure to provide adequate supervision of child/youth.
<b>2</b>	Child/youth has experienced a moderate level of neglect. This may include occasional unintended failure to provide adequate food, shelter, or clothing with corrective action.
<b>3</b>	Child/youth has experienced a severe level of neglect, including multiple and/or prolonged absences by adults, without minimal supervision, and failure to provide basic necessities of life on a regular basis.

**RATING AND PRACTICE CONSIDERATIONS**

- How old was the child/youth at age of neglect?
- Is the neglect ongoing?
- Who neglected the child/youth?
- What was the nature of the neglect?

## 5. MEDICAL TRAUMA

This item describes the severity of medical trauma. Not all medical procedures are experienced as traumatic. Medical trauma results when a medical experience is perceived by the child/youth as mentally or emotionally overwhelming. Potential medical traumas include, but are not limited to, the following examples: the onset of a life threatening illness; sudden painful medical events; chronic medical conditions resulting from an injury or illness or another type of traumatic event.

RATING	DEFINITION
0	No evidence that child/youth has experienced medical trauma.
1	Child/youth has had a medical experience that was mildly overwhelming for the child/youth. Examples include events that were acute in nature and did not result in ongoing medical needs and associated distress such as minor surgery, stitches, or a bone setting.
2	Child/youth has had a medical experience that was perceived as moderately emotionally or mentally overwhelming. Such events might include acute injuries and moderately invasive medical procedures such as major surgery that require only short-term hospitalization.
3	Child/youth has had a medical experience that was perceived as extremely emotionally or mentally overwhelming. The event itself may have been life threatening and may have resulted in chronic health problems that alter the child's/youth's physical functioning.

RATING AND PRACTICE CONSIDERATIONS	
<ul style="list-style-type: none"> <li>• What was the trauma?</li> <li>• How was it experienced by the child/youth?</li> </ul>	

## 6. WITNESS TO FAMILY VIOLENCE

This item describes the severity of exposure to family violence.

RATING	DEFINITION
0	No evidence that child/youth has witnessed family violence.
1	Child/youth has witnessed one episode of family violence.
2	Child/youth has witnessed repeated episodes of family violence but no significant injuries (i.e., requiring emergency medical attention) have been witnessed.
3	Child/youth has witnessed repeated and severe episodes of family violence or has had to intervene in episodes of family violence. Significant injuries have occurred and have been witnessed by the child/youth as a direct result of the violence.

**RATING AND PRACTICE CONSIDERATIONS** (*Witness to Family Violence*)

- Define family violence.
- Is there a culture of violence?
- Consider witnessed versus experienced.
- What was the outcome of the violence?
- How does the community think about violence?

**7. COMMUNITY VIOLENCE**

This item describes the severity of exposure to community violence.

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

**RATING AND PRACTICE CONSIDERATIONS**

- Is there a culture of violence in the community?
- How does the community view those who stand up against violence?

**8. SCHOOL VIOLENCE**

This item describes the severity of exposure to school violence.

RATING	DEFINITION
0	No evidence that child/youth has witnessed violence in the school setting.



<b>1</b>	Child/youth has witnessed occasional fighting or other forms of violence in the school setting. Child/youth has not been directly impacted by the violence (i.e., violence not directed at self or close friends) and exposure has been limited.
<b>2</b>	Child/youth has witnessed multiple instances of school violence and/or the significant injury of others in his/her school setting, or has had friends injured as a result of violence or criminal activity in the school setting, or has directly experienced violence in the school setting leading to minor injury.
<b>3</b>	Child/youth has witnessed repeated and severe instances of school violence and/or the death of another person in his/her school setting, or has had friends who were seriously injured as a result of violence or criminal activity in the school setting, or has directly experienced violence in the school setting leading to significant injury or lasting impact.

**RATING AND PRACTICE CONSIDERATIONS (*School Violence*)**

- How are individuals who stand up against violence viewed?
- How is the administration handling this?
- Does the child/youth feel that they are protected, or do they feel alone?
- What is the parent’s response to the school violence?

**9. NATURAL OR MAN-MADE DISASTERS**

This item describes the severity of exposure to either natural or man-made disasters.

RATING	DEFINITION
<b>0</b>	No evidence that child/youth has been exposed to natural or man-made disasters.
<b>1</b>	Child/youth has had second-hand exposure to disasters (i.e., on television, hearing others discuss disasters). This would include second-hand exposure to natural disasters such as a fire or earthquake or man-made disasters, including car accidents, plane crashes, or bombings.
<b>2</b>	Child/youth has been directly exposed to a disaster or witnessed the impact of a disaster on a family member or friend. For instance, a child/youth may observe a caregiver who has been injured in a car accident or fire or watch his neighbor’s house burn down.
<b>3</b>	Child/youth has been directly exposed to multiple and severe natural or man-made disasters and/or a disaster that caused significant harm or death to a loved one, or there is an ongoing impact or life disruption due to the disaster (e.g., house burns down, caregiver loses job).

**RATING AND PRACTICE CONSIDERATIONS**

- What was the outcome?
- What was the first response?
- How is the family coping?
- Does the family understand the potential impact on children/youth?
- Consider unsupervised television watching/news coverage.



## 10. WAR

This item describes the severity of exposure to war, political violence, or torture. Violence or trauma related to terrorism is not included here.

RATING	DEFINITION
0	No evidence that child/youth has been exposed to war, political violence, or torture.
1	Child/youth did not live in war-affected region or refugee camp, but family was exposed to war. Family members directly related to the child/youth may have been exposed to war, political violence, or torture; family may have been forcibly displaced due to the war. This does not include children/youth who have lost one or both parents during the war.
2	Child/youth has been exposed to war or political violence. He or she may have witnessed others being injured in the war, may have family members who were hurt or killed in the war, and may have lived in an area where bombings or fighting took place. Child/youth may have lost one or both parents during the war, or one or both parents may be physically or psychologically disabled from war so that they are not able to provide adequate caretaking of child/youth. Child/youth may have spent extended amount of time in refugee camp.
3	Child/youth has experienced the direct effects of war. Child/youth may have feared for his/her own life during war due to bombings or shelling very near to him/her. Child/youth may have been directly injured, tortured, or kidnapped. Child/youth may have served as soldiers, guerrilla, or other combatant in his/her home country.

### RATING AND PRACTICE CONSIDERATIONS

- Where was the violence – at home or in another location?
- Is this a long standing war or an acute incident?
- Was this activity expected or unexpected?
- What was the end result of the altercation?
- How does the child/youth view the war/incident?

## 11. TERRORISM

This item describes the degree to which a child/youth has been exposed to terrorism. Terrorism is defined as "the calculated use of violence or the threat of violence to inculcate fear, intended to coerce or to intimidate governments or societies in the pursuit of goals that are generally political, religious, or ideological." Terrorism includes attacks by individuals acting in isolation (e.g., sniper attacks).

RATING	DEFINITION
0	No evidence that child/youth has been exposed to terrorism or terrorist activities.

<b>1</b>	Child’s/youth’s community has experienced an act of terrorism, but the child/youth was not directly impacted by the violence (e.g., child/youth lives close enough to site of terrorism that he/she may have visited before or child/youth recognized the location when seen on TV, but child’s/youth’s family and neighborhood infrastructure was not directly affected). Exposure has been limited to pictures on television.
<b>2</b>	Child/youth has been exposed to terrorism within his/her community, but did not directly witness the attack. Child/youth may live near the area where attack occurred and be accustomed to visiting regularly in the past, infrastructure of child’s/youth’s daily life may be disrupted due to attack (e.g., utilities or school), and child/youth may see signs of the attack in neighborhood (e.g., destroyed building). Child/youth may know people who were injured in the attack.
<b>3</b>	Child/youth has witnessed the death of another person in a terrorist attack, or has had friends or family members seriously injured or died as a result of terrorism, or has directly been injured by terrorism leading to significant injury or lasting impact.

**RATING AND PRACTICE CONSIDERATIONS**

- Was the child/youth directly impacted as an individual?
- Was the child’s/youth’s family directly impacted?
- How did the child/youth become aware of the terrorism?

## 12. WITNESS / VICTIM TO CRIMINAL ACTIVITY

This item describes the severity of exposure to criminal activity. Criminal behavior includes any behavior for which an adult could go to prison, including drug-dealing, prostitution, assault, or battery.

RATING	DEFINITION
<b>0</b>	No evidence that child/youth has been victimized or witnessed significant criminal activity.
<b>1</b>	Strong suspicion or evidence that child/youth is a witness of at least one significant criminal activity.
<b>2</b>	Child/youth has witnessed multiple criminal activities and/or is a direct victim of criminal activity, or witnessed the victimization of a family or friend.
<b>3</b>	Child/youth has been exposed to chronic and/or severe instances of criminal activity and/or is a direct victim of criminal activity that was life threatening or caused significant physical harm, or child/youth witnessed the death of a loved one.

**RATING AND PRACTICE CONSIDERATIONS**

- What was the crime?
- What was the outcome for the victim?
- How does the child say they were affected?
- What do post-incident behaviors look like?
- Was the child/youth part of committing the crime?

### 13. PARENTAL CRIMINAL BEHAVIOR (Birth parents and legal guardians only)

This item rates the criminal behavior of birth parents, stepparents, and other legal guardians – not foster parents.

RATING	DEFINITION
0	No evidence that child's/youth's parents have ever engaged in criminal behavior.
1	One of child's/youth's parents has a history of criminal behavior or incarceration, but child/youth has not been in contact with this parent for at least one year.
2	One of child's/youth's parents has a history of criminal behavior resulting in a conviction or incarceration, and child/youth has been in contact with this parent in the past year.
3	Both of child's/youth's parents have history of criminal behavior resulting in incarceration.
RATING AND PRACTICE CONSIDERATIONS	
<ul style="list-style-type: none"> <li>• Is the child/youth or his/her siblings involved in the criminal behavior?</li> <li>• Are the parents members of a gang?</li> <li>• What is the family culture regarding crime?</li> </ul>	

### 14. DISRUPTION IN CAREGIVING / ATTACHMENT LOSSES

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

RATING	DEFINITION
0	No evidence that the child/youth has experienced disruptions in caregiving and/or attachment losses.
1	Child/youth may have experienced one disruption in caregiving but was placed with a familiar alternative caregiver, such as a relative (e.g., child/youth shifted from care of birth mother to paternal grandmother). Child/youth may or may not have had ongoing contact with primary attachment figure(s) during this disruption. Shift in caregiving may be temporary or permanent.
2	Child/youth has been exposed to 2 or more disruptions in caregiving with known alternate caregivers, or the child/youth has had at least one disruption involving placement with an unknown caregiver. Children/youth who have been placed in foster or other out-of-home care such as residential care facilities would be rated here.

3

Child/youth has been exposed to multiple/repeated placement changes (i.e., 3+ placements with a known caregiver or 2+ with unknown caregiver) resulting in caregiving disruptions in a way that has disrupted various domains of a child's/youth's life (e.g., loss of community, school placement, peer group). Examples would include a child/youth in several short-term unknown placements (e.g., moved from emergency foster care to additional foster care placements) and/or multiple transitions in and out of the family-of-origin (e.g., several cycles of removal and reunification).

**RATING AND PRACTICE CONSIDERATIONS** (*Disruption in Caregiving/Attachment Losses*)

- Who is caregiving now?
- Is current caregiver safe to parent children/youth?
- Does child/youth know what happened to end the last placement?
- Is child/youth worried about a past caregiver?

## Child Strengths Domain

***These ratings describe a range of assets that children and adolescents may possess that can facilitate healthy development. An absence of a strength is not necessarily a need but an indication that strength-building activities are indicated. In general strengths are more trait-like, stable characteristics; however, the 30-day rating window still applies unless overridden by the action levels, as described below.***

For this domain, the following ratings and action levels are used:

0 = Strengths exist that can be used as a centerpiece for a strength-based plan.

1 = Strengths exist but require some strength-building efforts in order for them to serve as a focus of a strength-based plan.

2 = Strengths have been identified but require significant strength-building efforts before they can be effectively utilized as a focus of a strength-based plan.

3 = Efforts are needed in order to identify potential strengths on which to build.

**\* When you have no information/evidence about a strength in this area, use a score of 3.**

### 15. FAMILY

Family refers to all family members as defined by the child/youth, or birth relatives and significant others with whom the child/youth is still in contact. Is the family (as defined by the child/youth) a support and strength to the child/youth?

RATING	DEFINITION
0	Significant family strengths. There is at least one family member who has a strong loving relationship with the child/youth and is able to provide significant emotional or concrete support.
1	Moderate level of family strengths. There is at least one family member with a strong loving relationship who is able to provide limited emotional or concrete support.
2	Mild level of family strengths. Family members are known, but currently none are able to provide emotional or concrete support.
3	Child/youth has no known family strengths. There are no known family members.

#### RATING AND PRACTICE CONSIDERATIONS

- Who is part of his/her family?
- How is family defined?
- Who is the best resource in the family?
- Who can you leverage in treatment?

## 16. INTERPERSONAL

This item refers to the interpersonal skills of the child or youth both with peers and adults – do not capture family/caregivers here – use the family item to do so.

RATING	DEFINITION
0	Significant interpersonal strengths. Child/youth has close friends and is friendly with others.
1	Moderate level of interpersonal strengths. Child/youth may have a history of forming positive relationships with peers and/or non-caregivers. Child/youth may have at least one healthy relationship and is friendly with others.
2	Mild level of interpersonal strengths. Child/youth has some social skills that facilitate positive relationships with peers and adults but may not have any current healthy friendships.
3	Very limited ability to make and maintain positive relationships. Child/youth lacks social skills and has no history of positive relationships with peers and adults.
RATING AND PRACTICE CONSIDERATIONS	
<ul style="list-style-type: none"> <li>• Does the child/youth have the personality to get what they need from others in a positive manner?</li> <li>• Do others want to help the child/youth?</li> </ul>	

## 17. EDUCATIONAL SETTING

This item refers to the strengths of the school system or the child’s preschool setting, and may or may not reflect any specific educational skills possessed by the child or youth.

RATING	DEFINITION
0	Child/youth is in school, involved with an educational plan (or IEP), and appears to exceed expectations. School works exceptionally well with family and caregivers to create a special learning environment that meets the child’s/youth’s needs. Someone at the school goes above and beyond to take a healthy interest in the educational success of the child/youth.
1	Child/youth is in school and has a plan that appears to be effective. School works fairly well with family and caregivers to ensure appropriate educational development.
2	Child/youth is in school but has a plan that does not appear to be effective.
3	Child/youth is either not in school or is in a school setting that does not further his/her education.
N/A	This item is only rated not applicable when a child/youth is not in a school or preschool setting.

**RATING AND PRACTICE CONSIDERATIONS (*Educational Setting*)**

- What is the family culture regarding education?
- How does the family feel about the school system?
- How does the school system feel about the family?
- Does the school advocate for the child/youth?

**18. VOCATIONAL**

Generally, this item is reserved for adolescents and is not applicable for children 14 years of age and younger. Computer skills would be rated here.

RATING	DEFINITION
0	Adolescent youth has vocational skills and is currently working in a natural environment.
1	Adolescent youth has pre-vocational and some vocational skills but limited work experience.
2	Adolescent youth has some pre-vocational skills but is not presently working in any area related to those skills. This also may indicate a youth with a clear vocational preference.
3	Adolescent youth has no known or identifiable vocational or pre-vocational skills and no expression of any future vocational preferences.
N/A	This item is not applicable when a child/youth is under 14 years old.

**RATING AND PRACTICE CONSIDERATIONS**

- Is vocation appropriate for this child/youth given age and development?
- Does the child/youth participate in other prevocational activities?
- Does the child/youth volunteer or participate in other community improvement activities?
- If in residential care without the ability to work in the community, does the child/youth participate in other activities that would encourage job skill development?

## 19. COPING AND SAVORING SKILLS

This item should be based on the psychological strengths that the child or youth might have developed, including both the ability to enjoy positive life experiences and manage negative life experiences. This should be rated independent of the child's/youth's current level of distress.

RATING	DEFINITION
0	Child/youth has exceptional psychological strengths. Both coping and savoring skills are well developed.
1	Child/youth has good psychological strengths. He/she has solid coping skills for managing distress or solid savoring skills for enjoying pleasurable events.
2	Child/youth has limited psychological strengths. For example, a child with very low self-esteem would be rated here.
3	Child/youth has no known or identifiable psychological strengths. This may be due to intellectual impairment or serious psychiatric disorders.

RATING AND PRACTICE CONSIDERATIONS	
<ul style="list-style-type: none"> <li>• Can the child/youth identify his/her coping/savoring skills?</li> <li>• Does he/she value them?</li> <li>• Does he/she believe in them?</li> </ul>	

## 20. OPTIMISM

This item should be based on the child's or youth's sense of himself/herself in his/her own future. This is intended to rate the child's/youth's positive future orientation.

RATING	DEFINITION
0	Child/youth has a strong and stable optimistic outlook on his/her life. Child/youth is future-oriented.
1	Child/youth is generally optimistic. Child/youth is likely able to articulate some positive future vision.
2	Child/youth has difficulties maintaining a positive view of himself/herself and his/her life. Child/youth may be overly pessimistic.
3	Child/youth has difficulties seeing any positives about himself/herself or his/her life.

**RATING AND PRACTICE CONSIDERATIONS (*Optimism*)**

- Can the child/youth identify his/her strengths or other things they do well?
- Can the child/youth incorporate these into his/her vision of the future?

**21. TALENTS / INTERESTS**

This item should be based broadly on any talent, creative or artistic skill, interest, or hobby a child or youth may have, including art, theatre, music, athletics, reading/writing, etc.

RATING	DEFINITION
0	Child/youth has significant creative/artistic strengths or serious interest. A child/youth who receives a significant amount of personal benefit from activities surrounding a talent, hobby, or interest would be rated here.
1	Child/youth has a notable talent or considerable hobby/interest. For example, a youth who is involved in athletics or plays a musical instrument would be rated here.
2	Child/youth has expressed interest in developing a specific talent or talents, interest, or hobby even if they have not developed any to date.
3	Child/youth has no known talents, interests, or hobbies.

**RATING AND PRACTICE CONSIDERATIONS**

- Does the child/youth have a natural talent or hobby?
- Is there someone who can mentor the child/youth?
- Does this talent or hobby have the potential to improve his/her functioning self-esteem?

**22. SPIRITUAL / RELIGIOUS**

This item should be based on the child’s/youth’s and their family’s involvement in spiritual or religious beliefs and activities.

RATING	DEFINITION
0	Child/youth has strong moral and spiritual strengths. Child/youth may be very involved in a religious community or may have strongly held spiritual or religious beliefs that can sustain or comfort him/her in difficult times.
1	Child/youth has some moral and spiritual strengths. Child/youth may be involved in a religious community.
2	Child/youth has few spiritual or religious strengths. Child/youth may have little contact with religious institutions.



<b>3</b>	Child/youth has no known spiritual or religious involvement.
<b>RATING AND PRACTICE CONSIDERATIONS (<i>Spiritual/Religious</i>)</b>	
<ul style="list-style-type: none"> <li>Does the child/youth have a natural community connection?</li> <li>What programs or services are available through this outlet?</li> <li>Is the community aware of this family and vice versa?</li> </ul>	

### 23. COMMUNITY LIFE

This item should be based on the child's or youth's level of involvement in the cultural aspects of life in his/her community.

RATING	DEFINITION
0	Child/youth has extensive and substantial long-term ties with the community. For example, he/she may be a member of a community group (e.g., girl or boy scouts) for more than one year, may be widely accepted by neighbors, or involved in other community activities, informal networks, etc.
1	Child/youth has significant community ties although they may be relatively short-term (e.g., past year).
2	Child/youth has limited ties and/or supports from the community.
3	Child/youth has no known ties or supports from the community.
<b>RATING AND PRACTICE CONSIDERATIONS</b>	
<ul style="list-style-type: none"> <li>Is the community aware of the needs of this child/youth?</li> <li>Are there resources within the community? Why might the family not access them?</li> <li>What is the culture of the community?</li> <li>Does the family identify with their community?</li> </ul>	

### 24. RELATIONSHIP PERMANENCE

This item refers to the stability of significant relationships in the child's or youth's life. This likely includes family members but may also include other individuals.

RATING	DEFINITION
0	Child/youth has very stable relationships. Family members, friends, and community have been stable for most of his/her life and are likely to remain so in the foreseeable future. Child/youth is involved with both parents.
1	Child/youth has had stable relationships, but there is some concern about instability in the near future (one year) due to transitions, illness, or age. A child/youth who has a stable relationship with only one parent may be rated here.

<b>2</b>	Child/youth has had at least one stable relationship over his/her lifetime but has experienced other instability through factors such as divorce, moving, removal from home, and death.
<b>3</b>	Child/youth does not have any stability in relationships.
<b>RATING AND PRACTICE CONSIDERATIONS (<i>Relationship Permanence</i>)</b>	
<ul style="list-style-type: none"> <li>Does the child/youth have anyone in his/her life that he/she believes will be a permanent connection?</li> </ul>	

## 25. RESILIENCE

This item refers to the child’s or youth’s ability to recognize his or her strengths and use them in times of need or to support his/her own development.

RATING	DEFINITION
<b>0</b>	Child/youth is able to recognize and uses his/her strengths for healthy development and problem-solving.
<b>1</b>	Child/youth recognizes his/her strengths but is not yet able to use them in support of his/her healthy development or problem-solving.
<b>2</b>	Child/youth has limited ability to recognize and use his/her strengths to support healthy development and/or problem-solving.
<b>3</b>	Child/youth fails to recognize his/her strengths and is therefore unable to utilize them.
<b>RATING AND PRACTICE CONSIDERATIONS</b>	
<ul style="list-style-type: none"> <li>Can the child/youth identify his/her own strengths?</li> <li>Can the child/youth connect his/her strengths to meeting his/her needs?</li> </ul>	

## 26. YOUTH INVOLVEMENT WITH CARE

This item refers to the child’s or youth’s participation in efforts to address his/her identified needs.

RATING	DEFINITION
<b>0</b>	Child/youth is knowledgeable of needs and helps direct planning to address them.
<b>1</b>	Child/youth is knowledgeable of needs and participates in planning to address them.

<b>2</b>	Child/youth is at least somewhat knowledgeable of needs or is not willing to participate in plans to address them.
<b>3</b>	Child/youth is neither knowledgeable about needs nor willing to participate in any process to address them.

**RATING AND PRACTICE CONSIDERATIONS** (*Youth Involvement with Care*)

- There may be a need for some psycho-education; however, this should not be the primary focus of this item.
- Is the child/youth compliant?
- Does he/she participate in creating positive plans for their care?
- Does child/youth actively contribute in meetings and discussions about him/her?

**27. USE OF FREE TIME**

This item refers to the child’s or youth’s ability to use free time in a constructive way.

RATING	DEFINITION
<b>0</b>	Child/youth has opportunities and is motivated to spend free time in a constructive manner.
<b>1</b>	Child/youth is knowledgeable of opportunities and/or sometimes participates in them.
<b>2</b>	Child/youth is at least somewhat knowledgeable of opportunities or is not willing to participate.
<b>3</b>	Child/youth is neither knowledgeable about nor willing to participate in constructive activities.

**RATING AND PRACTICE CONSIDERATIONS**

- Is the child/youth able to organize his/her free time in the program, community, at home?
- Does he/she look for and partake in positive activities?
- Is he/she open to various activities?
- If able, does he/she attend community events?

**28. PEER INFLUENCES**

Please rate the highest level from the **past 30 days**.

RATING	DEFINITION
<b>0</b>	Child’s/youth’s primary peer social network is a strong positive influence on each other.
<b>1</b>	Child/youth has peers in his/her primary peer social network who engage in prosocial behavior most of the time.



2	Child/youth has some peers who engage in prosocial behavior, but youth is not a primary member of this group.
3	Child/youth rarely spends time with prosocial peers and/or could be gang-involved.

**RATING AND PRACTICE CONSIDERATIONS** (*Peer Influences*)

- Does the child/youth have friends? Do the friends demonstrate good judgment?
- Are the child's/youth's current friends court-involved?
- Are they otherwise involved in their community?
- Do the friends use substances?

## Life Functioning Domain

***This domain describes how children and adolescents are doing in their various environments or life capacities. The items were identified from the children’s research literature on wraparound philosophy. Functioning well in all life capacities is the goal of a lifetime developmental framework.***

For this domain, the following ratings and action levels are used:

- 0 = A life domain in which the child is excelling. There is no evidence of concern and/or is an area of considerable strength.
- 1 = A life domain in which the child is doing okay. This is an area of potential strength. Historical function concerns can be captured here.
- 2 = A life domain in which the child is having problems. Help is needed to improve functioning into an area of strength.
- 3 = A life domain in which the child is having significant problems. Intensive help is needed to improve functioning into an area of strength.

### 29. FAMILY

Family ideally should be defined by the child/youth; however, in the absence of this knowledge consider birth and adoptive relatives and their significant others with whom the child/youth has contact as the definition of family. Foster families should only be considered if they have made a significant commitment to the child/youth. Is the family (as defined by the child/youth) functioning well together?

RATING	DEFINITION
0	Child/youth gets along well with family members.
1	Child/youth is doing adequately in relationships with family members, although some problems may exist. For example, some family members may have some problems in their relationships with child/youth.
2	Child/youth is having moderate problems with parents, siblings, and/or other family members. Frequent arguing and/or difficulties in maintaining any positive relationship may be observed.
3	Child/youth is having severe problems with parents, siblings, and/or other family members. This would include problems of domestic violence, constant arguing, etc.

#### RATING AND PRACTICE CONSIDERATIONS

- Who is in the family?
- Who does the child/youth identify as his/her family?
- Who is the person that represents the greatest need?

### 30. LIVING SITUATION

This item refers to how the child/youth is functioning in his/her current living arrangement, which could be with a relative, in a temporary foster home, shelter, etc.

RATING	DEFINITION
0	Child/youth is functioning well in his/her current living environment. Child/youth and caregivers feel comfortable and safe dealing with issues that come up in day-to-day life.
1	Mild problems with functioning in current living situation. Caregivers express some concern about child's/youth's behavior in living situation and/or child/youth and caregiver have some difficulty dealing with issues that arise in daily life.
2	Moderate to severe problems with functioning in current living situation. Child/youth and caregivers have difficulty interacting effectively with each other much of the time. Difficulties may create significant problems for others in the residence.
3	Profound problems with functioning in current living situation. Child/youth is at immediate risk of being removed from living situation.
RATING AND PRACTICE CONSIDERATIONS	
<ul style="list-style-type: none"> <li>• How often has the family moved, or are they in danger of being evicted?</li> <li>• How do they feel about their neighborhoods?</li> <li>• How does the child/youth fit into/feel about the current arrangement?</li> </ul>	

### 31. SOCIAL FUNCTIONING

This item refers to the child's/youth's social functioning from a developmental perspective. This should include the child's/youth's social or "soft" skills.

RATING	DEFINITION
0	Child/youth interacts appropriately with others and builds and maintains relationships.
1	Child/youth is having some difficulty interacting with others and building and/or maintaining relationships.
2	Child/youth often has problems interacting with others and building and maintaining relationships. These behaviors have been labeled as inappropriate by others.
3	Child/youth consistently and pervasively has problems interacting with others and building and maintaining relationships. Child is considered significantly socially challenged.

**RATING AND PRACTICE CONSIDERATIONS** (*Social Functioning*)

- What does the child/youth need?
- Are the child’s behaviors in social settings considered appropriate?
- Can the child/youth negotiate with others to get what they need?
- Is the child/youth on target developmentally?

**32. DEVELOPMENTAL / INTELLECTUAL**

This item rates the presence of intellectual or developmental disabilities. All developmental disabilities occur on a continuum; a child/youth with Autism may be designated a ‘0’, ‘1’, ‘2’, or ‘3’ depending upon the significance of the disability and the impairment.

RATING	DEFINITION
0	No evidence of developmental or intellectual disabilities.
1	Documented delay, learning disability, or documented borderline intellectual disability (FSIQ 70 to 85).
2	Evidence of a pervasive developmental disorder, including autism, Tourette syndrome, Down syndrome or other significant developmental delay, or child/youth has mild intellectual disability (FSIQ 50 to 69).
3	Moderate, severe, or profound developmental disability or FSIQ below 50.
N/A	Not applicable when the child’s/youth’s IQ is unknown and there is no evidence of a learning disability or other developmental delay.

**RATING AND PRACTICE CONSIDERATIONS**

- Is the child/youth on target developmentally?
- Has his/her development been impacted by trauma?

**33. RECREATIONAL**

This item is intended to reflect the child’s/youth’s access to and use of leisure time activities that are organized or scheduled.

RATING	DEFINITION
0	Child/youth makes full use of leisure time to pursue recreational activities that support his/her healthy development and enjoyment.
1	Child/youth at times has difficulty using leisure time to pursue recreational activities.



<b>2</b>	Child/youth is having moderate problems with recreational activities and may be unable to use leisure time to enjoy recreational activities.
<b>3</b>	Child/youth has no access to or interest in recreational activities. Child/youth has significant difficulties making use of leisure time.
<b>RATING AND PRACTICE CONSIDERATIONS (<i>Recreational</i>)</b>	
<ul style="list-style-type: none"> <li>• Are there recreational activities that are available to the child/youth?</li> <li>• How does the child's/youth's status as receiving services impact his/her ability to participate in activities?</li> </ul>	

### 34. LEGAL

This item describes the child's/youth's (not the family's) involvement with the legal system. This could include involvement in the Juvenile or Adult Justice Systems.

<b>RATING</b>	<b>DEFINITION</b>
<b>0</b>	Child/youth has no known legal difficulties.
<b>1</b>	Child/youth has a history of legal problems but currently is not involved with the legal system and is not currently on parole or probation.
<b>2</b>	Child/youth has some legal problems, is currently involved in the legal system, and may have active parole and/or probation mandates.
<b>3</b>	Child/youth has serious current or pending legal difficulties that place him/her at risk for a re-arrest, or youth is currently incarcerated.
<b>RATING AND PRACTICE CONSIDERATIONS</b>	
<ul style="list-style-type: none"> <li>• Does the child/youth understand what is happening?</li> <li>• Is the language used at an age appropriate level for the child/youth?</li> <li>• Does the child/youth have an advocate?</li> <li>• Does the child/youth understand what is at stake?</li> </ul>	

### 35. MEDICAL

This item refers to the child's/youth's physical health status.

<b>RATING</b>	<b>DEFINITION</b>
<b>0</b>	Child/youth has no current health problems or chronic conditions.
<b>1</b>	Child/youth has mild/treatable medical problems that require medical treatment.

<b>2</b>	Child/youth has chronic illness that requires ongoing medical intervention.
<b>3</b>	Child/youth has life threatening illness or medical condition.
<b>RATING AND PRACTICE CONSIDERATIONS</b> <i>(Medical)</i>	
<ul style="list-style-type: none"> <li>• Has the child/youth had a physical exam?</li> <li>• Does the child/youth have a medical home? Primary care doctor?</li> <li>• Is his/her primary care doctor involved in this plan?</li> <li>• What are some of the child’s/youth’s former or existing health issues?</li> <li>• Has the child/youth been hospitalized? Had surgery?</li> </ul>	

### 36. PHYSICAL

This item is used to identify physical limitations, including chronic conditions that entail impairment of eating, breathing, vision, hearing, mobility, or other functions.

<b>RATING</b>	<b>DEFINITION</b>
<b>0</b>	Child/youth has no physical limitations.
<b>1</b>	Child/youth has some physical condition that places mild limitations on activities. Conditions such as impaired hearing or vision would be rated here. Also rate here treatable medical conditions that result in physical limitations (e.g., asthma).
<b>2</b>	Child/youth has physical condition that notably impacts activities. Sensory disorders such as blindness, deafness, or significant motor difficulties would be rated here.
<b>3</b>	Child/youth has severe physical limitations due to multiple physical conditions.
<b>RATING AND PRACTICE CONSIDERATIONS</b>	
<ul style="list-style-type: none"> <li>• Is the child’s/youth’s functioning being impaired by a physical health issue?</li> <li>• Has the child/youth seen a dentist, eye doctor, etc.?</li> <li>• Does the child/youth have all necessary medications? Inhalers? Skin creams?</li> </ul>	

### 37. SLEEP

This item rates any disruptions in sleep regardless of the cause, including problems with going to bed, staying asleep, waking up early, or sleeping too much.

<b>RATING</b>	<b>DEFINITION</b>
<b>0</b>	Child/youth gets a full night’s sleep each night.

<b>1</b>	Child/youth has some problems sleeping. Generally, child/youth gets a full night’s sleep but at least once a week problems arise. This may include occasionally awakening or bed wetting or nightmares.
<b>2</b>	Child/youth is having problems with sleep. Sleep is often disrupted and child/youth seldom obtains a full night of sleep.
<b>3</b>	Child/youth is generally sleep-deprived. Sleeping is difficult for the child/youth and s/he is not able to get a full night’s sleep.

**RATING AND PRACTICE CONSIDERATIONS (*Sleep*)**

- Do the child’s/youth’s sleeping patterns impact his/her functioning?
- Who is deciding that his/her sleep is an issue?
- Is his/her sleep in line with others at his/her developmental stage?

**38. SEXUAL DEVELOPMENT**

This item looks at broad issues of sexual development, including sexual behavior, sexual identity, sexual concerns, and the reactions of significant others to any of these factors.

<b>RATING</b>	<b>DEFINITION</b>
<b>0</b>	No evidence of any problems with sexual development.
<b>1</b>	Mild to moderate problems with sexual development. May include concerns about sexual identity or anxiety about the reactions of others.
<b>2</b>	Significant problems with sexual development. May include inappropriate or high-risk sexual behavior, distress due to gender identity issues, and/or some experience of negative reactions of others.
<b>3</b>	Profound problems with sexual development. This level would include prostitution, very frequent risky sexual behavior, or sexual aggression and/or the expectation of specific life-threatening reactions by others.

**RATING AND PRACTICE CONSIDERATIONS**

- Is the child/youth on target?
- Has the child/youth been abused sexually?
- Has someone taken the responsibility to discuss healthy sexual development with him/her?

### 39. ACTIVITIES IN DAILY LIVING

This item rates the ability of the child/youth to perform activities of daily living (e.g., self-care, including feeding, bathing, dressing, grooming; work; and leisure activities).

RATING	DEFINITION
0	No evidence of problems with activities of daily living. The child/youth is fully independent across these areas, as developmentally appropriate.
1	Mild problems with activities of daily living. The child/youth is generally good with such activities but may require some adult support to complete some specific developmentally appropriate activities.
2	Moderate problems with activities of daily living. The child/youth has difficulties with developmentally appropriate activities.
3	Severe problems with activities of daily living. The child/youth requires significant and consistent adult support to complete developmentally appropriate activities.

#### RATING AND PRACTICE CONSIDERATIONS

- Remember to include appropriate developmental targets/milestones for the individual.
- Measure how this impacts functioning and not other people’s personal preferences.
- If a current support is temporary, rate this item without considering assistance from the support.

***The following three school-related items can be scored for children ages 3-5 years if they are in a preschool / day care setting or an early intervention program such as Head Start.***

### 40. SCHOOL BEHAVIOR

This item rates the behavior of the child or youth in school or school-like settings (e.g., Head Start, pre-school). A rating of ‘3’ would indicate a child/youth who is still having problems after special efforts have been made (e.g., problems in a special education class).

RATING	DEFINITION
0	No evidence of behavior problems at school or day care. Child/youth is behaving well.
1	Child/youth is having mild behavioral problems at school. May be related to relationships with teachers or with peers. A single detention might be rated here.

2	Child/youth is having moderate behavioral difficulties at school. He/she is disruptive and may receive sanctions, including suspensions or multiple detentions.
3	Child/youth is having severe problems with behavior in school. He/she is frequently or severely disruptive. School placement may be in jeopardy due to behavior.
N/A	Not applicable for children three years and younger or for children/youth not required/expected to be in school.

**RATING AND PRACTICE CONSIDERATIONS** (*School Behavior*)

- What do these behaviors look like?
- Is it consistent among all subjects/classes?
- How long has it been going on?
- How long has the child/youth been in the school?

### 41. SCHOOL ACHIEVEMENT

This item describes academic achievement and functioning.

RATING	DEFINITION
0	Child/youth is working at grade level, passing all classes, and is on track with his/her educational plan.
1	Child/youth is doing adequately in school, although some problems with achievement exist.
2	Child/youth is having moderate problems with school achievement. He/she may be failing some subjects and/or be at risk for failing the current grade.
3	Child/youth is having severe achievement problems. He/she may be failing most subjects or is more than one year behind same age peers in school achievement, and/or will certainly not pass to next grade level.
N/A	Not applicable for children three years and younger or any other child/youth not expected to be in school.

**RATING AND PRACTICE CONSIDERATIONS**

- Is the child/youth on task for themselves?
- What issues are impacting achievement?
- Is it consistent in all areas of education?

## 42. SCHOOL ATTENDANCE

If school is not in session, rate the last 30 days when school was in session.

RATING	DEFINITION
0	No evidence of attendance problems. Child/youth attends regularly.
1	Child/youth has some problems attending school, although he/she generally goes to school. He/she may miss up to one day per week on average, or he/she may have had moderate to severe problems in the past six months but has been attending school regularly in the past month.
2	Child/youth is having problems with school attendance. He/she is missing at least two days per week on average.
3	Child/youth is generally truant or refusing to go to school, or a school-aged child/youth is not enrolled in school.
N/A	Not applicable for children three years and younger or any other child/youth not expected to be in school.

### RATING AND PRACTICE CONSIDERATIONS

- Who is responsible for getting child/youth to school?
- Is school in session?
- Why does the child/youth report that he/she is not going to school? Has this been addressed?
- What is the rest of the child's/youth's family doing while the child/youth is supposed to be in school?

## Cultural Considerations Domain

**All children are members of some identifiable cultural group. These ratings describe possible problems that children or adolescents may experience with the relationship between their cultural membership and the predominant culture in which they live. Considerations about culture should include the values, beliefs, and experiences of the individual, family, and community.**

For this domain, the following ratings and action levels are used:

- 0 = There is no evidence of any needs.
- 1 = Requires monitoring, watchful waiting, or preventive activities.
- 2 = Requires action to ensure that this identified need or risk behavior is addressed.
- 3 = Requires immediate or intensive action.

### 43. LANGUAGE

This item includes both spoken and sign language. This item concerns any language-related needs a family might have that affect their participation in services.

RATING	DEFINITION
0	Child/youth and family have no problems communicating in English and do not require the assistance of a translator.
1	Child/youth and family speak some English, but potential communication problems exist due to limits on vocabulary or understanding of the nuances of the language.
2	Child/youth and/or significant family members do not speak English. Translator or native language speaker is needed for successful intervention, but qualified individual can be identified within natural supports.
3	Child/youth and/or significant family members do not speak English. Translator or native language speaker is needed for successful intervention, and no such individual is available from among natural supports.

#### RATING AND PRACTICE CONSIDERATIONS

- What language is spoken at home?
- What was the child's/youth's first language?
- Does everyone in the family speak English, etc.?
- Who translates when necessary?

#### 44. IDENTITY

Cultural identity refers to the child’s/youth’s view of himself/herself as belonging to a specific cultural group. This cultural group may be defined by a number of factors, including race, religion, ethnicity, geography, or lifestyle.

RATING	DEFINITION
0	Child/youth has clear and consistent cultural identity and is connected to others who share his/her cultural identity.
1	Child/youth is experiencing some confusion or concern regarding his/her cultural identity.
2	Child/youth has significant struggles with his/her own cultural identity. Child/youth may have cultural identity but is not connected with others who share this culture.
3	Child/youth has no connection to his/her cultural identity or is experiencing significant problems due to internal conflict regarding his/her cultural identity.
RATING AND PRACTICE CONSIDERATIONS	
<ul style="list-style-type: none"> <li>• How does the child/youth identify?</li> <li>• Is there pressure to identify as something different?</li> <li>• Is the child/youth connected with others who identify similarly?</li> </ul>	

#### 45. RITUAL

Cultural rituals are activities and traditions that are culturally-specific, including the celebration of holidays such as Kwanza, Cinco de Mayo, etc. Rituals also may include daily activities that are culturally-specific (e.g., praying toward Mecca at specific times, eating a specific diet, access to media). Rituals include being able to speak one’s primary language with others.

RATING	DEFINITION
0	Child/youth is consistently able to practice rituals consistent with his/her cultural identity.
1	Child/youth is generally able to practice rituals consistent with his/her cultural identity; however, he/she sometimes experiences some obstacles to the performance of these rituals.
2	Child/youth experiences significant barriers and is sometimes prevented from practicing rituals consistent with his/her cultural identity.
3	Child/youth is unable to practice rituals consistent with his/her cultural identity.
RATING AND PRACTICE CONSIDERATIONS	
<ul style="list-style-type: none"> <li>• What are the barriers?</li> <li>• Who is responsible for problem solving?</li> <li>• Is the child/youth able to advocate for himself/herself?</li> </ul>	

## 46. CULTURE STRESS

Culture stress refers to experiences and feelings of discomfort and/or distress arising from friction (real or perceived) between an individual’s own cultural beliefs, values, identity and the predominant culture in which he/she lives. Racism would be rated here.

RATING	DEFINITION
0	No evidence of stress between child’s/youth’s cultural identity and current living situation.
1	Some evidence of mild or occasional stress resulting from friction between the child’s/youth’s cultural identity and his/her current living situation.
2	Child/youth is experiencing cultural stress from friction between the child’s/youth’s cultural identity and current living situation, and that is causing some problems with functioning.
3	Child/youth is experiencing a high level of cultural stress between his/her cultural identity and current living situation that is making functioning very difficult under the present circumstances.
<b>RATING AND PRACTICE CONSIDERATIONS</b>	
<ul style="list-style-type: none"> <li>• What has discrimination looked like?</li> <li>• What do family members believe is their reality of discrimination?</li> </ul>	

## Child Behavioral / Emotional Needs Domain

***These items identify the behavioral health needs of the child or adolescent. While the CANS is not a diagnostic tool, it is designed to be consistent with diagnostic communication. In DSM, a diagnosis is defined by a set of symptoms that is associated with either dysfunction or distress. This definition is consistent with the ratings of '2' or '3' as defined by the action levels below.***

For this domain, the following ratings and action levels are used:

- 0 = There is no evidence of any needs.
- 1 = Requires monitoring, watchful waiting, or preventive activities.
- 2 = Requires action to ensure that this identified need or risk behavior is addressed.
- 3 = Requires immediate or intensive action.

### 47. ADJUSTMENT TO TRAUMA

This item covers the child's/youth's reaction to any traumatic or adverse childhood experience. This item covers adjustment disorders, post-traumatic stress disorder and other diagnoses from DSM that the child/youth may have as a result of their exposure to traumatic/adverse childhood experiences.

***This item should be rated as '1'-'3' for children/youth who are exhibiting any symptoms related to a traumatic or adverse childhood experience in their past. This item allows you to rate the overall severity of the broad range of symptoms they may be experiencing. The remaining items on the CANS will allow you to rate the specific types of symptoms.***

RATING	DEFINITION
0	There is no evidence that the child/youth has experienced any significant trauma or he/she has adjusted well to traumatic/adverse childhood experiences.
1	Child/youth has some mild problems with adjustment due to trauma that might ease with the passage of time. Child/youth may be in the process of recovering from a more extreme reaction to a traumatic experience.
2	Child/youth presents with a moderate level of symptoms. Symptoms can vary widely and may include sleeping or eating disturbances, regressive behavior, behavior problems or problems with attachment. Child/youth may have features of one or more diagnoses and may meet full criteria for a specific DSM diagnosis, including, but not limited to, diagnoses of post-traumatic stress disorder (PTSD) and adjustment.

3

Child/youth has severe symptoms as a result of traumatic or adverse childhood experiences that require intensive or immediate attention. Child/youth likely meets criteria for more than one diagnosis or would meet criteria for a developmental trauma disorder or a complex trauma disorder.

**RATING AND PRACTICE CONSIDERATIONS** (*Adjustment to Trauma*)

- What was the trauma?
- How is it connected to the current issue?
- What are the child’s/youth’s current coping skills?
- Who is supporting the child/youth?

**48. EMOTIONAL AND / OR PHYSICAL REGULATION**

These symptoms are characterized by difficulties with arousal regulation. This can include difficulties modulating or expressing emotions and energy states such as emotional outbursts or marked shifts in emotions, overly constricted emotional responses, and intense emotional responses, and/or evidence of constricted, hyperaroused, or quickly fluctuating energy level. The child/youth may demonstrate such difficulties with a single type or a wide range of emotions and energy states. This can also include difficulties with regulation of body functions, including disturbances in sleeping, eating, and elimination; over-reactivity or under-reactivity to touch and sounds; and physical or somatic complaints. This can also include difficulties with describing emotional or bodily states. The child’s/youth’s behavior likely reflects their difficulty with affective and physiological regulation, especially for younger children. This can be demonstrated as excessive and chronic silly behavior, excessive body movements, difficulties regulating sleep/wake cycle, and inability to fully engage in activities.

**Reminder: This item should be rated in the context of what is normative for a child’s or youth’s age and developmental stage.**

RATING	DEFINITION
0	Child/youth has no difficulties regulating emotional or physiological responses. Emotional responses and energy level are appropriate to the situation.
1	Child/youth has some minor and occasional difficulties with affect/physiological regulation. Child/youth could have some difficulty tolerating intense emotions and become somewhat jumpy or irritable in response to emotionally charged stimuli, or more watchful or hypervigilant in general, or have some difficulties with regulating body functions (e.g., sleeping, eating or elimination). Child/youth may also have some difficulty sustaining involvement in activities for any length of time or have some physical or somatic complaints.

2	Child/youth has moderate problems with affect/physiological regulation. Child/youth may be unable to modulate emotional responses or have more persistent difficulties in regulating bodily functions. The child/youth may exhibit marked shifts in emotional responses (e.g., from sadness to irritability to anxiety) or have contained emotions with a tendency to lose control of emotions at various points (e.g., normally restricted affect punctuated by outbursts of anger or sadness). Child/youth may also exhibit persistent anxiety, intense fear or helplessness, lethargy/loss of motivation, or have persistent physical or somatic complaints. Child’s/youth’s behavior likely reflects difficulties with affective or physiological over-arousal or reactivity (e.g., silly behavior, loose active limbs) or under-arousal (e.g., lack of movement and facial expressions, slowed walking and talking).
3	Child/youth with severe and chronic problems with highly dysregulated affective and/or physiological responses. Child/youth may have more rapid shifts in mood and an inability to modulate emotional responses (e.g., feeling out of control of their emotions or lacking control over their movement as it relates to their emotional states). The child/youth may also exhibit tightly contained emotions with intense outbursts under stress. Alternately, child/youth may be characterized by extreme lethargy, loss of motivation or drive, and no ability to concentrate or sustain engagement in activities (i.e., emotionally “shut down”). He/she may have more persistent and severe difficulties regulating sleep/wake cycle, eating patterns, or with elimination problems.

**RATING AND PRACTICE CONSIDERATIONS** (*Emotional and/or Physical Regulation*)

- What are the issues/symptoms?
- Have the symptoms/diagnosis been confirmed by a professional?

### 49. PSYCHOSIS

This item is used to rate symptoms of psychiatric disorders with a known neurological base. DSM disorders included on this item are schizophrenia and psychotic disorders (e.g., bipolar, NOS). The common symptoms of these disorders include hallucinations, delusions, unusual thought processes, strange speech, and bizarre/idiosyncratic behavior.

RATING	DEFINITION
0	No evidence of thought disturbances. Both thought processes and content are within normal range.
1	Child/youth exhibits evidence of mild disruption in thought processes or content. Child/youth may be somewhat tangential in speech or evidence somewhat illogical thinking (age inappropriate). This also includes children/youth with a history of hallucinations but none currently. The rating would be used for children/youth who are sub-threshold for one of the DSM diagnoses listed above.

<b>2</b>	Child/youth exhibits evidence of moderate disturbance in thought processes or content. Child/youth may be somewhat delusional or have brief or intermittent hallucinations. The child's/youth's speech may be at times quite tangential or illogical. This level would be used for children/youth who meet the diagnostic criteria for one of the disorders listed above.
<b>3</b>	Child/youth has a severe psychotic disorder. Child/youth frequently is experiencing symptoms of psychosis and frequently has no reality assessment. There is evidence of ongoing delusions or hallucinations or both. Command hallucinations would be coded here. This level is used for extreme cases of the diagnoses listed above.

**RATING AND PRACTICE CONSIDERATIONS (*Psychosis*)**

- Who has diagnosed the child/youth?
- When was the diagnosis made?
- Has culture been considered?
- What are the symptoms versus diagnosis?

**50. ATTENTION / CONCENTRATION**

Problems with attention, concentration, and task completion would be rated here. These may include symptoms that are part of DSM attention-deficit hyperactivity disorder. Inattention/distractibility not related to opposition would also be rated here.

<b>RATING</b>	<b>DEFINITION</b>
<b>0</b>	No evidence of attention or concentration problems. Child/youth is able to stay on task in an age-appropriate manner.
<b>1</b>	Child/youth has evidence of mild problems with attention or concentration. Child/youth may have some difficulties staying on task for an age-appropriate time period in school or play.
<b>2</b>	Child/youth has moderate attention problems. In addition to problems with sustained attention, child/youth may become easily distracted or forgetful in daily activities, have trouble following through on activities, and become reluctant to engage in activities that require sustained effort. A child/youth who meets DSM diagnostic criteria for ADHD would be rated here.
<b>3</b>	Child/youth has severe impairment of attention or concentration. A child/youth with profound symptoms of ADHD or significant attention difficulties related to another diagnosis would be rated here.

**RATING AND PRACTICE CONSIDERATIONS**

- Has the child/youth been diagnosed with ADHD or ADD?
- Is the child/youth impulsive?
- Has he/she made poor decisions with negative outcomes?
- What areas of his/her life have been affected?

## 51. IMPULSIVITY

Problems with impulse control and impulsive behaviors, including motoric disruptions, would be rated here.

RATING	DEFINITION
0	No evidence of age-inappropriate impulsivity in action or thought.
1	Child/youth has evidence of mild levels of impulsivity evident in either action or thought. The child/youth may behave in a fashion that suggests limited impulse control. For instance, child/youth may yell out answers to questions or may have difficulty waiting his/her turn. Child/youth may exhibit some motoric difficulties as well, for instance, pushing or shoving others without waiting turn.
2	Child/youth has moderate levels of impulsivity evident in behavior. The child/youth is frequently impulsive and may represent a significant management problem. A child/youth who often intrudes on others and often exhibits aggressive impulses would be rated here.
3	Child/youth has significant levels of impulsivity evident in behavior. Frequent impulsive behavior is observed or noted that carries considerable safety risk (e.g., running into the street, dangerous driving, or bike riding). The child/youth may be impulsive on a nearly continuous basis. He or she endangers self or others without thinking.
RATING AND PRACTICE CONSIDERATIONS	
<ul style="list-style-type: none"> <li>• Does the child’s/youth’s impulsivity put them at risk?</li> <li>• How has it impacted his/her life?</li> </ul>	

## 52. DEPRESSION

Symptoms included in this item are irritable or depressed mood, social withdrawal, sleep disturbances, weight/eating disturbances, and loss of motivation. This item can be used to rate symptoms of the following psychiatric disorders as specified in DSM: depressive disorders (major depressive disorder, dysthymia, NOS), bipolar disorder.

RATING	DEFINITION
0	Child/youth has no emotional problems. No evidence of depression.
1	Child/youth has mild emotional problems. Brief duration of depression, irritability, or impairment of peer, family, or academic functioning that does not lead to gross avoidance behavior.

<b>2</b>	Child/youth has a moderate level of emotional disturbance. Any diagnosis of depression would be coded here. This level is used to rate children/youth who meet the criteria for an affective disorder listed above.
<b>3</b>	Child/youth has a severe level of depression. This would include a child/youth who stays at home or in bed all day due to depression or one whose emotional symptoms prevent any participation in school, friendship groups, or family life. Disabling forms of depressive diagnoses would be coded here. This level is used to indicate an extreme case of one of the disorders listed above.

**RATING AND PRACTICE CONSIDERATIONS (*Depression*)**

- Remember to keep development in mind.
- Is the child/youth irritable?
- Is the child/youth refusing to get out of bed?

**53. ANXIETY**

This item describes the child’s/youth’s level of fearfulness, worrying, or other characteristics of anxiety.

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

**RATING AND PRACTICE CONSIDERATIONS**

- Does the child/youth have an anxious temperament?
- Has it impacted his/her functioning?
- Are the child’s/youth’s parents or caregivers anxious?

### 54. OPPOSITIONAL BEHAVIOR (Compliance with authority)

This item is intended to capture how the child/youth relates to authority. Oppositional behavior is different from conduct disorder in that the emphasis of the behavior is on non-compliance with authority rather than inflicting damage and hurting others.

RATING	DEFINITION
0	Child/youth is generally compliant.
1	Child/youth has mild problems with compliance with some rules or adult instructions. Child/youth may occasionally talk back to teacher, parent/caregiver; there may be letters or calls from school.
2	Child/youth has moderate problems with compliance with rules or adult instructions. A child/youth who meets the criteria for oppositional defiant disorder in DSM would be rated here.
3	This rating indicates that the child/youth has severe problems with compliance with rules or adult instructions. A child/youth rated at this level would be a severe case of oppositional defiant disorder. They would be virtually always non-compliant. Child/youth repeatedly ignores authority.
RATING AND PRACTICE CONSIDERATIONS	
<ul style="list-style-type: none"> <li>• Is the child/youth non-compliant with authority?</li> <li>• Is non-compliance related to a loyalty to his/her birth family?</li> <li>• Was the child/youth previously responsible for his/her siblings?</li> </ul>	

### 55. CONDUCT

These symptoms include antisocial behaviors like shoplifting, lying, vandalism, cruelty to animals, and assault. This item would include the symptoms of conduct disorder as specified in DSM.

RATING	DEFINITION
0	No evidence of behavior disorder.
1	Child/youth has a mild level of conduct problems. Child/youth may have some difficulties in school and home behavior. Problems are recognizable but not notably deviant for age, sex, and community. This might include occasional truancy, repeated severe lying, or petty theft from family.
2	Child/youth has a moderate level of conduct disorder. This could include episodes of planned aggressive or other anti-social behavior. A child/youth rated at this level should meet the criteria for a diagnosis of conduct disorder.

<b>3</b>	Child/youth has a severe conduct disorder. This could include frequent episodes of unprovoked, planned aggressive, or other anti-social behavior.
----------	---

**RATING AND PRACTICE CONSIDERATIONS (*Conduct*)**

- Does this child/youth have a diagnosis of conduct disorder?
- Would he/she be considered for a diagnosis of conduct disorder?
- Are his/her behaviors consistent with a diagnosis of conduct disorder?

**56. SUBSTANCE ABUSE**

These symptoms include use of alcohol and illegal drugs, the misuse of prescription medications and the inhalation of any substance for recreational purposes. This item is consistent with DSM substance-related disorders.

RATING	DEFINITION
<b>0</b>	There is no evidence that the child/youth has substance use difficulties at the present time. If the person is in recovery for greater than 1 year, they should be coded here, although this is unlikely for a child or youth.
<b>1</b>	Child/youth has mild substance use problems that might occasionally present problems for the person (e.g., intoxication, loss of money, reduced school performance, parental concern). This rating would be used for someone early in recovery (less than 1 year) who is currently abstinent for at least 30 days.
<b>2</b>	Child/youth has a moderate substance abuse problem that impairs his/her ability to function, but does not preclude functioning in an unstructured setting while participating in treatment.
<b>3</b>	Child/youth has a severe substance dependence condition that consistently impairs his/her ability to function. Substance abuse problems may present significant complications to the coordination of care for the child/youth. A substance-exposed infant who demonstrates symptoms of substance dependence would also be rated here.

**RATING AND PRACTICE CONSIDERATIONS**

- Is anyone concerned about the child’s/youth’s substance use?
- Has it gotten the child/youth into trouble?
- Is the child/youth concerned about his/her substance use?



## 57. ATTACHMENT DIFFICULTIES

This item should be rated within the context of the child's/youth's significant parental or caregiver relationships.

RATING	DEFINITION
0	No evidence of attachment problems. Child-caregiver relationship is characterized by mutual satisfaction of needs and child's/youth's development of a sense of security and trust. Caregiver appears able to respond to child/youth cues in a consistent, appropriate manner, and child/youth seeks age-appropriate contact with caregiver for both nurturing and safety needs.
1	Mild problems with attachment. There is some evidence of insecurity in the child-caregiver relationship. Caregiver may at times have difficulty accurately reading child/youth bids for attention and nurturance; may be inconsistent in response; or may be occasionally intrusive. Child/youth may have mild problems with separation (e.g., anxious/clingy behaviors in the absence of obvious cues of danger) or may avoid contact with caregiver in age-inappropriate way. Child/youth may have minor difficulties with appropriate physical/emotional boundaries with others.
2	Moderate problems with attachment. Attachment relationship is marked by sufficient difficulty as to require intervention. Caregiver may consistently misinterpret child/youth cues, act in an overly intrusive way, or ignore/avoid child/youth bids for attention/nurturance. Child/youth may have ongoing difficulties with separation, may consistently avoid contact with caregivers, and may have ongoing difficulties with physical or emotional boundaries with others.
3	Severe problems with attachment. Child/youth is unable to form attachment relationships with others (e.g., chronic dismissive/avoidant/detached behavior in caregiving relationships) OR child/youth presents with diffuse emotional/physical boundaries leading to indiscriminate attachment with others. Child/youth is considered at ongoing risk due to the nature of his/her attachment behaviors. A child/youth who meets the criteria for an attachment disorder in DSM would be rated here. Child/youth may have experienced significant early separation from or loss of caregiver, or have experienced chronic inadequate care from early caregivers, or child/youth may have individual vulnerabilities (e.g., mental health, developmental disabilities) that interfere with the formation of positive attachment relationships.

### RATING AND PRACTICE CONSIDERATIONS

- Has the child/youth been diagnosed with an attachment issue?
- What does the child's/youth's pre-placement history look like?
- How long has the child/youth been in current placement?
- Has attachment been considered an issue in the past?

## 58. EATING DISTURBANCES

These symptoms include problems with eating, including disturbances in body image, refusal to maintain normal body weight, recurrent episodes of binge eating and hoarding food. This item is consistent with DSM eating disorders.

RATING	DEFINITION
0	No evidence of eating disturbances.
1	Child/youth has a mild level of eating disturbance. This could include some preoccupation with weight, calorie intake, or body size or type when of normal weight or below weight. This could also include some binge eating patterns.
2	Child/youth has a moderate level of eating disturbance. This could include a more intense preoccupation with weight gain or becoming fat when underweight, restrictive eating habits or excessive exercising in order to maintain below normal weight, and/or emaciated body appearance. This level could also include more notable binge eating episodes that are followed by compensatory behaviors in order to prevent weight gain (e.g., vomiting, use of laxatives, excessive exercising). Child/youth may meet criteria for a DSM eating disorder (anorexia or bulimia nervosa).
3	Child/youth has a more severe form of eating disturbance. This could include significantly low weight where hospitalization is required or excessive binge-purge behaviors (at least once per day).
RATING AND PRACTICE CONSIDERATIONS	
<ul style="list-style-type: none"> <li>Do not include weight gained from medicines.</li> <li>Does child/youth have an unrealistic body image or an interest in exercise/body building?</li> </ul>	

## 59. BEHAVIORAL REGRESSIONS

This item is used to describe shifts in previously adaptive functioning evidenced in regression in behaviors or physiological functioning.

RATING	DEFINITION
0	No evidence of behavioral regression.
1	Child/youth has some regressions in age-level of behavior (e.g., thumb sucking, age-inappropriate whining).
2	Child/youth has moderate regressions in age-level of behavior, including loss of ability to engage with peers, stopping play or exploration in environment that was previously evident, or occasional bedwetting.

<b>3</b>	Child/youth has more significant regressions in behaviors in an earlier age, as demonstrated by changes in speech or loss of bowel or bladder control.
----------	--

**RATING AND PRACTICE CONSIDERATIONS** (*Behavioral Regressions*)

- Is it pathological or in line with environmental changes?
- How long has this been a problem?
- What is the behavior?

**60. SOMATIZATION**

Symptoms in this item include the presence of recurrent physical complaints without apparent physical cause or conversion-like phenomena (e.g., pseudoseizures).

RATING	DEFINITION
0	No evidence of somatic symptoms.
1	Child/youth has a mild level of somatic problems. This could include occasional headaches; stomach problems (e.g., nausea, vomiting); joint, limb, or chest pain without medical cause.
2	Child/youth has a moderate level of somatic problems or the presence of conversion symptoms. This could include more persistent physical symptoms without a medical cause or the presence of several different physical symptoms (e.g., stomach problems, headaches, backaches). Child/youth may meet criteria for a somatoform disorder. Additionally, the child/youth could manifest any conversion symptoms here (e.g., pseudoseizures, paralysis).
3	Child/youth has severe somatic symptoms causing significant disturbance in school or social functioning. This could include significant and varied symptomatic disturbance without medical cause.

**RATING AND PRACTICE CONSIDERATIONS**

- Has the child/youth had a complete physical exam?
- Does the child/youth have consistent medical care?
- What needs of the child/youth have previously been identified?
- Is this a function of development or communication?

## 61. ANGER CONTROL

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

RATING	DEFINITION
0	No evidence of any significant anger control problems.
1	Child/youth has some problems with controlling anger. He/she may sometimes become verbally aggressive when frustrated. Peers and family members are aware of and may attempt to avoid stimulating angry outbursts. Child/youth may have a history of physical aggression arising from inability to control anger, but none within the last 3 months.
2	Child/youth has moderate anger control problems. His/her temper has gotten him/her in significant trouble with peers, family, and/or school. This level may be associated with some physical violence, or increasing verbal outbursts. Others are likely quite aware of anger potential.
3	Child/youth has severe anger control problems. His/her temper is likely associated with frequent fighting that is often physical. Others likely fear him/her.

### RATING AND PRACTICE CONSIDERATIONS

- Clarify definition of appropriate anger management and emotional behavior.
- Consider culture. Is the child’s/youth’s family extroverted?
- Define yelling.

## 62. MOOD DISTURBANCE

Symptoms included in this item are symptoms of depressed mood, hypomania, or mania.

RATING	DEFINITION
0	Child/youth with no prolonged emotional/mood problems. No evidence of depression, hypomania, or mania.
1	Child/youth with prolonged emotional/mood problems. Evidence of depression, irritability, or other issues of mood causing mild problems with peers, family, or school functioning. Mild mood swings with some evidence of hypomania.
2	Child/youth with a moderate level of mood disturbance. This would include episodes of mania, depression, social withdrawal, school avoidance, or inability to experience happiness.
3	Child/youth with a severe level of mood disturbance. This would include a child/youth whose emotional symptoms prevent appropriate participation in school, friendship groups, or family life.

## RATING AND PRACTICE CONSIDERATIONS (*Mood Disturbance*)

- This item should be rated a '0' unless there is evidence of a mood disturbance impacting functioning.
- There may or may not be overlap with the rating for the depression item.
- Child/youth does not need to have a diagnosis of a mood or affective disorder in order to rate this item.

## Child Risk Behaviors Domain

**Risk behaviors are the types of things that can get children and adolescents in trouble or put them in danger of harming themselves or others. Notice that the time frames for the ratings change, particularly for the '1' and '3' ratings, away from the standard 30-day rating window.**

For this domain, the following ratings and action levels are used:

- 0 = There is no evidence of any needs.
- 1 = Requires monitoring, watchful waiting, or preventive activities.
- 2 = Requires action to ensure that this identified need or risk behavior is addressed.
- 3 = Requires immediate or intensive action.

### 63. SUICIDE WATCH

This item describes both suicidal and significant self-injurious behavior. A rating of '2' or '3' would indicate the need for a safety plan.

RATING	DEFINITION
0	Child/youth has no evidence or history of suicidal or self-injurious behaviors.
1	History of suicidal or self-injurious behaviors or significant ideation but no self-injurious behavior during the past 30 days.
2	Recent (last 30 days) but not acute (today) suicidal ideation or gesture. Self-injurious in the past 30 days (including today) without suicidal ideation or intent.
3	Current suicidal ideation and intent in the past 24 hours.

#### RATING AND PRACTICE CONSIDERATIONS

- Has the child/youth cut or otherwise inflicted harm on himself/herself?
- Is there a history or self-injurious behaviors or suicidal attempts or thoughts?
- Does the child/youth require a safety plan?

### 64. SELF-MUTILATION

This item includes repetitive, physically harmful behavior that generally serves as a self-soothing function to the child/youth.

RATING	DEFINITION
0	No evidence of any forms of self-mutilation (e.g., cutting, burning, face-slapping, head-banging).
1	History of self-mutilation but none evident in the past 30 days.
2	Engaged in self-mutilation that does not require medical attention.
3	Engaged in self-mutilation that requires medical attention.

#### RATING AND PRACTICE CONSIDERATIONS

- Has the child/youth been physically harming himself/herself?
- Is this suicidal behavior?
- Has the child/youth required medical attention as a result?

### 65. OTHER SELF-HARM

This item includes reckless and dangerous behaviors that, while not intended to harm self or others, place the child/youth or others at some jeopardy. Suicidal or self-mutilative behaviors are NOT rated here.

RATING	DEFINITION
0	No evidence of behaviors that place the child/youth at risk of physical harm.
1	History of behavior other than suicide or self-mutilation that places child/youth at risk of physical harm. This includes reckless and risk-taking behavior that may endanger the child/youth.
2	Engaged in behavior other than suicide or self-mutilation that places him/her in danger of physical harm. This includes reckless behavior or intentional risk-taking behavior.
3	Engaged in behavior other than suicide or self-mutilation that places him/her at immediate risk of death. This includes reckless behavior or intentional risk-taking behavior.

#### RATING AND PRACTICE CONSIDERATIONS

- Is the child/youth a natural risk-taker, or does this behavior have meaning?
- Does the child/youth derive joy from the activity, or is the activity an attempt to break through “numbness”?

## 66. DANGER TO OTHERS

This item includes actual and threatened violence. Imagined violence, when extreme, may be rated here. A rating of '2' or '3' would indicate the need for a safety plan.

RATING	DEFINITION
0	Child/youth has no evidence or history of aggressive behaviors or significant verbal aggression towards others (including people and animals).
1	History of aggressive behavior or verbal aggression towards others but no aggression during the past 30 days. History of fire-setting (not in past year) would be rated here.
2	Occasional or moderate level of aggression towards others, including aggression during the past 30 days or more recent verbal aggression.
3	Frequent or dangerous (significant harm) level of aggression to others. Child or youth is an immediate risk to others.
RATING AND PRACTICE CONSIDERATIONS	
<ul style="list-style-type: none"> <li>• Consider the family's culture of aggressive behavior.</li> <li>• Is the child/youth homicidal?</li> <li>• Do other authorities need to be involved?</li> </ul>	

## 67. SEXUAL AGGRESSION

Sexually abusive behavior includes both aggressive sexual behavior and sexual behavior in which the child or youth takes advantage of a younger or less powerful child through seduction, coercion, or force.

RATING	DEFINITION
0	No evidence of problems with sexual behavior in the past year.
1	Mild problems of sexually abusive behavior. For example, occasional inappropriate sexually aggressive/harassing language or behavior.
2	Moderate problems with sexually abusive behavior, For example, frequent inappropriate sexual behavior. Frequent disrobing would be rated here only if it was sexually provocative. Frequent inappropriate touching would be rated here.
3	Severe problems with sexually abusive behavior. This would include the rape or sexual abuse of another person involving sexual penetration.
RATING AND PRACTICE CONSIDERATIONS	
<ul style="list-style-type: none"> <li>• Has the child/youth been assessed?</li> <li>• Was the aggressive incident sexual in nature?</li> <li>• Has the incident been investigated?</li> </ul>	

## 68. RUNAWAY

In general, to classify as a runaway or elopement, the child/youth is gone overnight or very late into the night. Impulsive behavior that represents an immediate threat to personal safety would be rated here.

RATING	DEFINITION
0	No history of running away and no ideation involving escaping from the present living situation.
1	Child/youth has no recent history of running away but has expressed ideation about escaping present living situation or treatment. Child/youth may have threatened running away on one or more occasions or have a history (lifetime) of running away but not in the past year.
2	Child/youth has run away from home once or run away from one treatment setting within the past year. Also rated here is a child/youth who has run away to home (parental or relative) in the past year.
3	Child/youth has (1) run away from home and/or treatment settings within the last 7 days or (2) run away from home and/or treatment setting twice or more overnight during the past 30 days. Destination is not a return to home of parent or relative.
RATING AND PRACTICE CONSIDERATIONS	
<ul style="list-style-type: none"> <li>• Did child/youth run from home or group care setting?</li> <li>• Is the child/youth running to or from something?</li> </ul>	

## 69. DELINQUENCY

This item includes both criminal behavior and status offenses that may result from child or youth failing to follow required behavioral standards (e.g., truancy). Sexual offenses should be included as criminal behavior.

RATING	DEFINITION
0	Child/youth shows no evidence or has no history of criminal or delinquent behavior.
1	History of criminal or delinquent behavior but none in the past 30 days. Status offenses in the past 30 days would be rated here.
2	Moderate level of criminal activity, including a high likelihood of crimes committed in the past 30 days. Examples would include vandalism, shoplifting, etc.
3	Serious level of criminal or delinquent activity in the past 30 days. Examples would include car theft, residential burglary, gang involvement, etc.
RATING AND PRACTICE CONSIDERATIONS	
<ul style="list-style-type: none"> <li>• Has the child/youth been incarcerated?</li> <li>• Has the child/youth committed a crime?</li> <li>• Has he/she been truant?</li> </ul>	

## 70. JUDGMENT

This item describes the child’s/youth’s decision-making processes and awareness of consequences.

RATING	DEFINITION
0	No evidence of problems with judgment or poor decision-making that result in harm.
1	History of problems with judgment in which the child/youth makes decisions that are in some way harmful (e.g., a child/youth who has a history of hanging out with other children who shoplift).
2	Problems with judgment in which the child/youth makes decisions that are in some way harmful to his/her development and/or well-being that may place him/her at moderate risk of harm.
3	Problems with judgment that place the child/youth at risk of significant imminent physical harm.

RATING AND PRACTICE CONSIDERATIONS	
<ul style="list-style-type: none"> <li>• How old is the child/youth?</li> <li>• How advanced is the child’s/youth’s judgment? Consider brain development.</li> <li>• Do not include providers’ values system when assessing.</li> </ul>	

## 71. FIRE-SETTING

This item refers to behavior involving the intentional setting of fires that might be dangerous to the child/youth or others. This does not include the use of candles or incense or matches to smoke.

RATING	DEFINITION
0	No evidence or history of fire-setting behavior.
1	History of fire-setting but not in past six months.
2	Recent fire-setting behavior (in past six months) but not of the type that has endangered the lives of others (e.g., playing with matches) OR repeated fire-setting behavior over a period of at least two years even if not in the past six months.
3	Acute threat of fire-setting. Set fire that endangered the lives of others (e.g., attempting to burn down a house).

RATING AND PRACTICE CONSIDERATIONS	
<ul style="list-style-type: none"> <li>• Has the child/youth been assessed?</li> <li>• Was the incident intentional?</li> <li>• Were people’s lives in danger?</li> </ul>	

## 72. INTENTIONAL MISBEHAVIOR

This item describes intentional obnoxious social behaviors that a child/youth engages in to intentionally force adults to sanction him/her. This item should reflect problematic social behaviors (socially unacceptable behavior for the culture and community in which he/she lives) that put the child/youth at some risk of sanctions.

***It is not necessary that the child/youth have awareness of the purpose of his/her misbehavior (to provoke sanctions/reactions) in order to be rated here, as this behavior is not always conscious/planned behavior. This item should not be rated for children/youth who engage in such behavior solely due to developmental delays or lack of social skill.***

RATING	DEFINITION
0	Child/youth shows no evidence of problematic social behaviors.
1	Mild level of problematic social behaviors that force adults to sanction the child/youth. Provocative comments or behavior in social settings aimed at getting a negative response from adults might be included at this level.
2	Moderate level of problematic social behaviors. Child/youth may be intentionally getting in trouble in school or at home and the sanctions or threat of sanctions that result are causing problems in the child's/youth's life.
3	Severe level of problematic social behaviors. This would be indicated by frequent seriously inappropriate social behavior that forces adults to seriously and/or repeatedly sanction the child/youth. Social behaviors are sufficiently severe (cause harm to others) that they place the child/youth at risk of significant sanctions (e.g., expulsion, removal from the community).

### RATING AND PRACTICE CONSIDERATIONS

- Does the child/youth have an alternative way to get needs met?
- What is the child's/youth's goal?
- What is the misbehavior, and why might it be intentional?

## 73. SEXUALLY-REACTIVE BEHAVIORS

Sexually-reactive behavior includes both age-inappropriate sexualized behaviors that may place a child/youth at risk for victimization or risky sexual practices.

RATING	DEFINITION
0	No evidence of problems with sexually-reactive behaviors or high-risk sexual behaviors.

<b>1</b>	Some evidence of sexually-reactive behavior. Child/youth may exhibit occasional inappropriate sexual language or behavior, flirts when age-inappropriate, or engages in unprotected sex with single partner. This behavior does not place child/youth at great risk. A history of sexually provocative behavior would be rated here.
<b>2</b>	Moderate problems with sexually-reactive behavior that place child/youth at some risk. Child/youth may exhibit more frequent sexually-provocative behaviors in a manner that impairs functioning, engage in promiscuous sexual behaviors or have unprotected sex with multiple partners.
<b>3</b>	Significant problems with sexually-reactive behaviors. Child/youth exhibits sexual behaviors that place child/youth or others at immediate risk.

**RATING AND PRACTICE CONSIDERATIONS (*Sexually-Reactive Behaviors*)**

- What is the behavior? Why it is being considered sexually-reactive?
- Is the child/youth at risk?
- Are other children/youth at risk?
- Is a safety plan necessary?

**74. BULLYING**

This item rates the child’s/youth’s involvement as the aggressor, not the victim.

<b>RATING</b>	<b>DEFINITION</b>
<b>0</b>	Child/youth has never engaged in bullying at school or in the community.
<b>1</b>	Child/youth has been involved with groups that have bullied other youth either in school or the community; however, youth has not had a leadership role in these groups.
<b>2</b>	Child/youth has bullied other youth in school or community. Youth has either bullied individually or led a group that bullied.
<b>3</b>	Child/youth has repeatedly utilized threats or actual violence to bully youth in school and/or community.

**RATING AND PRACTICE CONSIDERATIONS**

- This item does not rate the victim.
- If a youth is gang-involved, or has the potential to be recruited, then this item should be rated.
- If the bullying has resulted in legal action, this item should be rated.

## 75. VICTIMIZATION

This item is used to examine the history of a pattern of victimization and assess level of current risk for victimization.

RATING	DEFINITION
0	No evidence of recent victimization and no significant history of victimization within the past year. Youth may have been robbed or burglarized on one or more occasions in the past, but no pattern of victimization exists. He/she is not presently at risk for re-victimization.
1	Child/youth has a history of victimization but has not been victimized to any significant degree in the past year. He/she is not presently at risk for re-victimization.
2	Child/youth has been recently victimized (within the past year) but is not in acute risk of re-victimization. This might include physical or sexual abuse, significant psychological abuse by family or friend, extortion, or violent crime.
3	Child/youth has been recently victimized and is in acute risk of re-victimization. Examples include working as a prostitute or living in an abusive relationship.
RATING AND PRACTICE CONSIDERATIONS	
<ul style="list-style-type: none"> <li>• Is there a history or pattern of exploitation?</li> <li>• Does the youth know how to keep himself/herself safe?</li> <li>• Is he/she able to actualize a plan?</li> <li>• Does the child/youth value himself/herself?</li> </ul>	

## Items for Children Five Years Old and Younger

*The following items are designed primarily for any child who is five years old or younger or developmentally disabled (DD); however, these items should also be rated for any child/youth if it is felt that there were significant early childhood events in the child's/youth's developmental history (e.g., substance exposure). Please rate the child/youth on all items. Mark N/A if the item is not relevant or applicable to the child/youth, or if early developmental history is unknown. Historical information should be captured as a '1' for youth older than 5 years of age.*

*Historical information is critical when planning for youth and families.*

### 76. MOTOR

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

RATING	DEFINITION
0	Child's fine and gross motor functioning appears normal. There is no reason to believe that the child has any problems with motor functioning.
1	Child has mild fine (e.g., using scissors) or gross motor skill deficits. The child may have exhibited delayed sitting, standing, or walking, but has since reached those milestones.
2	Child has moderate motor deficits. A non-ambulatory child with fine motor skills (e.g., reaching, grasping) or an ambulatory child with severe fine motor deficits would be rated here. A full-term newborn who does not have a sucking reflex in the first few days of life would be rated here.
3	Child has severe or profound motor deficits. A non-ambulatory child with additional movement deficits would be rated here, as would any child older than 6 months who cannot lift his/her head.
N/A	Not applicable

#### RATING AND PRACTICE CONSIDERATIONS

- Is it a fine or a gross motor issue?
- How much is it impacting the child's/youth's functioning?

## 77. SENSORY

This item describes the child's ability to use all senses: vision, hearing, smell, touch, taste, and kinesthetics.

RATING	DEFINITION
0	Child's sensory functioning appears normal. There is no reason to believe that the child has any problems with sensory functioning.
1	Child has mild impairment on a single sense (e.g., mild hearing deficits, correctable vision problems).
2	Child has moderate impairment on a single sense or mild impairment on multiple senses (e.g., difficulties with sensory integration, diagnosed need for occupational therapy).
3	Child has significant impairment on one or more senses (e.g., profound hearing or vision loss).
N/A	Not applicable
RATING AND PRACTICE CONSIDERATIONS	
<ul style="list-style-type: none"> <li>• Why is this being considered an issue?</li> <li>• What sensory area is being considered?</li> </ul>	

## 78. COMMUNICATION

This item describes the child's ability to communicate through any medium, including all spontaneous vocalizations and articulations.

RATING	DEFINITION
0	Child's receptive and expressive communication appears developmentally appropriate. There is no reason to believe that the child has any problems communicating.
1	Child's receptive abilities are intact, but child has limited expressive capabilities (e.g., if the child is an infant, he/she engages in limited vocalizations; if older than 24 months, he/she can understand verbal communication, but others have unusual difficulty understanding the child).
2	Child has limited receptive and expressive capabilities.
3	Child is unable to communicate in any way, including pointing or grunting.
N/A	Not applicable

**RATING AND PRACTICE CONSIDERATIONS** (*Communication*)

- How does the child communicate?
- Is this consistent with those in his/her life?
- Is his/her functioning being impacted?

**79. FAILURE TO THRIVE**

Symptoms of failure to thrive focus on normal physical development such as growth and weight gain.

RATING	DEFINITION
0	Child does not appear to have any problems with regard to weight gain or development. There is no evidence of failure to thrive.
1	Child has mild delays in physical development (e.g., below the 25th percentile in terms of height or weight).
2	Child has significant delays in physical development that could be described as failure to thrive (e.g., is below the 10th percentile in terms of height or weight).
3	Child has severe problems with physical development that puts his/her life at risk (e.g., is at or beneath the 1st percentile in height or weight).
N/A	Not applicable

**RATING AND PRACTICE CONSIDERATIONS**

- What is the child’s pre-placement history?
- What is his/her race/ethnicity?
- Who is responsible for the child?

**80. FEEDING / ELIMINATION**

This item refers to all issues of eating and/or elimination. Pica would be rated here.

RATING	DEFINITION
0	Child does not appear to have any problems with feeding or elimination.
1	Child has mild problems with feeding and/or elimination (e.g., picky eating).

<b>2</b>	Child has moderate to severe problems with feeding and/or elimination. Problems are interfering with functioning in at least one area.
<b>3</b>	Child has profound problems with feeding and/or elimination.
<b>N/A</b>	Not applicable

**RATING AND PRACTICE CONSIDERATIONS** (*Feeding/Elimination*)

- Are these in line with the child’s development?
- What type/level of care does he/she require?

**81. BIRTH WEIGHT**

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

<b>RATING</b>	<b>DEFINITION</b>
<b>0</b>	Child is within normal range for weight and has been since birth. A child with a birth weight of 2500 grams (5.5 pounds) or greater would be rated here.
<b>1</b>	Child was born underweight but is now within normal range or child is slightly beneath normal range. A child with a birth weight of between 1500 grams (3.3 pounds) and 2499 grams would be rated here.
<b>2</b>	Child is considerably under weight to the point of presenting a development risk to the child. A child with a birth weight of 1000 grams (2.2 pounds) to 1499 grams would be rated here.
<b>3</b>	Child is extremely under weight to the point where the child’s life is threatened. A child with a birth weight of less than 1000 grams (2.2 pounds) would be rated here.
<b>N/A</b>	Not applicable

**RATING AND PRACTICE CONSIDERATIONS**

- Is it consistent with parents’ body size and make-up?
- Was he/she adopted?
- Is the information unknown?
- Do parents describe birth weight in the same manner as professionals?

## 82. PRENATAL CARE

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

RATING	DEFINITION
0	Child's birth mother had adequate prenatal care (e.g., 10 or more planned visits to a physician) that began in the first trimester. Child's mother did not experience any pregnancy-related illnesses.
1	Child's birth mother had some short-comings in prenatal care, or had a mild form of a pregnancy-related illness. A child whose mother had 6 or fewer planned visits to a physician would be rated here (her care must have begun in the first or early second trimester). A child whose mother had a mild or well-controlled form of pregnancy-related illness such as gestational diabetes, or who had an uncomplicated high-risk pregnancy, would be rated here.
2	Child's birth mother received poor prenatal care, initiated only in the last trimester, or had a moderate form of pregnancy-related illness. A child whose mother had 4 or fewer planned visits to a physician would be rated here. A mother who experienced a high-risk pregnancy with some complications would be rated here.
3	Child's birth mother had no prenatal care, or had a severe form of pregnancy-related illness. A mother who had toxemia/preclampsia would be rated here.
N/A	Not applicable

### RATING AND PRACTICE CONSIDERATIONS

- Did the birth mother receive prenatal care consistently?
- Did she plan on parenting while she was pregnant?

## 83. SUBSTANCE EXPOSURE

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

RATING	DEFINITION
0	Child had no in utero exposure to alcohol or drugs, and there is currently no exposure in the home.
1	Child had either mild in utero exposure (e.g., mother ingested alcohol or tobacco in small amounts fewer than four times during pregnancy), or there is current alcohol and/or drug use in the home.
2	Child was exposed to significant alcohol or drugs in utero. Any ingestion of illegal drugs during pregnancy (e.g., heroin, cocaine, methamphetamine), or use of alcohol or tobacco, would be rated here.

<b>3</b>	Child was exposed to alcohol or drugs in utero and continues to be exposed in the home. Any child who evidenced symptoms of substance withdrawal at birth (e.g., crankiness, feeding problems, tremors, weak and continual crying) would be rated here.
----------	---

<b>N/A</b>	Not applicable
------------	----------------

**RATING AND PRACTICE CONSIDERATIONS (*Substance Exposure*)**

- Were there laboratory results which identify the infant as substance-exposed?
- What was the parent’s response?
- Is education necessary now regarding potential outcomes to exposure?

**84. LABOR AND DELIVERY**

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

<b>RATING</b>	<b>DEFINITION</b>
---------------	-------------------

<b>0</b>	Child and birth mother had normal labor and delivery. A child who received an Apgar score of 7- 10 at birth would be rated here.
----------	--

<b>1</b>	Child or mother had some mild problems during delivery, but child does not appear to be affected by these problems. An emergency C-Section or a delivery-related physical injury (e.g., shoulder displacement) to the child would be rated here.
----------	--

<b>2</b>	Child or mother had problems during delivery that resulted in temporary functional difficulties for the child or mother. Extended fetal distress, postpartum hemorrhage, or uterine rupture would be rated here. A child who received an Apgar score of 4-7 or who needed some resuscitative measures at birth would be rated here.
----------	---

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

<b>N/A</b>	Not applicable
------------	----------------

**RATING AND PRACTICE CONSIDERATIONS**

- Where did the birth take place? Was it in a hospital?
- How do the parents describe the child’s birth? Is this consistent with practitioners?

### 85. PARENT OR SIBLING PROBLEMS

This item describes how the child’s parents and older siblings have done/are doing in their respective developments.

RATING	DEFINITION
0	Child’s parents have no developmental disabilities. The child has no siblings, or existing siblings are not experiencing any developmental or behavioral problems.
1	Child’s parents have no developmental disabilities. The child has siblings who are experiencing some mild developmental or behavioral problems (e.g., attention deficit, oppositional defiant, or conduct disorders). It may be that child has at least one healthy sibling.
2	Child’s parents have no developmental disabilities. The child has a sibling who is experiencing a significant developmental or behavioral problem (e.g., a severe version of any of the disorders cited above, or any developmental disorder).
3	One or both of child’s parents have been diagnosed with a developmental disability, or child has multiple siblings who are experiencing significant developmental or behavioral problems (all siblings must have some problems).
N/A	Not applicable
RATING AND PRACTICE CONSIDERATIONS	
<ul style="list-style-type: none"> <li>• What issues do the parents and/or siblings have? Are they similar or different?</li> <li>• Do they have resources to meet their needs?</li> </ul>	

### 86. MATERNAL AVAILABILITY

This item addresses the primary caretaker’s emotional and physical availability to the child in the weeks immediately following the birth. Rate maternal availability up until 3 months (12 weeks) post-partum.

RATING	DEFINITION
0	Child’s mother/primary caretaker was emotionally and physically available to the child in the weeks following the birth.
1	Primary caretaker experienced some minor or transient stressors which made him/her slightly less available to the child (e.g., another child in the house under two years of age, an ill family member for whom the caretaker had responsibility, a return to work before the child reached six weeks of age).

<b>2</b>	Primary caretaker experienced a moderate level of stress sufficient to make him/her significantly less emotionally and physically available to the child in the weeks following the birth (e.g., major marital conflict, significant post-partum recuperation issues or chronic pain, two or more children in the house under four years of age).
<b>3</b>	Primary caretaker was unavailable to the child to such an extent that the child’s emotional or physical well-being was severely compromised (e.g., a psychiatric hospitalization, a clinical diagnosis of severe Post-Partum Depression, any hospitalization for medical reasons which separated caretaker and child for an extended period of time, divorce or abandonment).
<b>N/A</b>	Not applicable
<b>RATING AND PRACTICE CONSIDERATIONS</b> ( <i>Maternal Availability</i> )	
<ul style="list-style-type: none"> <li>Were there any issues identified post-birth that may have impacted the child’s functioning?</li> </ul>	

### 87. CURIOSITY

This item describes the child’s self-initiated efforts to discover his/her world.

RATING	DEFINITION
<b>0</b>	Child shows exceptional curiosity. Infants display mouthing and banging of objects within grasp; older children crawl or walk to objects of interest.
<b>1</b>	Child shows good curiosity. An ambulatory child who does not walk to interesting objects, but who will actively explore them when presented to him/her, would be rated here.
<b>2</b>	Child shows limited curiosity. Child may be hesitant to seek out new information or environments, or reluctant to explore even presented objects.
<b>3</b>	Child shows very limited or no observable curiosity. Child may seem frightened of new information or environments.
<b>N/A</b>	Not applicable
<b>RATING AND PRACTICE CONSIDERATIONS</b>	
<ul style="list-style-type: none"> <li>Is the child’s curiosity in line with development?</li> <li>Have any individuals identified this as an area for concern?</li> </ul>	

## 88. PLAYFULNESS

This item describes the child’s enjoyment of play alone and with others.

RATING	DEFINITION
0	Child has substantial ability to play with self and others. Child enjoys play, and if old enough, regularly engages in symbolic and means-end play. If still an infant, child displays changing facial expressions in response to different play objects.
1	Child has good play abilities. Child may enjoy play only with self or only with others, or may enjoy play with a limited selection of toys.
2	Child has limited ability to enjoy play. Child may remain preoccupied with other children or adults to the exclusion of engaging in play, or may exhibit impoverished or unimaginative play.
3	Child has significant problems with play both by his/herself and with others. Child does not engage in symbolic or means-end play, although he/she will handle and manipulate toys.
N/A	Not applicable
RATING AND PRACTICE CONSIDERATIONS	
<ul style="list-style-type: none"> <li>• Does the child play in a manner consistent with his/her development?</li> <li>• Have concerns been identified?</li> <li>• Is professional intervention necessary?</li> </ul>	

## 89. TEMPERAMENT

This item describes the child’s general mood state and ability to be soothed.

RATING	DEFINITION
0	Child has an easy temperament. She/he is easily calmed or distracted when angry or upset.
1	Child has some mild problems being calmed, soothed, or distracted when angry or upset. Child may have occasional episodes or extended crying or tantrums.
2	Child has a difficult temperament. Child has difficulty being calmed, soothed, or distracted. Persistent episodes of crying, tantrums, or other difficult behaviors are observed.
3	Child has significant difficulties being calmed, soothed, or distracted when angry or upset. Repeated and extreme persistent episodes of crying, tantrums, or other difficult behaviors are observed when the child is angry or upset.
N/A	Not applicable

**RATING AND PRACTICE CONSIDERATIONS (*Temperament*)**

- What is the child’s temperament?
- When is his/her temperament an issue?
- Does it impact the child’s functioning?

**90. DAY CARE / PRESCHOOL**

RATING	DEFINITION
0	Child has no problems in day care or preschool environments.
1	Child has mild problems in day care or school environments.
2	Child has difficulties in day care or preschool environments. These problems may include things such as separation anxiety or difficult behavior.
3	Child has significant problems in day care or preschool environments. Child may have recently been asked to stop attending.
N/A	Not applicable

**RATING AND PRACTICE CONSIDERATIONS**

- Does child attend an out-of-home placement? What type?
- How does the child respond to this placement?

## Transition to Adulthood

**The following items are designed primarily for youth 14 years, 6 months of age and older; however, these items should also be rated for any child/youth if it is felt that transition issues apply (e.g., youth less than 14 years, 6 months old in a parenting role). Please rate child/youth on all items. Mark N/A if item is not relevant or applicable to child/youth.**

### 91. INDEPENDENT LIVING SKILLS

This item focuses on the presence or absence of skills and impairments in independent living abilities or the readiness to take on those responsibilities.

RATING	DEFINITION
0	Youth is fully capable of independent living. No evidence of any deficits or barriers that could impede maintaining own home.
1	Youth has mild impairment of independent living skills. Some problems exist with maintaining reasonable cleanliness, diet, etc. Problems with money management may occur at this level. These problems are generally addressable with training or supervision.
2	Youth has moderate impairment of independent living skills. Notable problems with completing tasks necessary for independent living are apparent. Difficulty with cooking, cleaning, and self-management when unsupervised would be common at this level. Problems are generally addressable with in-home services and supports.
3	Youth has profound impairment of independent living skills. This youth would be expected to be unable to live independently given their current status. Problems require a structured living environment.
N/A	Not applicable

#### RATING AND PRACTICE CONSIDERATIONS

- Is the youth in line with typical development?
- Are the tasks being requested in line with youth’s abilities?

## 92. TRANSPORTATION

This item is used to rate the level of transportation required to ensure that the youth could effectively participate in his/her own treatment and in other life activities. Only unmet transportation needs should be rated here.

RATING	DEFINITION
0	Youth has no unmet transportation needs.
1	Youth has occasional unmet transportation needs (e.g., appointments). These needs would be no more than weekly and not require a special vehicle. The needs can be met with minimal support, for example, assistance with bus routes to facilitate independent navigation, or provision of a bus card.
2	Youth has occasional transportation needs that require a special vehicle or frequent transportation needs (e.g., daily to work or therapy) that do not require a special vehicle. Youth can self-transport with a med-van service.
3	Youth requires frequent (e.g., daily to work or therapy) transportation in a special vehicle. He/she is completely reliant on others for transportation and cannot self-transport.
N/A	Not applicable

### RATING AND PRACTICE CONSIDERATIONS

- Rate unmet transportation needs.
- Is the youth’s home and services accessible via public transportation?
- Can the youth access public transportation?

## 93. PARENTING ROLES

This item is intended to rate the youth in any caregiver roles. For example, an individual with a son or daughter or an individual responsible for an elderly parent or grandparent would be rated here. Include pregnancy as a parenting role.

RATING	DEFINITION
0	Youth has a parenting role and he/she is functioning appropriately in that role.
1	Youth has responsibilities as a parent but occasionally experiences difficulties with this role.

<b>2</b>	Youth has responsibilities as a parent, and either the youth is struggling with these responsibilities or these issues are currently interfering with the youth’s functioning in other life domains.
<b>3</b>	Youth has responsibilities as a parent and the youth is currently unable to meet these responsibilities, the dependent is at risk, or these responsibilities are making it impossible for the youth to function in other life domains. Youth has the potential of abuse or neglect in his/her parenting.
<b>N/A</b>	Not applicable, as youth is not a parent.

**RATING AND PRACTICE CONSIDERATIONS (*Parenting Roles*)**

- Is the youth caring for children, siblings, or older adults?
- Parentified children should not be assessed here, but rather as “exploited”.
- Does the youth need assistance with the responsibility of parenting? How much?
- Is there a need for parenting education, support, or intervention?
- Is the youth parenting an adult with mental health, substance abuse, or other issues?

**94. INTIMATE RELATIONSHIPS**

This item is used to rate the youth’s current status in terms of romantic/intimate relationships.

<b>RATING</b>	<b>DEFINITION</b>
<b>0</b>	Adaptive partner relationship. Youth has a strong, positive, partner relationship with another individual, or they have maintained a positive partner relationship in the past but are not currently in an intimate relationship.
<b>1</b>	Mostly adaptive partner relationship. Youth has a generally positive partner relationship with another individual. This relationship may, at times, impede the youth’s healthy development.
<b>2</b>	Limited adaptive partner relationship. The youth has a recent history of being in a domestically-violent relationship or a recent history of being in a relationship where he/she was overly dependent on his/her partner. Youth may or may not be currently involved in any partner relationship with another individual.
<b>3</b>	Significant difficulties with partner relationships. Youth is currently involved in a negative or domestically-violent relationship or a relationship where he/she is totally dependent on his/her partner.
<b>N/A</b>	Not applicable

**RATING AND PRACTICE CONSIDERATIONS** (*Intimate Relationships*)

- Does the youth or others report issues with close relationships? When does this become a problem?
- Is the youth transitioning, maturing, or having a first-time experience?

**95. MEDICATION COMPLIANCE**

This item focuses on the level of the youth’s willingness or ability to participate in taking prescribed medications.

RATING	DEFINITION
0	Youth self-administers any prescribed medications as prescribed and without reminders or is not currently on any medication.
1	Youth will take prescribed medications routinely, but sometimes needs reminders to maintain compliance. Also, a history of medication non-compliance but no current problems would be rated here.
2	Youth is sporadically non-compliant. This person may be resistant to taking prescribed medications or may tend to overuse his/her medications. He/she might comply with prescription plans for periods of time (1-2 weeks) but generally does not sustain taking medication in prescribed dose or protocol. This would include youth who are sporadically non-compliant with medications for physical health that may place youth at medical risk.
3	Youth has refused to take prescribed medications during the past 30-day period or has abused his/her medications to a significant degree (e.g., overdosing or overusing medications to a dangerous degree).
N/A	Not applicable

**RATING AND PRACTICE CONSIDERATIONS**

- Does the youth remember to take his/her medications?
- When prompted, does the youth take medications?
- Does the youth abuse medications?

## 96. EDUCATIONAL ATTAINMENT

This rates the degree to which the youth has completed his/her planned education.

RATING	DEFINITION
0	Youth has achieved all educational goals OR has no educational goals and educational attainment has no impact on lifetime vocational functioning.
1	Youth has set educational goals and is currently making progress towards achieving them.
2	Youth has set educational goals but is currently not making progress toward achieving them.
3	Youth has no educational goals and lack of educational attainment is interfering with youth's lifetime vocational functioning.
N/A	Not applicable
RATING AND PRACTICE CONSIDERATIONS	
<ul style="list-style-type: none"> <li>• Is the youth on track educationally?</li> <li>• Is traditional school the best fit for him/her?</li> <li>• Is the youth allowed to explore other options?</li> </ul>	

## 97. JOB FUNCTIONING

This item is intended to describe functioning in vocational settings, not job attainment.

RATING	DEFINITION
0	Youth is gainfully employed in a job and experiencing no problems in attendance, performance or relationships at work.
1	Youth is gainfully employed but may have some difficulties at work with attendance, performance or relationships.
2	Youth has significant job-related problems with attendance, performance, or relationships.
3	Youth is experiencing severe problems in an employment situation with performance or relationships. Youth may have recently been fired.
N/A	Not applicable

**RATING AND PRACTICE CONSIDERATIONS (*Job Functioning*)**

- Does the youth have a job?
- Is the job appropriate?
- Is the youth experiencing success in the job?

**98. TRANSITION TO ADULT SERVICES SYSTEM**

Successful transition to an adult services system requires cooperation between the client and those professionals representing him/her. This item rates the client’s readiness for transition, including paperwork/referrals, scheduled appointments, and intakes.

RATING	DEFINITION
0	No evidence that there are any barriers to successful transition.
1	Client and professional are progressing towards successful transition but require significant support/monitoring to meet timeframes/requirements.
2	Client and professional are waiting for paperwork/referral, etc. There is some concern that timeframes will not be met.
3	Transition at this time is not likely, as the appropriate steps have not been completed or will not be completed in time.
N/A	Client is not transitioning to adult services system.

**RATING AND PRACTICE CONSIDERATIONS**

- Consider the adult services that a youth may need to transition (e.g., residential, guardianship, Social Security Insurance) and the youth’s current plan and preparation to do so.
- Does someone else (supervisor/natural support) need to become involved/contacted?
- Who is responsible for this process/individual steps?
- Is anyone concerned about the process/timeframes?

## Caregiver Resources and Needs

**These ratings should be done with a focus on permanency plan caregivers. However, when a temporary placement is impacting a child's functioning the temporary caregivers can be scored. Caregiver ratings should be completed by household. If multiple households are involved in the permanency planning, then this section should be completed once for each household under consideration.**

**PLEASE NOTE: Rate the caregiver who has the highest needs and may impact child's functioning negatively. Use a 30-day window to rate caregivers.**

For this domain, the following ratings and action levels are used:

- 0 = There is no evidence of any needs. This is a strength.
- 1 = Requires monitoring, watchful waiting, or preventive activities (history is captured here).
- 2 = Requires action to ensure that this identified need or risk behavior is addressed.
- 3 = Requires immediate or intensive action.

### 99. PHYSICAL HEALTH

Physical health includes medical and physical challenges faced by the caregiver.

RATING	DEFINITION
0	Caregiver has no physical health limitations that impact assistance or attendant care.
1	Caregiver has some physical health limitations that interfere with provision of assistance or attendant care.
2	Caregiver has significant physical health limitations that prevent them from being able to provide some needed assistance or make attendant care difficult.
3	Caregiver is physically unable to provide any needed assistance or attendant care, or child/youth has no known caregiver.

#### RATING AND PRACTICE CONSIDERATIONS

- Does caregiver have any physical limitations that impact his/her ability to parent?
- Will the caregiver receive a level of medical care that will prohibit caregiving?

### 100. MENTAL HEALTH

This item refers to the caregiver’s mental health status. Serious mental illness would be rated as a ‘2’ or ‘3’ unless the individual is in recovery.

RATING	DEFINITION
0	Caregiver has no mental health limitations that impact assistance or attendant care.
1	Caregiver has some mental health limitations that interfere with provision of assistance or attendant care.
2	Caregiver has significant mental health limitations that prevent them from being able to provide some needed assistance or make attendant care difficult.
3	Caregiver is unable to provide any needed assistance or attendant care due to serious mental illness, or child/youth has no known caregiver.
RATING AND PRACTICE CONSIDERATIONS	
<ul style="list-style-type: none"> <li>• What is the caregiver’s mental health issue?</li> <li>• How, when, and by whom was it diagnosed?</li> <li>• What does it mean in terms of caregiving versus contact?</li> </ul>	

### 101. SUBSTANCE USE

This item rates the caregiver’s pattern of alcohol and/or drug use. Substance-related disorders would be rated as a ‘2’ or ‘3’ unless the individual is in recovery.

RATING	DEFINITION
0	Caregiver has no substance-related limitations that impact assistance or attendant care.
1	Caregiver has some substance-related limitations that interfere with provision of assistance or attendant care. Rate a history of substance use for individuals in recovery here.
2	Caregiver has significant substance-related limitations that prevent them from being able to provide some needed assistance or make attendant care difficult.
3	Caregiver is unable to provide any needed assistance or attendant care due to serious substance dependency or abuse, or child/youth has no known caregiver.
RATING AND PRACTICE CONSIDERATIONS	
<ul style="list-style-type: none"> <li>• Is caregiver using substances?</li> <li>• Is it impacting his/her parenting?</li> </ul>	

### 102. DEVELOPMENTAL

This item describes the caregiver’s developmental status in terms of low IQ, mental retardation, or other developmental disabilities.

RATING	DEFINITION
0	Caregiver has no developmental limitations that impact assistance or attendant care.
1	Caregiver has some developmental limitations that interfere with provision of assistance or attendant care.
2	Caregiver has significant developmental limitations that prevent them from being able to provide some needed assistance or make attendant care difficult.
3	Caregiver is unable to provide any needed assistance or attendant care due to serious developmental disabilities, or child/youth has no known caregiver.
RATING AND PRACTICE CONSIDERATIONS	
<ul style="list-style-type: none"> <li>• Are there any developmental delays present?</li> <li>• Does the caregiver have services?</li> <li>• Does it impact his/her parenting?</li> </ul>	

### 103. SUPERVISION

This item is used to determine the caregiver's capacity to parent by providing effective supervision, monitoring, and effective discipline as needed by the child/youth.

RATING	DEFINITION
0	Supervision, monitoring, and discipline are appropriate, functioning well, and are effective.
1	Supervision, monitoring, and discipline are generally adequate but inconsistent. This may include a placement in which one member is capable of appropriate monitoring and supervision but others are not capable or not consistently available.
2	Appropriate supervision, monitoring, and effective discipline are very inconsistent and frequently absent.
3	Appropriate supervision, monitoring, and effective discipline are nearly always absent or inappropriate, or child/youth has no known caregiver.

**RATING AND PRACTICE CONSIDERATIONS (*Supervision*)**

- Is the caregiver successfully parenting?
- Is the child/youth following rules at home?

**104. INVOLVEMENT WITH CARE**

This item should be based on the level of involvement the caregiver has in the planning and provision of child welfare and related services.

RATING	DEFINITION
0	Caregiver is actively involved in the planning and/or implementation of services and is able to be an effective advocate on behalf of the child/youth.
1	Caregiver is consistently involved in the planning and/or implementation of services for the child/youth but is not an active advocate on behalf of the child/youth.
2	Caregiver is minimally involved in the care of the child/youth. Caregiver may visit child/youth when in out-of-home placement, but does not become involved in service planning and implementation.
3	Caregiver is uninvolved with the care of the child/youth. Caregiver may want child/youth out of home or fails to visit child/youth when in residential placement, or child/youth has no known caregiver.

**RATING AND PRACTICE CONSIDERATIONS**

- Does the caregiver drop the child/youth off at meetings?
- Does the caregiver follow through on suggestions, homework, etc.?
- Does the caregiver know what is going on with his/her child?
- Remember to keep culture in mind for this item. Are the family’s cultural needs being respected?
- Do not communicate gossip – evidence is necessary for a rating.

### 105. KNOWLEDGE

This item should be based on caregiver’s knowledge of the specific strengths, needs, development, legal rights, and supports of the child/youth in his/her care, as well as the caregiver’s ability to understand the rationale for the treatment or management of needs. The caregiver’s understanding of his/her child’s needs should include an understanding of the intersection between normative development and the impact of trauma.

RATING	DEFINITION
0	Present caregiver is fully knowledgeable about the child/youth’s psychological strengths, needs, developmental capacity, and functioning.
1	Present caregiver, while being generally knowledgeable about the child/youth, has some mild deficits in knowledge or understanding of the child/youth’s needs or developmental capacity and functioning. Caregivers and providers are able to work together to negotiate disagreements.
2	Significant deficits exist in the caregiver's ability to understand the child/youth’s strengths, needs, and developmental capacity. There is disagreement between the caregivers and/or providers regarding the child/youth’s needs which is interfering with care. Without agreement, the child’s/youth’s progress will be impacted.
3	Caregiver has no understanding of the child’s/youth’s current condition, or the child/youth has no known caregiver. The caregiver is unable to cope with the child/youth given his/her status at the time, not because of the needs of the child/youth but because the caregiver does not understand or accept the situation. There is disagreement between the caregivers and/or providers regarding the child’s/youth’s needs which places the child/youth at risk of significant negative outcomes. The lack of agreement may place the family in jeopardy of significant problems or sanctions.

#### RATING AND PRACTICE CONSIDERATIONS

- Does the caregiver agree with clinician’s understanding of presenting needs and strengths?
- Is the caregiver’s alternate understanding acceptable? Does it pose a risk?
- Does the caregiver’s lack of knowledge interfere with his/her ability to safely care for the child/youth?
- Does the caregiver appreciate how a child’s/youth’s history or trauma may impact his/her functioning?
- Does the caregiver’s knowledge impact the child/youth in a negative way?

### 106. ORGANIZATION

This item should be based on the ability of the caregiver to participate in or direct the organization of the household, services, and related activities.

RATING	DEFINITION
0	Caregiver is well-organized and efficient.

<b>1</b>	Caregiver has minimal difficulties with organizing or maintaining household to support needed services. For example, he/she may be forgetful about appointments or occasionally fail to call back case manager.
<b>2</b>	Caregiver has moderate difficulty organizing or maintaining household to support needed services.
<b>3</b>	Caregiver is unable to organize household to support needed services, or child/youth has no known caregiver.

**RATING AND PRACTICE CONSIDERATIONS (*Organization*)**

- Are the caregiver’s calendar, space, and time organized?

**107. SOCIAL RESOURCES**

This item refers to the social assets (extended family) and resources that the caregiver can bring to bear in addressing the multiple needs of the child/youth and family.

<b>RATING</b>	<b>DEFINITION</b>
<b>0</b>	Caregiver has sufficient resources so that there are few limitations on what can be provided for the child/youth.
<b>1</b>	Caregiver has the necessary resources to help address the child's/youth's major and basic needs, but those resources might be stretched.
<b>2</b>	Caregiver has limited resources (e.g., a grandmother living in same town who is sometimes available to watch the child/youth).
<b>3</b>	Caregiver has severely limited resources that are available to assist in the care and treatment of the child/youth, or child/youth has no known caregiver.

**RATING AND PRACTICE CONSIDERATIONS**

- Does caregiver have familial, community, or peer supports?
- Are individuals, organizations, or service providers willing to work with him/her?



### 108. RESIDENTIAL STABILITY

This item rates the caregiver’s current and likely future housing circumstances.

RATING	DEFINITION
0	Family/caregiver is in stable housing with no known risks of instability.
1	Family/caregiver is currently in stable housing but there are significant risks of housing disruption (e.g., loss of job).
2	Family/caregiver has moved frequently or has very unstable housing.
3	Family/caregiver is currently homeless, or child/youth has no known caregiver.
RATING AND PRACTICE CONSIDERATIONS	
<ul style="list-style-type: none"> <li>• How many times has the caregiver moved in the last year?</li> <li>• Is the caregiver in danger of being evicted?</li> <li>• Does he/she need to move now?</li> <li>• Is he/she homeless?</li> </ul>	

### 109. SAFETY

This item refers to the safety of the assessed child/youth. It does not refer to the safety of other family or household members based on any danger presented by the assessed child/youth.

RATING	DEFINITION
0	Present placement is as safe or safer for the child/youth (in his or her present condition) as could be reasonably expected.
1	Present placement environment presents some mild risk of neglect, exposure to undesirable environments (e.g., drug use or gangs in neighborhood, etc.) but that no immediate risk is present.
2	Present placement environment presents a moderate level of risk to the child/youth, including such things as the risk of neglect or abuse or exposure to individuals who could harm the child/youth.
3	Present placement environment presents a significant risk to the well-being of the child/youth. Risk of neglect or abuse is imminent and immediate. Individuals in the environment offer the potential of significantly harming the child/youth, or child/youth has no known caregiver.

**RATING AND PRACTICE CONSIDERATIONS** (*Safety*)

- Is the child/youth safe?

**110. MARITAL / PARTNER VIOLENCE**

This item describes the degree of difficulty or conflict in the caregiver relationship.

RATING	DEFINITION
0	Caregivers appear to be functioning adequately. There is no evidence of notable conflict in the caregiver relationship. Disagreements are handled in an atmosphere of mutual respect and equal power.
1	Mild to moderate level of family problems, including marital difficulties and caregiver arguments. Caregivers are generally able to keep arguments to a minimum when child/youth is present. Occasional difficulties in conflict resolution or use of power and control by one partner over another.
2	Significant level of caregiver difficulties, including frequent arguments that often escalate to verbal aggression or the use of verbal aggression by one partner to control the other. Child/youth often witnesses these arguments between caregivers or the use of verbal aggression by one partner to control the other.
3	Profound level of caregiver or marital violence that often escalates to mutual attacks or the use of physical aggression by one partner to control the other. These episodes may exacerbate child's/youth's difficulties or put the child/youth at greater risk, or child/youth has no known caregiver.

**RATING AND PRACTICE CONSIDERATIONS**

- Has the caregiver been the victim or the perpetrator in violence?
- How many relationships of this nature has he/she been involved with?
- What has motivated the caregiver in the past to keep his/her children safe?

### 111. CAREGIVER POST-TRAUMATIC REACTIONS

This item describes post-traumatic reactions faced by caregiver, including emotional numbing and avoidance, nightmares, and flashbacks that are related to his/her child’s or own traumatic experiences.

RATING	DEFINITION
0	Caregiver has adjusted to traumatic experiences without notable post-traumatic stress reactions.
1	Caregiver has some mild adjustment problems related to his/her child’s or their own traumatic experiences. Caregiver may exhibit some guilt about his/her child’s trauma or become somewhat detached or estranged from others.
2	Caregiver has moderate adjustment difficulties related to traumatic experiences. Caregiver may have nightmares or flashbacks of the trauma.
3	Caregiver has significant adjustment difficulties associated with traumatic experiences. Symptoms might include intrusive thoughts, hypervigilance, and constant anxiety, or child/youth has no known caregiver.

RATING AND PRACTICE CONSIDERATIONS	
<ul style="list-style-type: none"> <li>• Has the caregiver experienced trauma? How has he/she coped in the past?</li> <li>• How do these issues impact his/her ability to parent?</li> <li>• Is he/she receiving services?</li> <li>• Is the caregiver an active or inactive military service member?</li> <li>• Has the caregiver served during active time of war?</li> </ul>	

### 112. FINANCIAL RESOURCES

Please rate the highest level from the **past 30 days**.

RATING	DEFINITION
0	Caregiver has sufficient financial resources to raise the child/youth.
1	Caregiver has some financial resources that meet most of the needs of the child/youth.
2	Caregiver has limited financial resources and needs substantial assistance to meet the needs of their child/youth.
3	Caregiver has no financial resources. Child’s needs are not being met due to financial need. Caregiver needs significant financial resources, or child/youth has no known caregiver.



**RATING AND PRACTICE CONSIDERATIONS** (*Financial Resources*)

- Do not rate issues related to desire; for example, wanting an iPad should not be rated here. If youth cannot attend college because of finances, this should be rated here.
- Certainly rate instances when a child has inadequate clothing, food, or shelter, but the latest trends should not be included.
- If a caregiver is unable to afford quality childcare or is reliant on assistance, that should be rated here.

**113. FAMILY STRESS**

Please rate the highest level from the **past 30 days**.

RATING	DEFINITION
0	Caregiver is able to manage the stress of child(ren)'s needs.
1	Caregiver has some problems managing the stress of child(ren)'s needs.
2	Caregiver has notable problems managing the stress of child(ren)'s needs. This stress interferes with their capacity to give care.
3	Caregiver is unable to manage the stress associated with child(ren)'s needs. This stress prevents caregiver from parenting, or child/youth has no known caregiver.

**RATING AND PRACTICE CONSIDERATIONS**

- Are there numerous providers visiting the home or requesting that the family come in for an office visit?
- Does the child's/youth's behavior cause extraordinary challenges for the family?
- How have the child's/youth's struggles impacted relationships within the family?

**114. ACCESSIBILITY TO CHILD CARE RESOURCES AND/OR RESPITE**

Please rate the highest level from the **past 30 days**.

RATING	DEFINITION
0	Caregiver has access to sufficient/affordable child care resources and/or respite, or child/youth has no known caregiver.
1	Caregiver has limited access to sufficient/affordable child care resources and/or respite. Needs are met minimally by existing, available resources.



<b>2</b>	Caregiver has limited access to sufficient/affordable child care resources and/or respite. Current resources do not meet the caregiver’s needs.
<b>3</b>	Caregiver has no access to child care resources and/or respite.

**RATING AND PRACTICE CONSIDERATIONS** (*Accessibility to Child Care*)

- If a family requires state-sponsored assistance, this item should be rated either a ‘2’ or a ‘3’.
- Professionals and caregivers should share their understanding of the words “affordable” and “sufficient.”
- If transportation is the issue, then remember to also rate the “transportation” item.
- If finances are the issue, remember to also rate the “financial resources” item.

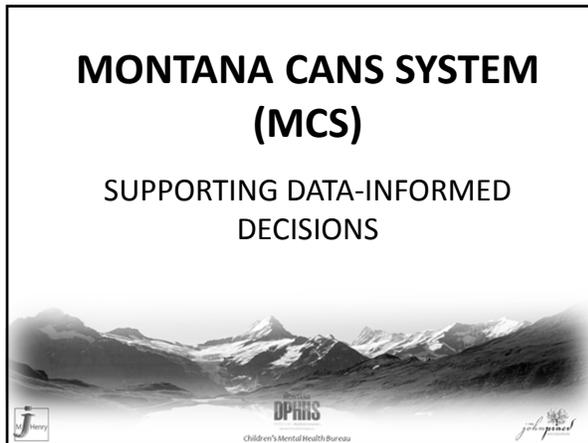
**115. TRANSPORTATION**

This item is used to rate the level of transportation required to ensure that the caregiver could effectively participate in the care for his/her child’s treatment and in other life activities. Only unmet transportation needs should be rated here.

<b>RATING</b>	<b>DEFINITION</b>
<b>0</b>	No evidence of an unmet transportation need, or child/youth has no known caregiver.
<b>1</b>	Caregiver has occasional unmet transportation needs (e.g., child’s appointments). These needs would be no more than weekly and do not require a special vehicle for the child.
<b>2</b>	Caregiver has occasional transportation needs that require a special vehicle for the child, or frequent transportation needs (e.g., daily to child’s therapy, etc.) that do not require a special vehicle.
<b>3</b>	Caregiver requires frequent (e.g., daily to child’s therapy) transportation for his/her child in a special vehicle.

**RATING AND PRACTICE CONSIDERATIONS**

- If public transportation is available, this should be considered a resource and subsequently not an unmet need.
- If finances prohibit using public transportation, this should be considered a need for this area.
- If there is no action to be taken, then this item should be rated a ‘0’ or ‘1’.




---

---

---

---

---

---

---

---




---

---

---

---

---

---

---

---




---

---

---

---

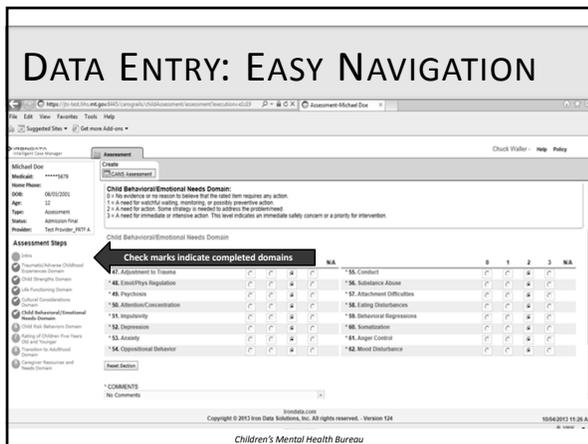
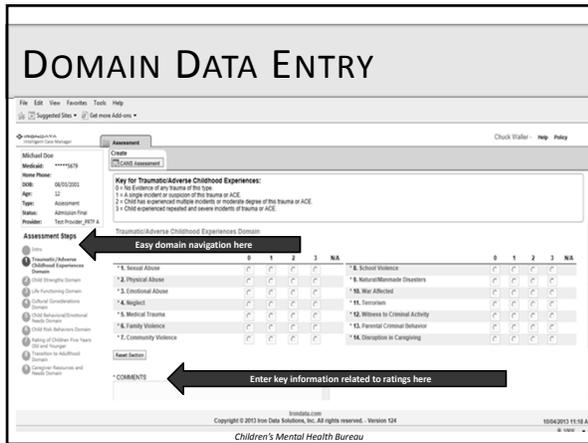
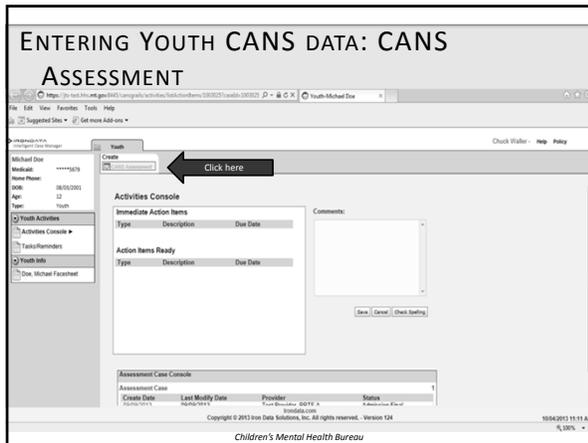
---

---

---

---





**USING CANS IN PLANNING:  
AUTOMATED REPORTS**

**Currently Available:**

- CANS Assessment Report
- MT CANS Treatment Summary Report

*Coming Soon...*

- Treatment Progress Report – Client Level
- Agency Clinical Formulation- Program and/or Agency Level

  
 Children's Mental Health Bureau

---

---

---

---

---

---

---

---

---

---

**CANS ASSESSMENT REPORT**

Finalized CANS Assessment Report

Child's Name :	Doe, Michael	Finalized Date :	Sep 9, 2013
DOB :	Aug 3, 2001	Provider :	Test Provider_PRTF A
Child Medicaid No. :	123445679	LQC/Provider Type :	PRTF
		Finalized By :	Waller, Chuck M.

Traumatic/Adverse Childhood Experiences Domain

**Key for Traumatic/Adverse Childhood Experiences:**

0 = No Evidence of any trauma of this type.  
 1 = A single incident or suspicion of this trauma or ACE.  
 2 = Child has experienced multiple incidents or moderate degree of this trauma or ACE.  
 3 = Child experienced repeated and severe incidents of trauma or ACE.

Items	Rating	Items	Rating
1. Sexual Abuse	0	8. School Violence	0
2. Physical Abuse	2	9. Natural/Manmade Disasters	3
3. Emotional Abuse	0	10. War Affected	0
4. Neglect	0	11. Terrorism	3
5. Medical Trauma	0	12. Witness to Criminal Activity	0
6. Family Violence	1	13. Parental Criminal Behavior	1
7. Community Violence	0	14. Disruption in Caregiving	3

Comments and supporting information for rating :  
 none at this time

Children's Mental Health Bureau

---

---

---

---

---

---

---

---

---

---

**MT CANS TREATMENT SUMMARY REPORT**

<b>MT CANS TREATMENT SUMMARY REPORT</b>	Child's Name :	Doe, Michael
	Child Medicaid No. :	123445679
	DOB :	Aug 3, 2001
	Finalized Date :	Sep 9, 2013
	Provider :	Test Provider_PRTF A
	LQC/Provider Type :	PRTF
	Finalized By :	Waller, Chuck M.

Traumatic/Adverse Childhood Experiences Domain

Item : Physical Abuse	2
Item : Natural/Manmade Disasters	3
Item : Terrorism	3
Level of Traumatic/Adverse Experiences : <b>Profound</b>	

Child Strengths Domain

Item : Interpersonal	3	Item : Youth Involvement	2
Item : Educational	3	Item : Use of Free Time	3
Item : Coping/Problem Solving Skills	3	Item : Peer Influence	3
Item : Optimism	3		
Item : Talents/Interests	2		
Item : Community Life	2		
Item : Relationship Permanence	2		
Level of Need for Strength Development : <b>Profound</b>			

Life Functioning Domain

Item : Family	2
Item : Living Situation	2
Item : Social Functioning	2
Item : School Behavior	2
Item : School Achievement	3
Level of Life Functioning Needs : <b>Profound</b>	

Cultural Considerations Domain

Level of Problem(s) in Cultural Consideration : **None**

Child Behavioral/Emotional Needs Domain

Children's Mental Health Bureau

---

---

---

---

---

---

---

---

---

---

### TREATMENT PROGRESS REPORT: CLIENT

Domain Charts Per Client

Please select the Client and Domain and then click on the report you would like to view.

Client:  1. Select a Client from the pull down menu

Domain:  2. Select a specific Domain or select All Domains (default) from the pull down menu

Client Score in Opening and Last Assessments 3. Click on one of the two links to run a report

Actionable Items in All Assessments

Domain	Opening Assessment	Last Assessment
Psychosis	1.0	1.0
Impulse/Hyper	1.0	1.0
Depression	1.0	1.0
Anxiety	1.0	1.0
Oppositional	1.0	1.0
Conduct	1.0	1.0
Substance Use	1.0	1.0
Eating Disturbances	1.0	1.0
Behavioral Regression	1.0	1.0
Somatization	1.0	1.0
Anger Control	1.0	1.0
Adjustment to Trauma	1.0	1.0

---

---

---

---

---

---

---

---

---

---

---

---

### AGENCY CLINICAL FORMULATION- PROGRAM AND/OR AGENCY LEVEL

Program:

Clinical Formulation	Initial	Reassessment
BE Oppositional	70	40
BE Anger Control	50	20
Risk Beh Discrepancy	45	15
Risk Beh Judgment	15	15
BE Conduct	20	15
BE Depression	20	15
IDF Legal	50	40
IDF School Achievement	50	30
IDF School Attendance	40	30
IDF School Behavior	45	20

Children's Mental Health Bureau

---

---

---

---

---

---

---

---

---

---

---

---

### ADDITIONAL MCS FEATURES

- Add CANS Certified Providers to the MCS
- Search for children and youth currently in the MCS
- Resources regarding CANS, MT CMHB,

Children's Mental Health Bureau

---

---

---

---

---

---

---

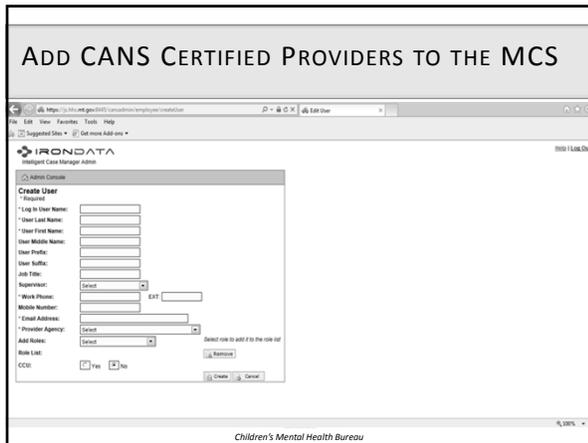
---

---

---

---

---




---

---

---

---

---

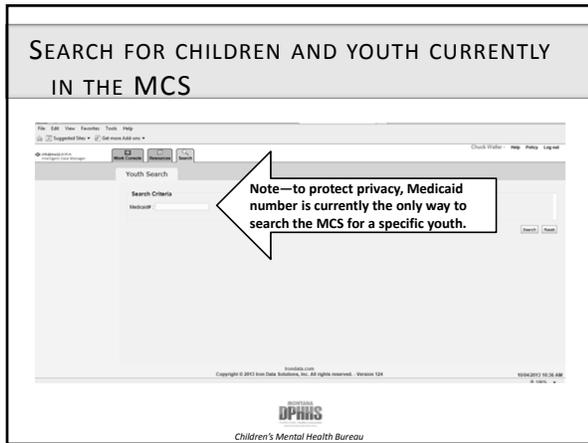
---

---

---

---

---




---

---

---

---

---

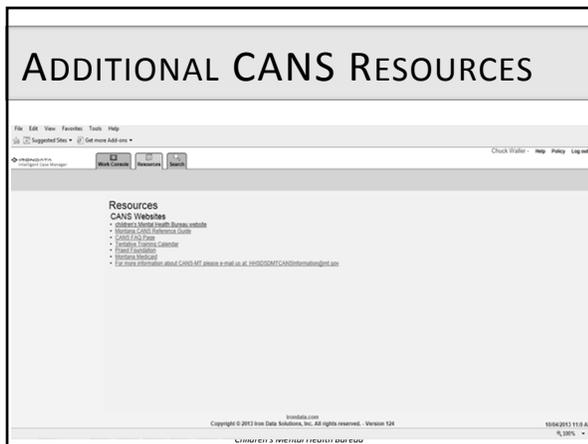
---

---

---

---

---




---

---

---

---

---

---

---

---

---

---

**WHERE CAN YOU GET MORE INFO?**

*Visit:*

<http://dphhs.mt.gov/dsd/CMB>

*Contact:*

Robin Albee or Jamie Olson  
Children's Mental Health Bureau  
406-444-7394  
RALbee@mt.gov

Dan Carlson-Thompson  
Children's Mental Health Bureau  
406-444-1460  
DCarlson-Thompson@mt.gov



---

---

---

---

---

---

---

---

Congratulations! You have completed your Montana CANS Certification training.

**You are now eligible to attempt CANS certification.**

Montana CANS certification is done through the Praed Foundation CANS training website at

[www.canstraining.com](http://www.canstraining.com)

- To become certified to use the tool you must read a 1-page fictional vignette and rate items on the Montana CANS.
- You must score at least a .70 to pass certification.
- The certification is valid for one year and to continue using the CANS tool you must recertify annually.
- The cost to become certified and have access to the CANS training website is \$10 per year and is the responsibility of the individual provider. Providers should check with their specific agency to determine if the cost of the CANS Training site membership is reimbursable.
- Once registered, you can visit [www.canstraining.com](http://www.canstraining.com) at any time to refresh your CANS information or take a practice vignette to refresh rating a CANS. We encourage you to take full advantage of the site.

**Here are the next steps you need to become CANS certified and have full access to the Praed Foundation CANS Training site. See screenshots on page 2 for more details.**

1. Go to [www.canstraining.com](http://www.canstraining.com) Recommended Browsers: Chrome, Safari or Firefox
2. Click 'Register' to create an account
3. Complete your profile by creating a username and password and add demographic information.
4. Choose Montana for your jurisdiction and select your agency affiliation.
5. Once you have completed the registration process click on the green 'Get access!' button.
6. Go to 'billing information', complete payment information and click 'complete transaction'.

*Please note: You must finalize your registration and payment to have access to the materials.*

7. Click 'Profile Overview' – Click on **Montana CANS** box
  8. Please use practice vignettes by clicking '**Practice Tests**' box BEFORE you attempt certification
  9. When you are ready to attempt certification please click '**Final Exam**' box on the bottom right of the page.
- You have 2 hours to complete the test. You can close the page and when you return to the site it will resume your saved test.
  - You will have 3 chances to pass the test.

#### Helpful Tips

**Use your Montana CANS Reference Guide for the test and in practice.**

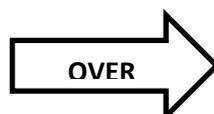
**Refer to the item- and rating-specific definitions to ensure reliable ratings.**

- Read vignette assumptions
- Consider anchor definitions
- Child Strengths: Rate the Strengths -“best”
- No evidence for Strengths: Rate 3
- Caregiver Domain: Rate the worst and who impacts child most
- Look for evidence to support item ratings
- What level of action would you take based on evidence and rating definitions
- Life Functioning Domain: Rate the Needs -“worst”
- No evidence for Needs: Rate 0
- Refer to your CANS reference manual often to ensure evidence supported rating per item.

See next page for [www.canstraining.com](http://www.canstraining.com) screenshots as a reference to the steps outlined above.



Children's Mental Health Bureau



### Praed Foundation Collaborative Training Website

fr | es | en

Login in or register for certification training on the CANS, ANSA, FAST and other communimetric tools



User / Email:

Password:

Remember Me

[Login](#) [Forgot Password?](#) [Register](#)

### CREATE ACCOUNT

Username:

First Name:

Last Name:

Email:

Password:

Repeat Password:

By clicking "Register", you are indicating that you have read and agreed to the [Terms of Use](#) and [Privacy Policy](#).

[REGISTER](#) [Login](#) [Forgot Password?](#)

### CREATE ACCOUNT

Jurisdiction:

Agency:

Street Address 1:

Street Address 2 (optional):

Country:

State / Province / Region:

City:

Postal Code:

Phone:

By clicking "Register", you are indicating that you have read and agreed to the [Terms of Use](#) and [Privacy Policy](#).

[COMPLETE](#) [Login](#) [Forgot Password?](#)

### User MTTTEST TEST

Profile Overview

Test History

My Receipts

Notifications



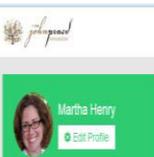
#### MTTTEST TEST

Taking : 2 Subjects

Taking Subjects

[Click here to complete your registration for Montana and gain access to the material!](#)

[Get access!](#)



Stream: My Content

Learning (0)

**Last Viewed**

- 

TCOM & Advanced Tools  
by Dr. John Lyons  
Price:
- 

Montana CANS  
by Lauren Schmidt  
Price:
- 

CANS Conference 2013 Materials  
by Lauren Schmidt  
Price:

← Previous | Next →

#### Text

A large number of individuals have participated in the mass collaboration to develop and refine various versions of the Child and Adolescent Needs and Strengths information integration tool. These include CANS for various child serving areas such as mental health, developmental disabilities, juvenile justice, child welfare, and the National Child Traumatic Stress Network (NCTSN) CANS-Comprehensive. The CANS information integration tool is designed to support individual case planning and the planning and evaluation of service systems. The CANS-Comprehensive is an open domain tool for use in service delivery systems that address the mental health of children, adolescents, and their families. The copyright is held by the Praed Foundation to ensure that it remains free to use for those who are trained and certified in CANS.

For more information about CANS and its history, please contact:

**John S. Lyons, Ph.D. Praed Foundation**  
University of Ottawa 550 N Kingsbury St. #101  
145 Jean-Jacques-Lussier (352) Chicago, IL 60654  
Ottawa ON K1N 6N5 Canada praedfoundation@yahoo.com  
Phone: (613) 864-4940 www.praedfoundation.org  
jlyons@uottawa.ca

Beginning December 1, 2011, Montana identified the Child and Adolescent Needs and Strengths (CANS) as the functional assessment tool that state agencies and providers will use to communicate youth and family needs and strengths. This effort is intended to support Montana youth's and families' resilience in their challenges with mental illness. Many assisted with the process of identifying, customizing, and adopting the CANS for Montana. Among those are Montana providers of Children's Mental Health Services and System of Care Planning Committee (SOC) members, which includes representatives from:

- How to Use the CANS
- Introduction
- Action Levels of the CANS
- Exposure to Potentially Traumatic/Adverse Childhood Experiences Domain
- Child Strengths
- Life Functioning Domain
- Cultural Considerations Domain
- Child Behavioral/Emotional Needs Domain
- Child Risk Behaviors
- Ratings of Children Five Years Old and Younger
- Transition to Adulthood
- Caregiver Resources and Needs
- Practice Tests
- Final Exam

If you have specific questions about the Montana CANS please e-mail [HHSDSDMTCANSInformation@mt.gov](mailto:HHSDSDMTCANSInformation@mt.gov) or call the Children's Mental Health Bureau at 406-444-4545.



## How to get started in the Montana CANS System (MCS) January 9 2014

Following the Certification training please remember to go to the Praed Foundation site and take your certification test: [www.canstraining.com](http://www.canstraining.com)  
When you have passed the certification test with a .70 or higher please check to see if your agency already has a Provider Administrator role within the MCS (Montana CANS System)

The MCS Provider Administrator function is a position designed to enable Provider Agencies to add their own employees into the Montana CANS System. A Provider Administrator must be initially entered into the MCS by Children's Mental Health Bureau staff. Thereafter, this Provider Administrator can add other employees from their agency to the MCS and assign them specific roles and responsibilities.

Your agency may already have a designated Provider Administrator being used either with MCS or with Magellan.

Every MCS user, regardless of role, needs to have an ePass login. A user's MCS Log In User Name must match their ePass login, or he/she won't be able to access the MCS  
<https://app.mt.gov/epass/epass>

The Montana CANS System will house CANS data as well as allow your agency to run reports and allow the state to run reports. These reports were discussed in the TCOM portion of the CANS training. The MCS also has data export functionality so that provider agencies can download their own raw CANS data.

There is lots of useful information that can be found on the Children's Mental Health Bureau website: <http://www.dphhs.mt.gov/mentalhealth/children/index.shtml>  
Look under the left hand side under Montana CANS for general information and for information related to the Montana CANS System.

If your agency does not have a designated Provider Administrator or you have other questions please have your agency identify someone and fill out the form found on the CMHB website <http://dphhs.mt.gov/dsd/CMB/MCS-Information> and return to the CMHB or contact:

CANS Hotline 406-444-7394  
Robin Albee, [ralbee@mt.gov](mailto:ralbee@mt.gov), 406-444-2727  
Jamie Olsen, [jgainesolsen@mt.gov](mailto:jgainesolsen@mt.gov), 406-444-7392  
Children's Mental Health Bureau DPHHS MT  
111 N Sanders Suite 307, Helena MT 59601  
Fax 406-444-5913

# Hard-coded MCS Reports

- Youth level Reports: Finalized CANS Assessment Report and CANS Summary Report
- Clinician—Supervisor level Report: Treatment Progress Report
- Program Level Report: Clinical Formulation Report

# Hard-coded MCS Reports

- Individual Youth level Reports: Finalized CANS Assessment Report and CANS Summary Report
- Individual Youth level, over-time, Report: Treatment Progress Report
- Aggregate Program Level Report: Clinical Formulation Report

# Finalized CANS Assessment Report

## Finalized CANS Assessment Report

<b>Child's Name :</b>	Doe, Michael	<b>Finalized Date :</b>	Sep 9, 2013
<b>DOB :</b>	Aug 3, 2001	<b>Provider :</b>	Test Provider_PRTF A
<b>Child Medicaid No. :</b>	123445679	<b>LOC/Provider Type :</b>	PRTF
		<b>Finalized By :</b>	Waller, Chuck M.

### Traumatic/Adverse Childhood Experiences Domain

**Key for Traumatic/Adverse Childhood Experiences:**

- 0 = No Evidence of any trauma of this type.
- 1 = A single incident or suspicion of this trauma or ACE.
- 2 = Child has experienced multiple incidents or moderate degree of this trauma or ACE.
- 3 = Child experienced repeated and severe incidents of trauma or ACE.

Items	Rating	Items	Rating
1. Sexual Abuse	0	8. School Violence	0
2. Physical Abuse	2	9. Natural/Manmade Disasters	3
3. Emotional Abuse	0	10. War Affected	0
4. Neglect	0	11. Terrorism	3
5. Medical Trauma	0	12. Witness to Criminal Activity	0
6. Family Violence	1	13. Parental Criminal Behavior	1
7. Community Violence	0	14. Disruption in Caregiving	3

**Comments and supporting information for rating :**

none at this time

<b>Child's Name :</b>	Doe, Michael	<b>Finalized Date :</b>	Sep 9, 2013
<b>DOB :</b>	Aug 3, 2001	<b>Provider :</b>	Test Provider_PRTF A
<b>Child Medicaid No. :</b>	123445679	<b>LOC/Provider Type :</b>	PRTF
		<b>Finalized By :</b>	Waller, Chuck M.

### Child Strengths Domain

**Key for Child Strengths Domain:**

- 0 = Centerpiece strength
- 1 = Useful strength
- 2 = Identified strength
- 3 = Not yet identified strength / No information about a strength in this area

Items	Rating	Items	Rating
15. Family	1	22. Spiritual/Religious	1
16. Interpersonal	3	23. Community Life	2
17. Educational	3	24. Relationship Permanence	2
18. Vocational	N/A	25. Resilience	1
19. Coping/Savoring Skills	3	26. Youth Involvement	2
20. Optimism	3	27. Use of Free Time	3
21. Talents/Interests	2	28. Peer Influences	3

**Comments and supporting information for rating :**

none at this time

# CANS Summary Report

## MT CANS TREATMENT SUMMARY REPORT

**Child's Name :** Band, Steven Miller  
**Child Medicaid No. :** 151515151  
**DOB :** Aug 7, 2000  
**Finalized Date :** Aug 29, 2013  
**Provider :** Test Provider\_PRTF A  
**LOC/Provider Type :** 1915i  
**Finalized By :** Waller, Chuck M.

### Traumatic/Adverse Childhood Experiences Domain

Item : Parental Criminal Behavior	2
<b>Level of Trauma/Childhood Experiences : Moderate</b>	

### Child Strengths - Assets

Item : Family	0
Item : Spiritual/Religious	0
Item : Community Life	0
Item : Relationship Permanence	0

### Child Strengths Building / Identification Areas

Item : Interpersonal	3	Item : Youth Involvement	3
Item : Educational	3	Item : Use of Free Time	3
Item : Vocational	3	Item : Peer Influences	3
Item : Coping/Savoring Skills	3		
Item : Optimism	3		
Item : Talents/Interests	3		
Item : Resilience	3		

**Level of Need for Strength Development : Profound**

### Life Functioning Domain

Item : Physical	2
Item : Sleep	2
Item : Sexual Development	3
Item : Activities in Daily Living	3

**Level of Life Functioning Needs : Profound**

### Cultural Considerations Domain

**Level of Problem(s) in Cultural Consideration : None**

### Child Behavioral/Emotional Needs Domain

Item : Adjustment to Trauma	3
Item : Oppositional Behavior	2
Item : Conduct	2
Item : Substance Abuse	2

**Level of Child Behavioral/Emotional Needs : Profound**

### Child Risk Behaviors Domain

Item : Suicide Watch	2
Item : Self-Mutilation	2
Item : Other Self-Harm	2
Item : Danger to Others	2
Item : Sexual Aggression	2
Item : Runaway	2

**Level of Risk Behaviors : Profound**

### Rating of Children Five Years Old and Younger

**None**

### Transition to Adulthood Domain

**None**

### Caregiver Resources and Needs Domain

Item : Supervision	3
Item : Involvement with Care	3
Item : Safety	2
Item : Marital/Partner Violence	3
Item : Financial Resources	3
Item : Family Stress	2

**Level of Caregiver Mother : Profound**

**Level of Caregiver Father : None**

# Treatment Progress Report

Reports

**Treatment Progress Report**

Showing page 1 of 10

**Treatment Progress Report**

Finalized Date : 2014-03-13      Finalized By : Sherry Stevens  
 Provider Agency Name : Test 1915i\_Provider A      Client Name : Mock, Cans  
 LOC / Service Type : 1915i      Medicaid No. : 147587896  
 DOB : 2000-01-08  
 Client : Mock, Cans  
 Comparison Values : Admission CANS compared to Next-to-last Update CAN  
 Report Run Date : 03/17/2014

**Traumatic/Adverse Childhood Experiences Domain**

Category	Opening Assessment	Last Assessment
Sexual Abuse	2	2
Physical Abuse	2	2
Emotional Abuse	2	2
Neglect	2	2
Medical Trauma	2	2
Witness to Family Violence	2	2
Community Violence	2	2
School Violence	2	2
Natural/Manmade Disasters	2	2
War Affected	2	2
Terrorism Affected	2	2
Witness to Criminal Activity	2	2

Copyright © 2014 Iron Data Solutions, Inc. All rights reserved. - Version 1.0

**Treatment Progress Report**

Showing page 3 of 10

Client : Mock, Cans  
 Comparison Values : Admission CANS compared to Next-to-last Update CAN  
 Report Run Date : 03/17/2014

**Life Functioning Domain**

Domain	Opening Assessment	Last Assessment
Family	2	1
Living Situation	1	1
Social Functioning	3	2
Developmental/Intellectual	0	0
Recreational	0	0
Legal	0	0
Medical	2	2
Physical	0	0
Sleep	0	0
Sexual Development	0	0
Activities in Daily Living	0	0
School Behavior	2	1
School Achievement	0	1
School Attendance	0	1

Legend: Opening Assessment (Red), Last Assessment (Blue)

Copyright © 2014 Iron Data Solutions, Inc. All rights reserved. - Version 1.0

# Clinical Formulation Report

Reports

[View Reports](#)

- Finalized CANS Assessment Report
- CANS Summary Report
- Treatment Progress Report
- Clinical Formulation Report

## Clinical Formulation Report

Showing page 1 of 1

Go to page:

### Clinical Formulation Report

From 07/01/2013 to 02/27/2014

Comparison Value :

Admission CANS compared to Discharge CANS

Total no. of Children records used :

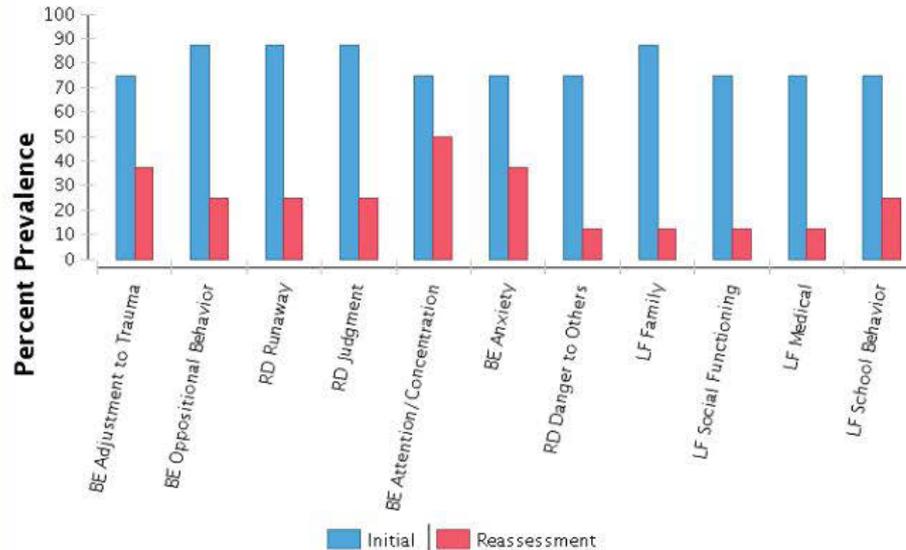
8

LOC/Service type:

PRTF

No. of Children records used :

8



# Montana CANS System (MCS) and next steps

- Phase 3 Enhancements
- Pentaho Ad hoc reporting tool
- Provider access to Pentaho.
- Provider-level Pivot Charts—flexibility

## PREPARING FOR RECERTIFICATION

- Certification in CANS is required on an annual basis with a .70 and above.
- Individual certification is done by reading a test vignette and rating each item on the MT CANS.
- Montana CANS certification is done through [www.canstraining.com](http://www.canstraining.com) and there are additional resources available to you on the site. *Please note, if you do not recertify within 90 days of your expiration date your account will be deleted from [www.canstraining.com](http://www.canstraining.com)*

### Helpful Tips

- Schedule at least 2 hours of time, take notes, and create an environment free of disruptions and distractions.
- Watch 'CANS Overview and TCOM & Advanced Tools' videos by Dr. John Lyons at [www.canstraining.com](http://www.canstraining.com) (under 'My Courses' Tab) -- look for the video  icon.
- Use your Montana CANS Reference Guide for testing and in practice.
  - Familiarize yourself with the items by reading through the Table of Contents
- Refer to the item- and rating-specific definitions to ensure reliable ratings.
- It is suggested that you complete a few *Practice Tests* before attempting a *Final Exam* for CANS Certification at [www.canstraining.com](http://www.canstraining.com)
- Regardless of your Practice Test score, review your ratings compared to the recommended ratings for each item on the test. For any item where you are 2 or 3 ratings from the recommended, make note and look for any patterns. **This can only be done at the time you receive your results.** The system does not store these.
- Only rate items based on evidence available in the vignette. Do not 'make a movie' of the child/youth and family; focus on only what you know from the vignette.
- Do not try to predict future behavior or create casual inferences while rating the CANS.
- If you do not have any evidence of a need for any item rated on the Needs Scale, it should be rated with a 0.
- If you do not have any evidence of a strength for any item rated on the Strengths Scale, it should be rated with a 3.



For more information, visit:

<http://dphhs.mt.gov/dsd/CMB>

Call: 406-444-4545





CMHB is excited to announce another resource for those seeking to increase their knowledge of the Montana CANS.

In September 2014 CMHB recorded our Master CANS Trainers, Martha Henry and Michael McManus of MJ Henry Associates conducting a live Montana CANS certification training.

The videos are for your use to become certified or recertified in the Montana CANS. For initial certification CMHB suggests that you attend a live training conducted by your agency certified CANS trainer/coach or attend a live quarterly training conducted by the CMHB certified CANS trainers. The videos can also be used to augment coaching under direction of a Certified CANS trainer.

To access these videos please follow the link: <http://www.therapservices.net/request-to-watch-montana-cmhb-videos/>

The screenshot below is an example of what you will see once you click on the link. Please note the blanks identified with asterisks need to be completed. You will then be directed to enter a password. The password is **CANS-MT**

Please note that this video is hosted on the Therap Montana site which is used by Montana Medicaid Providers of the developmental disabilities program.

Thank you and we hope you find this resource helpful.

