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# ILLINOIS MEDICAID

# Crisis Assessment Tool

## IM-CAT 2025

Lifespan Behavioral Health Crisis Assessment Tool

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2025  
REFERENCE  
GUIDE

# ACKNOWLEDGEMENTS

The Illinois Medicaid-Crisis Assessment Tool (IM-CAT) 2025 is a crisis subset of the Illinois-Medicaid Comprehensive Assessment of Needs and Strengths (IM+CANS 2024). The CAT began as the Childhood Severity of Psychiatric Illness (CSPI) tool which was created to assess appropriate use of psychiatric hospital and residential treatment services. It has been revised over the years, each time with a large number of individuals collaborating. The CSPI-2 was developed based on work done in collaboration with the New Jersey Division of Behavioral Healthcare as a component of the Division of Children’s Behavioral Health Services. The CSPI-3.0 version was developed as a lifespan assessment in collaboration with individuals from the Illinois Departments of Children and Family Services (DCFS), Human Services (DHS) and Healthcare and Family Services (HFS). The IM-CAT integrated information from the CSPI-Early Childhood and the IM+CANS; content contributors included April Fernando, PhD, Stacey Cornett, LISW, IMH-E, and Kathleen Hoffmans, PhD.

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Literary Preface/Comment regarding gender references:

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

Additionally, “individual” is being utilized in reference to “child,” “youth,” “adolescent,” “young adult,” and “adult.” This is due to the broad range of ages to which this reference group applies.

For more information on the IM-CAT 2025, contact:

**Illinois Department of Healthcare and Family Services (HFS)**

HFS.IATP@illinois.gov • (217) 557-1000  
201 S. Grand Avenue East • Springfield, IL 62763

For specific permission to use this tool, please contact the Praed Foundation:

<b>John S. Lyons, PhD</b> Director Center for Innovation in Population Health Professor, Health, Management and Policy University of Kentucky College of Public Health <a href="mailto:John.Lyons@uky.edu">John.Lyons@uky.edu</a>	<b>Joy Dicus</b> Implementation Lead Center for Innovation in Population Health University of Kentucky College of Public health <a href="mailto:Joy.Dicus@uky.edu">Joy.Dicus@uky.edu</a>
<b>Praed Foundation</b> <a href="http://praedfoundation.org">http://praedfoundation.org</a> <a href="mailto:info@praedfoundation.org">info@praedfoundation.org</a>	

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# INTRODUCTION

## ILLINOIS MEDICAID-CRISIS ASSESSMENT TOOL

The Illinois Medicaid – Crisis Assessment Tool (IM-CAT) 2025 is a decision support and communication tool to allow for the rapid and consistent communication of the needs of individuals experiencing a crisis that threatens their safety or well-being or the safety of the community. It is intended to be completed by those who are directly involved with the individual. The form serves as both a decision support tool and as documentation of the identified needs of the individual served along with the decisions made with regard to treatment and placement at the time of the crisis.

The IM-CAT 2025 is composed of a subset of indicators from the Illinois Medicaid-Comprehensive Assessment of Needs and Strengths (IM+CANS) 2024 tool, which serves as the standardized assessment for all Illinois individuals who may access publicly-funded behavioral health services. The IM-CAT 2025 and the IM+CANS 2024 together comprise a broader toolkit of linked assessments that are designed to meet the unique needs of multiple public payer systems, while also breaking down barriers to accessing behavioral health treatment. This suite of assessments is designed to reduce the duplicate collection of administrative and clinical data points needed to appropriately assess a client's needs and strengths while establishing a commonality of language between clients, families, providers, and payer systems.

## ILLINOIS MEDICAID-COMPREHENSIVE ASSESSMENT OF NEEDS AND STRENGTHS 2024

The IM+CANS 2024 serves as the foundation of Illinois' efforts to transform its publicly funded behavioral health service delivery system. The original version was developed as the result of a collaborative effort between the Illinois Departments of Healthcare and Family Services (HFS), Human Services-Division of Mental Health (DHS-DMH), and Children and Family Services (DCFS). The comprehensive IM+CANS 2024 assessment provides a standardized, modular framework for assessing the global needs and strengths of individuals who require mental health treatment in Illinois. Today, the IM+CANS 2024 incorporates:

- A complete set of core and modular CANS indicators, addressing domains such as Risk Behaviors, Trauma Exposure, Behavioral/Emotional Needs, Life Functioning, Substance Use, Developmental Disabilities, and Cultural Needs;
- A fully integrated mental health assessment (MHA) and treatment plan;
- A physical Health Risk Assessment (HRA); and,
- A population-specific addendum for youth involved with the child welfare system.

At the core of the IM+CANS 2024 is the Child and Adolescent Needs and Strengths (CANS), the Adult Needs and Strengths Assessment-Transition to Adulthood (ANSA-T), and the Adult Needs and Strengths Assessment (ANSA), communimetric tools that contain a set of core and modular indicators that identify an individual's strengths and needs using a '0' to '3' scale. These individual indicators support care planning and level of care decision-making, facilitate quality improvement

initiatives, and monitor the outcomes of services. Additional data fields were added to the IM+CANS 2024 indicators to support a fully integrated MHA, placing mental health treatment in Illinois on a new pathway built around a person-centered, data-driven approach.

The IM+CANS 2024 also includes a Health Risk Assessment (HRA), developed to support a holistic, wellness approach to assessment and treatment planning by integrating physical health and behavioral health in the assessment process. The HRA is a series of physical health questions for the individual that is designed to: 1) assess general health; 2) identify any modifiable health risks that can be addressed with a primary health care provider; 3) facilitate appropriate health care referrals, as needed; and 4) ensure the incorporation of both physical and behavioral health needs directly into care planning.

## SIX KEY PRINCIPLES OF A COMMUNIMETRIC TOOL

The IM-CAT 2025 is a communimetric tool, and there are six key principles that should be considered when completing the ratings.

- 1. Indicators were selected because they are each relevant to service/treatment planning.**  
An indicator exists because it might lead you down a different pathway in terms of planning actions.
- 2. Each indicator uses a 4-level rating system designed to translate immediately into action levels.** An indicator rated '2' or '3' requires action. For a description of these action levels, please see below.
- 3. Ratings should describe the individual, not the individual in services.** If an intervention is present that is masking a need but must stay in place, this should be factored into the rating consideration and would result in a rating of an actionable need (i.e., '2' or '3').
- 4. Culture and development should be considered prior to establishing the action levels.** Cultural responsivity involves considering whether cultural factors are influencing the expression of needs and strengths. Ratings should be completed considering the individual's developmental and/or chronological age depending on the indicator. In other words, anger control is not relevant for a very young child but would be for a young adult regardless of developmental age. Alternatively, school achievement should be considered within the framework of expectations based on the individual's developmental age.
- 5. The ratings are generally "agnostic as to etiology."** In other words, this is a descriptive tool; it is about the "what" not the "why." While most indicators are purely descriptive, there are a few indicators that consider cause and effect; see individual indicator descriptions for details on when the "why" is considered in rating these indicators.
- 6. A 30-day window is used to make sure assessments stay relevant to the individual's present circumstances.** The CAT is a communication tool and a measure of an individual's story during a crisis. The 30-day time frame should be considered in terms of whether an indicator is a need within the time frame within which the specific behavior

may or may not have occurred. The action levels assist in understanding whether a need is currently relevant even when no specific behavior has occurred during the time frame.

## RATING NEEDS

The IM-CAT 2025 is easy to learn and is well liked by individuals and families, providers and other partners in the services system because it is easy to understand and does not necessarily require complex scoring or calculations in order to be meaningful to the client and their family.

As a communimetric tool, the indicators on the IM-CAT 2025 are selected to represent the key information needed in order to decide the best intervention strategy for an individual during a time of crisis.

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

In order to enhance the reliability of the IM-CAT 2025, anchor points have been designed to facilitate the translation of levels of each indicator into the four action levels described above. It should be noted that these anchor points represent guidelines. Since it is not feasible to exhaustively define all circumstances that might fit a particular level, the assessor may use some clinical judgment to determine the rating when no clear choice is obvious. This judgment should be guided by a decision on the appropriate level of action required for the specific indicator.

A primary goal of this tool is to further communicate with both the individual and family and for the individual's system of care. As such, consistency and reliability in the use of this tool is important. Therefore, formal training is required prior to any staff completing this tool based on an actual crisis assessment. Annual certification on the tool is also required.

Please note that a 30-day window is used. This window is just to remind the rater that the interest is in describing the individual's immediate needs in this regard. The use of the word 'history' in many of the ratings of 1 refers to lifetime history. In other words, if an individual attempted suicide five years ago but is not actively suicidal, a rating of 1 would be appropriate.

The IM-CAT 2025 includes indicators regarding substance use. Individual and family responses to questions about these indicators may suggest the likelihood of a co-occurring substance use disorder or may suggest that the individual is presenting signs, symptoms, and behaviors influenced by co-occurring issues. The purpose for these questions is not to establish the presence or specific type of a substance abuse disorder, but to alert clinicians to the impact substance use may have on the individual's crisis.

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# CRISIS ASSESSMENT TOOL

The Illinois Medicaid-Crisis Assessment Tool 2025 core indicators are noted below.

While most indicators are relevant for individuals at any age, some indicators are age-specific and should be rated as age-applicable. Indicators specific for an age range are noted below and in the indicator descriptions. Outside the specified age range, the indicator should be rated using the 'N/A' option.

## CORE INDICATORS

### RISK BEHAVIORS

Victimization/Exploitation

0-5: Self-Harm

1-5: Aggressive Behavior

3-21: Flight Risk/Runaway

3+: *Suicide Risk [A]*

3+: Decision Making

3+: Intentional Misbehavior

6+: Sexually Problematic Behavior

6+: Fire Setting

6+: Danger to Others

6+: Other Self-Harm (Recklessness)

6+: Non-Suicidal Self-Injurious Behavior

6+: Delinquent/Criminal Behavior

### BEHAVIORAL/EMOTIONAL NEEDS

Depression

Anxiety

Adjustment to Trauma

Atypical/Repetitive Behaviors

0-5: Failure to Thrive

3-18: Oppositional Behavior/Non-  
Compliance with Authority

3+: Anger Control/Frustration Tolerance

3+: Impulsivity/Hyperactivity

6+: Conduct/Antisocial Behavior

6+: Psychosis (Thought Disorder)

6+: Mania

6+: Substance Use

### FUNCTIONING NEEDS

Living Situation

Family Functioning

Social Functioning

Developmental/Intellectual

Medication Compliance

0-5: Feeding/Elimination

0-21: School/Preschool/Daycare

1+: Sleep

16+: Parental/Caregiving Role

16+: Job Functioning/Employment

### CAREGIVER RESOURCES & NEEDS

Supervision

Involvement with Care

Caregiver Residential Stability

Health/Behavioral Health

Family Stress

0-21: Empathy with Children

### PROTECTION

Safety

Family Violence

## MODULE

### [A] SUICIDE RISK MODULE

Ideation

Intent

Planning

History

Awareness of Others' Suicide

# DOMAINS & INDICATOR DESCRIPTIONS

Unless otherwise specified, rate the highest level **from the past 30 days** based on relevant information from all sources.

---

For **all Domains**, use the following categories and action levels:

- 0 No evidence of any needs; no need for action.
- 1 Need or risk behavior that requires monitoring, watchful waiting, or preventive action based on history, suspicion, or disagreement.
- 2 Need is interfering with functioning. Action is required to ensure that the identified need or risk behavior is addressed.
- 3 Need is dangerous or disabling. Intensive and/or immediate action is required to address the need or risk behavior.

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**Note:** Specific time frames noted in some of the rating levels are intended to be guidelines and not rules (e.g., “not in the past 24 hours” in level 2 of Suicide Risk). Always consider the indicator rating within the context of the action levels described on p. 6 above. This may mean that the rating still falls in that level even though the behavior occurred outside the specified time frame.

# RISK BEHAVIORS

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## VICTIMIZATION/EXPLOITATION

This indicator describes an individual who has been victimized by others. This indicator is used to examine a history and pattern of being the object of abuse and/or whether the individual is at current risk for re-victimization. This indicator includes children or youth who are currently being bullied at school or in their community. It would also include individuals who are victimized in other ways (e.g., sexual abuse, sexual exploitation, inappropriate expectations based on a child's level of development, an individual who is forced to take on a parental level of responsibility, etc.).

---

### Questions to Consider:

- Has the individual ever been bullied or the victim of a crime?
  - Has the individual traded sexual activity for goods, money, affection, or protection?
  - Has the individual been a victim of human trafficking?
  - Is the individual parentified or has taken on parental responsibilities and has this impacted their functioning?
- 

### Ratings and Descriptions

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

No evidence that the individual has experienced victimization or exploitation. They may have been bullied, robbed, or burglarized on one or more occasions in the past, but no pattern of victimization exists. Individual is not presently at risk for re-victimization or exploitation.

---

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

Suspicion or history of victimization or exploitation, but the individual has not been victimized to any significant degree in the past year. Individual is not presently at risk for re-victimization or exploitation.

---

- 2 *Need is interfering with functioning. Action is required to ensure that the identified need or risk behavior is addressed.*

Individual has been recently victimized (within the past year) and may be at risk of re-victimization. This might include physical or sexual abuse, significant psychological abuse by family or friend, sexual exploitation, or violent crime.

---

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

Individual has been recently or is currently being victimized or exploited, including human trafficking (e.g., labor or sexual exploitation including the production of pornography, sexually explicit performance, or sexual activity) or living in an abusive relationship, or constantly taking on responsibilities of being a parent to other family members. [continues]

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**VICTIMIZATION/EXPLOITATION continued**

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**Supplemental Information:** Sexual exploitation includes any situation, context, or relationship where the individual receives something (e.g., food, accommodations, drugs and alcohol, cigarettes, affection, gifts, money, etc.) as a result of performing sexual activities, and/or others performing sexual activities on them. This includes commercial sexual exploitation in which a third party receives payment for the sexual exploitation of the individual.

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**SELF-HARM (Ages 0-5)**

This indicator includes reckless and dangerous behaviors that, while not intended to harm self or others, place the young child or others at some jeopardy. This may include behavior that is repetitive and self-soothing (i.e., non-suicidal self-injury), including head banging, hair pulling, etc.

---

**Questions to Consider:**

- Does the child bang their head or do other self-harming behaviors?
  - If so, does the caregiver's support help stop the behavior?
- 

**Ratings and Descriptions**

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

There is no evidence of self-harm behaviors.

---

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

There is a history, suspicion, or some evidence of self-harm behaviors. These behaviors are controllable by the caregiver.

---

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

Child's self-harm behaviors, such as head banging, cannot be impacted by a supervising adult and interferes with their functioning.

---

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

Child's self-harm behavior puts their safety and well-being at risk.

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NA Individual is 6 years old or older. For individuals 6 years old or older, rate the Non-Suicidal Self-Injurious Behaviors and Other Self-Harm indicators.

---

**Supplemental Information:** This indicator combines two CAT indicators for the early childhood population: Non-Suicidal Self-Injurious Behavior (Self-Mutilation) and Other Self Harm (Recklessness). Reckless and risk-taking behavior should be rated in this indicator. [continues]

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## SELF-HARM (Ages 0-5) continued

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

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

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

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

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

#### Axis I

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

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## AGGRESSIVE BEHAVIOR (Ages 1-5)

This indicator rates the child's violent or aggressive behaviors. The intention of the behavior is to cause significant bodily harm to others. A supervising adult is also taken into account in this rating, as a rating of '2' or '3' could signify a supervising adult who is not able to control the child's violent behaviors. The child should be 12 months old or older in order to rate this indicator.

---

### Questions to Consider:

- Does the child get into frequent fights with others?
  - Has the child been aggressive with caregivers?
  - Does the child frequently attempt to hurt others, throw objects or attack?
  - Have teachers/childcare workers contacted caregiver with concerns about the child's aggression or hitting/biting behaviors?
- 

### Ratings and Descriptions

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

No evidence of aggressive behavior towards people or animals.

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

History, suspicion or concerns of aggressive behavior towards people or animals that have not yet interfered with functioning.

---

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

Clear evidence of aggressive behavior toward animals or others. Behavior is persistent, and caregiver's attempts to change behavior have not been successful. Help is needed.

---

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

Child exhibits a dangerous level of aggressive behavior involving harm to animals or others. Caregivers are unable to manage this behavior.

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NA Individual is younger than 12 months old OR 6 years old or older. For individuals 6 years old or older, rate the Danger to Others indicator.

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**FLIGHT RISK/RUNAWAY (Ages 3-21)**

This indicator describes the risk of leaving or running away from a living situation. This indicator can also refer to any planned or impulsive running or ‘bolting’ behavior that presents a risk to the safety of the child or youth. Factors to consider in determining level of risk include age of the young person, frequency and duration of escape episodes, timing and context, and other risky activities while running.

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**Questions to Consider:**

- Has the child/youth ever left or run away from their placement? Has child/youth bolted or run away from home, school, or any other place?
  - If so, where did they go? How long did they stay away? How were they found?
  - Does the child/youth ever threaten to leave or run away?
- 

**Ratings and Descriptions**

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

Child/youth has no history of bolting, leaving, running away or ideation of escaping from current living situation.

---

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

Child/youth has no recent history of bolting, leaving or running away but has expressed ideation about escaping current living situation. Child/youth may have threatened to leave or run away on one or more occasions or has a history of leaving/running away but not in the recent past.

---

- 2 *Need is interfering with functioning. Action is required to ensure that the identified need or risk behavior is addressed.*

Child/youth has left, bolted, or run from home or one treatment setting one time. Also rated here is a child/youth who has run home (parental or relative).

---

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

Child/youth has left, bolted, or run from home and/or treatment settings in the recent past and presents an imminent flight risk. A child/youth who is currently absent without leave or noted as a runaway is rated here.

---

NA Individual is younger than 3 years old OR 22 years old or older.

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**Supplemental Information:** An independent adult who can leave on their own is not rated on this indicator.

**Understanding flight risk in young children:** Exploring the inside and outside world — with supervision, of course — is important for young children’s emotional, social, and physical development. They’re learning to talk, to walk and run, and to assert their independence. During this stage, caregivers will be balancing the need for safety and supervision [continues]

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**FLIGHT RISK/RUNAWAY continued**

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with the child's need to explore, learn, and gain independence, which may result in times when toddlers or young children wander off or run away from their caregivers (Gavin, 2015). For some children, however, wandering off or running away (sometimes called bolting or elopement) may become more serious and may place the child at risk for harm.

Some common reasons for bolting/elopement include (CDC, 2019):

- Enjoyment of running or exploring
- To get to a place he or she enjoys (like a pond)
- To get out of a situation that causes stress (for example, being asked to do something at school or getting away from a loud noise)
- Engaging in risk-taking or impulsive behaviors as a response to stress or stimulation
- To test the boundaries of caregiver-relationships and/or to trigger a response from a caregiver

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### SUICIDE RISK (Ages 3+)\*

This indicator describes both suicidal and significant self-injurious behavior. This indicator rates overt and covert thoughts and efforts on the part of a child/youth to end their life. A rating of '2' or '3' would indicate the need for a safety plan. **The individual should be 3 years old or older to rate this indicator.** Note the specific time frames for each action level.

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#### Questions to Consider:

- Is the individual talking about hating themselves, wanting to die, having a wish or plan to die or to kill themselves?
  - Has the individual tried to commit suicide?
- 

#### Ratings and Descriptions

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

No evidence of suicidal ideation or behaviors.

---

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

History of suicidal ideation, but no recent ideation or gesture. History of suicidal behaviors or significant ideation but none during the past 30 days.

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

Recent ideation or gesture but not in the past 24 hours. Recent (last 30 days), but not acute (today), suicidal ideation or gesture.

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

Current suicidal ideation and intent in the past 24 hours OR command hallucinations that involve self-harm.

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NA Individual is younger than 3 years old.

---

**Supplemental Information:** Since a history of suicidal ideation and gestures is a predictor of future suicide, any child/youth with a history is rated at least a '1.' **A rating of '2' or '3' would indicate the need for a safety plan.**

---

**\*A rating of '1,' '2,' or '3' on this indicator triggers the completion of the [A] Suicide Risk Module.**

---

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## [A] SUICIDE RISK MODULE (AGES 3+)

---

### IDEATION

This indicator describes whether the individual has recently thought about hurting themselves.

---

#### Questions to Consider:

- Does the individual ever think about hurting themselves?
  - When did these thoughts happen and what is the content?
- 

#### Ratings and Descriptions

- |   |  |
|---|--|
| 0 | No evidence of suicidal ideation.                                  |
| 1 | History, but no recent ideation.                                   |
| 2 | Recent ideation but not in past 24 hours.                          |
| 3 | Current ideation OR command hallucinations that involve self-harm. |
- 

---

### INTENT

This indicator describes the level of intent the individual has of harming themselves.

---

#### Questions to Consider:

- Does the individual have any intent for harming/killing themselves?
  - If so, how recent was it?
- 

#### Ratings and Descriptions

- |   |  |
|---|--|
| 0 | No evidence of intent to harm themselves.        |
| 1 | History, but no recent intent to commit suicide. |
| 2 | Recent intent to commit suicide.                 |
| 3 | Current intention.                               |
- 

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---

**PLANNING**

This indicator describes whether the individual has recently had a plan to commit suicide.

---

**Questions to Consider:**

- Does the individual have a plan on how they will commit suicide?
  - If so, how realistic or lethal is that plan?
- 

**Ratings and Descriptions**

- |       |  |
|-------|--|
| 0     | No evidence of a concrete plan to harm themselves.                 |
| <hr/> |  |
| 1     | A vague notion of a plan, but the plan is not realistic.           |
| <hr/> |  |
| 2     | Individual has a plan to commit suicide that is feasible.          |
| <hr/> |  |
| 3     | Individual has a plan that is immediately accessible and feasible. |
- 

---

**HISTORY OF ATTEMPTS**

This indicator refers to suicidal ideation or/and behaviors that an individual engages in. Please rate the highest level experienced.

---

**Questions to Consider:**

- Does individual have a history of suicide attempts?
- 

**Ratings and Descriptions**

- |       |   |
|-------|---|
| 0     | No lifetime history of suicidal ideation or attempt.                                  |
| <hr/> |   |
| 1     | Lifetime history of significant suicidal ideation but no potentially lethal attempts. |
| <hr/> |   |
| 2     | Lifetime history of potentially lethal suicide attempt.                               |
| <hr/> |   |
| 3     | Lifetime history of multiple potentially lethal suicide attempts.                     |
- 

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## **AWARENESS OF OTHERS' SUICIDE**

Sometimes knowledge of someone else's suicide has an effect on an individual. If the individual is aware of another's suicide, this indicator refers to the impact of the suicide on the individual.

---

### **Questions to Consider:**

- Is the individual aware of another person's suicide (either someone personally known such as a family member or friend, or a public figure)?
  - Did learning about the suicide have an effect on the individual?
- 

### **Ratings and Descriptions**

- |       |  |
|-------|--|
| 0     | No evidence that the individual is impacted by the recent suicide of another. Either the individual does not know about another's suicide, or that knowledge did not negatively impact the individual.   |
| <hr/> |  |
| 1     | Someone known to the individual recently committed suicide. The person could be known to the individual personally or a public figure they have a sense of connection with. Knowledge of the suicide has impacted the individual in some negative way. |
- 

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**End of Suicide Risk Module**

---

## DECISION MAKING (Ages 3+)

This indicator describes the individual's age-appropriate decision-making process and understanding of choices and consequences. This rating should reflect the degree to which an individual can concentrate on an issue, think through decisions, anticipate consequences of decisions, and follow through on decisions.

---

### Questions to Consider:

- How is the individual's decision-making process and ability to make good decisions?
  - Does the individual struggle to make decisions?
  - Does the individual typically make good choices for themselves? Does their decision-making repeatedly lead to undesirable consequences?
  - Does the individual struggle with following through on decisions they have made?
- 

### Ratings and Descriptions

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

No evidence of problems with judgment or poor decision-making that result in harm to development and/or well-being.

---

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

There is a history or suspicion of problems with decision making in which the individual makes decisions that are in some way harmful to their development and/or well-being.

---

- 2 *Need is interfering with functioning. Action is required to ensure that the identified need or risk behavior is addressed.*

Problems with judgment in which the individual makes decisions that are in some way harmful to their development and/or well-being. As a result, more supervision is required than expected for their age.

---

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

Individual makes decisions that would likely result in significant physical harm to self or others. Therefore, individual requires intense and constant supervision, over and above that expected for individual's age.

---

- NA Individual is younger than 3 years old.
- 

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## INTENTIONAL MISBEHAVIOR (Ages 3+)

This indicator describes intentional behaviors that an individual engages in to force others to administer consequences. This indicator should reflect problematic social behaviors (socially unacceptable behavior for the culture and community in which the individual lives) that put the individual at some risk of consequences. It is not necessary that the individual be able to articulate that the purpose of their misbehavior is to provide reactions/consequences to rate this indicator. There is always, however, a benefit to the individual resulting from this unacceptable behavior even if it does not appear this way on the face of it (e.g., individual feels more protected, more in control, less anxious because of the sanctions). This indicator should not be rated for individuals who engage in such behavior solely due to developmental delays.

---

### Questions to Consider:

- Does the individual intentionally do or say things to upset others or get in trouble with people in positions of authority (e.g., teachers, parents)?
  - Has the individual engaged in behavior that was insulting or rude which resulted in sanctions for the individual such as school suspension, job dismissal?
- 

### Ratings and Descriptions

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

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

---

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

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

---

- 2 *Need is interfering with functioning. Action is required to ensure that the identified need or risk behavior is addressed.*

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

---

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

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

---

NA Individual is younger than 3 years old. [continues]

---

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**INTENTIONAL MISBEHAVIOR continued**

---

**Supplemental Information:** This indicator refers to an individual engaging in obnoxious, inappropriate or irritating behaviors that force others to sanction them. The individual may be intentionally misbehaving in order to force others to sanction them. Examples would include a youth who intentionally tests their foster parents to see whether they will be kicked out.

- Individuals generally know the likely sanctions. Sometimes they will pick one sanction over another (e.g., kicked out of school rather than failing academically).
- In order to rate a '2' or '3' on this indicator, there must be clear evidence that the individual is intentionally misbehaving (rather than not having control of their behavior, which would be rated in Impulsivity/Hyperactivity) AND the individual is trying to receive a specific consequence. A rating of '2' could be a child who, several times a week, is intentionally getting into trouble at preschool in order to have mother pick them up early.
- If it is not clear that the behavior is intentional, or what the individual stands to gain from getting in trouble, or if it is not directed at an authority figure, a rating of '1' for suspicion would be recommended. A '1' could also be used for an individual seeking attention.

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## SEXUALLY PROBLEMATIC BEHAVIOR (Ages 6+)

This indicator describes issues around sexual behavior including developmentally-inappropriate or age-inappropriate sexual behavior.

---

### Questions to Consider:

- Has the individual ever been involved in sexual activities or done anything sexually inappropriate?
  - Has the individual ever had difficulties with sexualized behavior or problems with physical/ sexual boundaries?
- 

### Ratings and Descriptions

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

No evidence of challenges with sexual behavior.

---

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

History or suspicion of challenges with sexual behavior. This includes occasional inappropriate sexual behavior, language, or dress. Poor boundaries with regards to physical/sexual contact may be rated here.

---

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

Individual's sexual behaviors are impairing functioning in at least one life area. For example, frequent inappropriate sexual behavior or disinhibition, including public disrobing, multiple older (i.e., age-inappropriate) sexual partners, or frequent sexualized language. Age-inappropriate sexualized behavior or lack of physical/sexual boundaries is rated here.

---

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

Severe problems with sexual behavior including sexual exploitation, exhibitionism, sexually aggressive behavior, or other severe sexualized or sexually reactive behavior that puts individual or others at risk of physical harm.

---

NA Individual is younger than 6 years old.

---

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**FIRE SETTING (Ages 6+)**

This indicator refers to behavior involving the intentional setting of fires that might be dangerous to the individual or others. This includes both malicious and non-malicious fire setting. This does NOT include the use of candles or incense or matches to smoke or accidental fire setting.

---

**Questions to Consider:**

- Has the individual ever played with matches, or set a fire? If so, what happened?
  - Did the fire setting behavior destroy property or endanger the lives of others?
- 

**Ratings and Descriptions**

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

No evidence of fire setting by the individual.

---

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

History or suspicion of fire setting but not within the past six months.

---

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

Recent fire-setting behavior (during the past six months) but not of the type that endangered the lives of others, OR repeated fire-setting behavior over a period of at least two years, even if not within the past six months.

---

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

Acute threat of fire setting. Individual has set fires that endangered the lives of others (e.g., attempting to burn down a house).

---

NA Individual is younger than 6 years old.

---

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**DANGER TO OTHERS (Ages 6+)**

This indicator rates the individual's actual or threatened violent or aggressive behavior. The intention of this behavior is to cause significant bodily harm to others. A rating of '2' or '3' would indicate the need for a safety plan.

---

**Questions to Consider:**

- Has the individual ever injured another person on purpose?
  - Does the individual get into physical fights?
  - Has the individual ever threatened to kill or seriously injure others?
- 

**Ratings and Descriptions**

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

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

---

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

History of aggressive behavior or verbal threats of aggression towards others but no aggression during the past 30 days. History of fire setting (not in past year) would be rated here.

---

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

Occasional or moderate level of aggression towards others, including aggression during the past 30 days or more recent verbal threats of aggression or homicidal ideation in the last 30 days.

---

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

Acute homicidal ideation with a plan, frequent or dangerous (significant harm) level of aggression to others. Individual is an immediate risk to others.

---

NA Individual is younger than 6 years old. For individuals younger than 6 years old, rate Aggressive Behavior (Age 0-5 indicator).

---

**Supplemental Information:** Imagined violence, when extreme, may be rated here. Physically harmful aggression or command hallucinations that involve the harm of others, or an individual setting a fire that placed others at significant risk of harm would be rated a '3.' Reckless behavior that may cause physical harm to others is not rated on the indicator.

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**OTHER SELF-HARM (RECKLESSNESS) (Ages 6+)**

This indicator includes reckless and dangerous behaviors that, while not intended to harm self or others, place the individual or others in some jeopardy. **Suicidal or non-suicidal self-injurious behaviors are not rated here.**

---

**Questions to Consider:**

- Does the individual ever put themselves in dangerous situations? Do they act without thinking?
  - Has the individual ever talked about or acted in a way that might be dangerous to themselves (e.g., reckless behavior such as riding on top of cars, reckless driving, climbing bridges, etc.)?
- 

**Ratings and Descriptions**

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

No evidence of behaviors (other than suicide or non-suicidal self-injurious behaviors) that place the individual at risk of physical harm.

---

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

There is a history or suspicion of or mild reckless or risk-taking behavior (other than suicide or non-suicidal self-injurious behaviors) that places individual at risk of physical harm.

---

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

Engaged in reckless or intentional risk-taking behavior (other than suicide or non-suicidal self-injurious behaviors) that places the individual in danger of physical harm.

---

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

Engaged in reckless or intentional risk-taking behavior (other than suicide or non-suicidal self-injurious behaviors) that places the individual at immediate risk of death.

---

NA Individual is younger than 6 years old. For individuals younger than 6 years old, rate Self-Harm (Age 0-5 indicator).

---

**Supplemental Information:** Any behavior that the individual engages in that has significant potential to place them in danger of physical harm would be rated here. This indicator provides an opportunity to identify other potentially self-destructive behaviors (e.g., reckless driving, subway surfing, unprotected sex, substance use). If the individual frequently exhibits significantly poor judgment that has the potential to place themselves in danger, but has yet to actually do so, a rating of '1' might be used to indicate the need for prevention. A rating of '3' is used for an individual that has placed themselves in significant physical jeopardy during the rating period.

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**NON-SUICIDAL SELF INJURIOUS BEHAVIOR (Ages 6+)**

This indicator includes repetitive, physically harmful behavior that generally serves as a self-soothing function to the individual (e.g., cutting, carving, burning self, face slapping, head banging, etc.).

---

**Questions to Consider:**

- Does the individual ever purposefully hurt themselves (e.g., cutting)?
  - Does the behavior serve a self-soothing purpose (e.g., numb emotional pain, move the focus of emotional pain to the physical)?
  - Does the individual use this behavior as a release?
- 

**Ratings and Descriptions**

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

No evidence of any forms of self-injury.

---

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

A history of self-injurious behavior but none within the past 30 days or minor self-injuring behavior (e.g., scratching) in the last 30 days that does not require any medical attention.

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

Engaged in self-injurious behavior in the last 30 days requiring medical assessment (e.g., cutting, burns, piercing skin with sharp objects, repeated head banging) that has potential to cause safety risk to the individual.

---

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

Engaged in one or more incidents of self-injurious behavior in the last 30 days requiring medical intervention (e.g., sutures, surgery) and that is significant enough to put the individual's health at risk.

---

NA Individual is younger than 6 years old. For individuals younger than 6 years old, rate Self-Harm (Age 0-5 indicator).

---

**Supplemental Information:** Suicidal behavior is not self-mutilation. Carving and cutting on the arms or legs are common examples of self-mutilation behavior. Repeatedly piercing or scratching one's skin would be included. Generally, body piercings and tattoos are not considered a form of self-injury. Self-mutilation is thought to have addictive properties since generally the self-abusive behavior results in the release of endorphins (naturally produced morphine-like substances) that provide a calming feeling. The individual usually feels somehow better after having hurt themselves. Self-injury could be a reaction to trauma or related to a developmental disability, but it's not necessary to know the cause for crisis assessment purposes.

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**DELINQUENT/CRIMINAL BEHAVIOR (Ages 6+)**

This indicator includes both criminal behavior and status offenses that may result from individuals failing to follow required behavioral standards (e.g., truancy, curfew violations, vandalism, underage drinking/drug use, driving without a license). Sexual offenses should be included as delinquent/criminal behavior. If caught, the individual could be arrested for this behavior.

---

**Questions to Consider:**

- Do you know of laws that the individual has broken (even if they have not been charged or caught)?
  - Has the individual ever been arrested? Has the individual been incarcerated?
  - Is the individual on probation?
- 

**Ratings and Descriptions**

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

No evidence or history of delinquent or criminal behavior.

---

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

There is a history or suspicion of delinquent or criminal behavior, but none in the past 30 days. Status offenses in the past 30 days would be rated here.

---

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

Individual has been engaged in delinquent or criminal behavior during the past year, but the behavior does not represent a significant physical risk to others in the community. Examples would include vandalism and shoplifting.

---

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

Individual has been engaged in violent criminal activity during the past year that represents a significant risk to others in the community. Examples would include car theft, residential burglary, gang involvement, rape, armed robbery, and assault.

---

NA Individual is younger than 6 years old.

---

**Supplemental Information:** When rating children or youth: This indicator uses the mental health rather than the juvenile justice definition of delinquency, reflecting behaviors that we know about. Since the primary goal of the intervention is to prevent the individual from future harm, it is necessary to assess behaviors of which we are aware. The general vagueness of this indicator prevents placing the individual in any legal jeopardy from the assessment (i.e., no specific crimes are identified, just a level of risk).

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## BEHAVIORAL/EMOTIONAL NEEDS

**NOTE:** Information on DSM diagnoses is provided for informational and descriptive purposes only. This tool should not be used for diagnostic purposes, and an individual does not need to have a specific diagnosis in order to be rated actionable (i.e., '2' or '3') on an indicator.

---

### DEPRESSION

This indicator describes symptoms such as irritable or depressed mood, social withdrawal, sleep disturbances, weight/eating disturbances, and loss of motivation, interest, or pleasure in daily activities. This indicator can be used to describe symptoms of the depressive disorders as specified in DSM.

---

#### Questions to Consider:

- Is individual concerned about possible depression or chronic low mood and irritability?
  - Has the individual withdrawn from normal activities?
  - Does the individual seem lonely or not interested in others?
- 

#### Ratings and Descriptions

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

No evidence of problems with depression.

---

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

History or suspicion of depression or evidence of depression associated with a recent negative life event with minimal impact on life domain functioning. Brief duration of depression, irritability, or impairment of peer, family, or academic functioning that does not lead to pervasive avoidance behavior.

**Ages 0-5:** Infants may appear to be withdrawn and slow to engage at times during the day. Older children are irritable or do not demonstrate a range of affect.

---

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

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

**Ages 0-5:** Infants demonstrate a change from previous behavior and appear to have a flat affect with little responsiveness to interaction most of the time. Older children may have negative verbalizations, dark themes in play and demonstrate little enjoyment in play and interactions. [continues]

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**DEPRESSION continued**

---

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

Clear evidence of disabling level of depression that makes it virtually impossible for the individual to function in any life domain. This rating is given to an individual with a severe level of depression. This would include an individual who stays at home or in bed all day due to depression or one whose emotional symptoms prevent any participation in school or work, recreational activities, friends or relationships with others, or family life. Disabling forms of depressive diagnoses would be rated here.

---

**Supplemental Information:** Depression is a disorder that is thought to affect about 7% of the general population of the United States. It appears to be equally common in adolescents and adults. It might be somewhat less common among children, particularly young children.

The main difference between depression in children and youth and depression in adults is that among children and youth, hypersomnia (oversleeping) and hyperphagia (overeating) are more likely, and melancholic symptoms, particularly psychomotor disturbances, are more common in older individuals. (DSM 5-TR, pg. 189). Both youth and adults may use illicit drugs or overuse prescription drugs to self-medicate.

Common behaviors that may be observed or reported include depressed mood or the loss of interest or pleasure in all or nearly all activities for most of the day, changes in appetite or weight, sleep (inability to sleep or maintain sleep, or sleeping too much) and psychomotor activity; decreased energy; feelings of worthlessness or guilt; difficulty thinking, concentrating or making decisions; or thoughts of death, suicidal ideation, a suicide attempt, or a specific plan for suicidal behavior. (DSM 5-TR, pg. 185)

Although there is substantial cross-cultural variation in the prevalence, course and symptomatology of depression, a syndrome similar to major depressive disorder can be identified across diverse cultural contexts. Symptoms commonly associated with depression across cultural contexts include social isolation or loneliness, anger, crying, and diffuse pain. A wide range of other somatic complaints are common and vary by cultural context. Understanding the significance of these symptoms requires exploring their meaning in local social contexts. (DSM 5-TR, pg. 189-190)

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

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**DEPRESSION continued**

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

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

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

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## ANXIETY

This indicator describes evidence of symptoms associated with DSM anxiety disorders characterized by excessive fear and anxiety and related behavioral disturbances (including avoidance behaviors). Panic attacks can be a prominent type of fear response.

---

### Questions to Consider:

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

### Ratings and Descriptions

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

No evidence of anxiety symptoms.

---

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

History, suspicion, or evidence of some anxiety. This level is used to rate either a mild phobia or anxiety problem that is not yet causing the individual significant distress or markedly impairing functioning in any important context.

---

- 2 *Need is interfering with functioning. Action is required to ensure that the identified need or risk behavior is addressed.*

Clear evidence of anxiety associated with either anxious mood or significant fearfulness. Anxiety has interfered in the individual's ability to function in at least one life domain.

---

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

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

---

**Supplemental information:** As noted in the DSM, Anxiety Disorders share features of excessive fear (i.e., emotional response to real or perceived imminent threat) and anxiety (i.e., anticipation of future threat) and related behavioral disturbances (e.g., panic attacks, avoidance behaviors, restlessness, being easily fatigued, difficulty concentrating, irritable mood, muscle tension, sleep disturbance, etc.) which cause significant impairment of functioning or distress. Anxiety disorders differ from one another in the types of objects or situations that induce fear, anxiety, or avoidance behavior, and the associated cognitive ideation.

Common behaviors that may be observed or reported include excessive anxiety and worry (apprehensive expectation) where the intensity, duration or frequency of the worry is out of proportion to the actual likelihood or impact of the anticipated event. Children tend to worry excessively about their competence or quality of performance, and the focus of their worry may shift from one concern to another. Many individuals experience restlessness or feeling keyed up or on edge, being easily fatigued, difficulty concentrating or mind going blank, irritability, muscle tension, and disturbed sleep. (DSM 5-TR, pg. 251) [continues]

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## ANXIETY continued

---

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

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

- Worry about certain events
- Agitation
- Fatigability
- Inattention
- Irritability (e.g., easily frustrated)
- Muscle tension and difficulty relaxing
- Sleep disturbances
- Avoidance: fear, reluctance, or refusal to engage in certain activities
- Withdrawing: freezing, shrinking, or clinging/hiding
- Failing to speak
- Crying and/or tantruming
- Negative affect
- Difficulty separating from familiar caregivers
- Difficulty with daily transitions
- Physical symptoms such as stomachaches, headaches, excessive sweating, increased heart rate, increased blinking, or dizziness

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

#### Axis I:

- Following a stressful event, traumatic experience, and/or permanent loss of a primary caregiver, a rating of '2' or '3' may be consistent with symptoms of **Adjustment Disorder**, **PTSD**, and **Complicated Grief Disorder of Early Childhood**, respectively (*see Adjustment to Trauma indicator*).
- When anxiety is related to interference with a child's compulsions (repetitive behaviors that children are driven to perform according to rigid rules), a rating of '2' or '3' may be consistent with symptoms of **Obsessive-Compulsive Disorder**.
- When anxiety is related to separation from the primary caregiver, a rating of '2' or '3' may be consistent with a diagnosis of **Separation Anxiety Disorder** (*see Attachment*).
- When anxiety is related to social or performance situations that involve exposure to unfamiliar people or possible scrutiny by others, a rating of '2' or '3' may be consistent with a diagnosis of **Social Anxiety Disorder (Social Phobia)**. [continues]

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**ANXIETY continued**

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- When anxiety manifests as a failure to speak in specific social situations (despite being able to speak in other situations), a rating of '2' or '3' may be consistent with a diagnosis of **Selective Mutism**.
  - When anxiety is related to the presence of novel/unfamiliar objects, people, and situations, a rating of '2' or '3' may be consistent with **Inhibition to Novelty Disorder**.
  - When anxiety and worry occur during two or more activities or settings and within two or more relationships, a rating of '2' or '3' may be consistent with a diagnosis of **Generalized Anxiety Disorder (GAD)**.
- 

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## ADJUSTMENT TO TRAUMA

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

---

### Questions to Consider:

- Has the individual experienced a traumatic event?
  - Does the individual experience frequent nightmares? Are they troubled by flashbacks?
  - How is the individual adjusting to the trauma? What are their current coping skills?
- 

### Ratings and Descriptions

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

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

---

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

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

---

- 2 *Need is interfering with functioning. Action is required to ensure that the identified need or risk behavior is addressed.*

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

**Ages 0-5:** Infants may have developmental regression, and/or eating and sleeping disturbance. Older children may have all of the above as well as behavior symptoms, tantrums, and withdrawn behavior.

---

- 3 *Need is dangerous or disabling. Intensive and/or intensive action is required to address the need or risk behavior.*

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

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## ADJUSTMENT TO TRAUMA continued

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**Supplemental Information:** This is one indicator where speculation about why a person is displaying a certain behavior is considered. There should be an inferred link between the trauma and behavior.

- An individual who meets diagnostic criteria for a Trauma-Related Adjustment Disorder, Posttraumatic Stress Disorder and other Trauma- and Stressor-Related Disorders from DSM 5-TR as a result of their exposure to traumatic/adverse childhood experiences would be rated a '2' or '3' on this indicator.
- This indicator should be rated '1,' '2' or '3' for individuals who have any type of symptoms/needs that are related to their exposure to a traumatic/adverse event. These symptoms should also be rated in the Traumatic Stress Symptoms Module.

For Adolescent Adoptees: Most adolescents are focused on developing their sense of identity and exploring who they are and what they want to become. For adopted teens this process can be more complex as they must integrate the influences of their adoptive and birth families without always knowing fully what those influences are. Thus, for some adolescents, adjustment to trauma behaviors may be related to their adoption and should be considered when rating this indicator.

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

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

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

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

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## ADJUSTMENT TO TRAUMA continued

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

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

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

#### Axis I

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

#### Axis IV

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

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## ATYPICAL/REPETITIVE BEHAVIORS

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

---

### Questions to Consider:

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

### Ratings and Descriptions

- |       |   |
|-------|---|
| 0     | <i>No evidence of any needs; no need for action.</i><br>No evidence of atypical behaviors (repetitive or stereotyped behaviors) in the individual.  |
| <hr/> |   |
| 1     | <i>Need or risk behavior that requires monitoring, watchful waiting, or preventive action based on history, suspicion, or disagreement.</i><br>Atypical behaviors (repetitive or stereotyped behaviors) reported by caregivers or familiar individuals that may have mild or occasional interference in the individual's functioning. |
| <hr/> |   |
| 2     | <i>Need is interfering with functioning. Action is required to ensure that the identified need or risk behavior is addressed.</i><br>Atypical behaviors (repetitive or stereotyped behaviors) generally noticed by unfamiliar people and have notable interference in the individual's functioning.                                   |
| <hr/> |   |
| 3     | <i>Need is dangerous or disabling. Intensive and/or immediate action is required to address the need or risk behavior.</i><br>Atypical behaviors (repetitive or stereotyped behaviors) occur with high frequency, and are disabling or dangerous.   |
- 

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**FAILURE TO THRIVE (Ages 0-5)**

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

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**Questions to Consider:**

- Has the child had problems with the ability to gain weight or grow, or are there current problems?
  - Has the child's growth and weight caused any medical problems?
  - Are there any concerns about the child's eating habits? Is the child's doctor concerned about the child's growth or weight gain?
- 

**Ratings and Descriptions**

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

No evidence of failure to thrive.

---

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

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

---

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

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

---

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

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

---

NA Individual is 6 years old or older.

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**OPPOSITIONAL BEHAVIOR/NON-COMPLIANCE WITH AUTHORITY (Ages 3 thru 18)**

This indicator rates the child/youth's relationship with authority figures. Generally, oppositional behavior -- argumentative/defiant behavior or vindictiveness -- is displayed in response to conditions set by a parent, teacher, or other authority figure with responsibility for and control over the child/youth.

---

**Questions to Consider:**

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

**Ratings and Descriptions**

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

No evidence of oppositional behaviors.

---

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

History or mild level of defiance towards authority figures that has not yet begun to cause functional impairment. Child/youth may occasionally talk back to teacher, parent/caregiver; there may be letters or calls from school.

---

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

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

---

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

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

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NA Individual is younger than 3 years old OR individual is 19 years old or older. [continues]

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**OPPOSITIONAL BEHAVIOR continued**

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**Supplemental Information:** 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.

- A '0' is used to indicate that a child or youth is generally compliant, recognizing that all children and youth fight authority sometimes.
- A '1' is used to indicate a problem that has started recently (in the past 6 months) and has not yet begun to cause significant functional impairment or a problem that has begun to be resolved through successful intervention.
- A '3' should be used only for children and youth whose oppositional behavior puts them at some physical peril.

Symptoms are associated with **Oppositional Defiant Disorder** as described in the DSM: A pattern of angry/irritable mood, argumentative/defiant behavior, or vindictiveness lasting at least 6 months and including 4 symptoms from any of the following categories:

- Angry/Irritable Mood: (1) often loses temper; (2) often touchy or easily annoyed; (3) often angry and resentful.
  - Argumentative/Defiant Behavior: (4) often argues with authority figures/adults; (5) often actively defies or refuses to comply with adult's requests or rules; (6) often deliberately annoys others; (7) often blames others for his/her mistakes or misbehavior.
  - Vindictiveness: (8) has been spiteful or vindictive at least twice in the last 6 months. (DSM 5-TR 2022, pg. 522-523)
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## ANGER CONTROL/FRUSTRATION TOLERANCE (Ages 3+)

This indicator captures the individual's ability to identify and manage their anger when frustrated.

---

### Questions to Consider:

- How does the individual control their emotions?
  - Do they get upset or frustrated easily?
  - Do they overreact if someone criticizes or rejects them?
  - Does the individual seem to have dramatic mood swings?
- 

### Ratings and Descriptions

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

No evidence of any anger control problems.

**Age 3-5:** Child is able to deal with frustration in age and developmentally appropriate ways.

---

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

History, suspicion of, or evidence of some problems with controlling anger. Individual may sometimes become verbally aggressive when frustrated. Peers, co-workers and family are aware of and may attempt to avoid stimulating angry outbursts.

**Ages 3-5:** Child demonstrates some difficulties dealing with frustration. Child may sometimes become agitated, verbally hostile, aggressive, or anxious when frustrated.

---

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

Individual's difficulties with controlling their anger are impacting functioning in at least one life domain. Their temper has resulted in significant trouble with peers, family, co-workers and/or school. Anger may be associated with physical violence. Others are likely quite aware of anger potential.

**Age 3-5:** Child struggles with tolerating frustration. Child's reaction to frustration impairs functioning in at least one life domain. They may throw a tantrum when frustrated.

---

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

Individual's temper or anger control problem is dangerous. Individual frequently get into fights that are often physical. Others likely fear them.

**Age 3-5:** Child engages in severe tantrums when frustrated. Others may be afraid of child's tantrums or the child may hurt self or others during tantrums.

---

NA Individual is younger than 3 years old.

---

**Supplemental Information:** Everyone gets angry at times. This indicator is intended to identify individuals who are more likely than average to become angry and lose control in such a way that it leads to problems with functioning. A '3' describes an individual whose anger has put themselves or others in physical peril within the rating period. [continues]

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## ANGER CONTROL/FRUSTRATION TOLERANCE (Ages 3+) continued

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

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

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

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

#### Axis I

- Following a stressful or traumatic event, a rating of ‘2’ or ‘3’ may be consistent with symptoms of **PTSD** or **Adjustment Disorder** (*see Adjustment to Trauma indicator*).
- A rating of ‘2’ or ‘3’ may be consistent with symptoms of **Disorder of Dysregulated Anger and Aggression of Early Childhood (DDAA)**.
- A rating of ‘2’ or ‘3’ related to tantruming may be consistent with symptoms of:
  - **Depressive Disorder of Early Childhood** (*see Depression indicator*)
  - **Generalized Anxiety Disorder** (*see Anxiety indicator*)
  - **Social Anxiety Disorder**, when tantrums occur following exposure to a feared social situation (*see Anxiety indicator*)

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## IMPULSIVITY/HYPERACTIVITY (Ages 3+)

Problems with impulse control and impulsive behaviors, including motoric disruptions, are rated here. This includes behavioral symptoms associated with Attention-Deficit/Hyperactivity Disorder (ADHD) and Impulse-Control Disorders as indicated in the DSM.

---

### Questions to Consider:

- Does the child/ youth's impulsivity put them at risk?
  - How has the child/youth's impulsivity impacted their life?
  - Is the child/youth unable to sit still for any length of time? Do they have trouble paying attention for more than a few minutes?
  - Is the child/youth able to control themselves?
- 

### Ratings and Descriptions

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

No evidence of symptoms of loss of control of behavior.

---

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

There is a history or evidence of some impulsivity evident in action or thought that place the individual at risk of future functioning difficulties. The individual may exhibit limited impulse control, e.g., individual may yell out answers to questions or may have difficulty waiting their turn. Some motor difficulties may be present as well, such as pushing or shoving others.

---

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

Clear evidence of problems with impulsive, distractible, or hyperactive behavior that interferes with the individual's functioning in at least one life domain. This indicates an individual with impulsive behavior who may represent a significant management problem for adults (e.g., caregivers, teachers, coaches, employers, etc.). An individual who often intrudes on others and often exhibits aggressive impulses would be rated here.

---

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

Clear evidence of a dangerous level of hyperactivity and/or impulsive behavior that places the individual at risk of physical harm. This indicates an individual with frequent and significant levels of impulsive behavior that carries considerable safety risk (e.g., running into the street, dangerous driving or bike riding). The individual may be impulsive on a nearly continuous basis. The individual endangers self or others without thinking.

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NA Individual is younger than 3 years old. [continues]

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## IMPULSIVITY/HYPERACTIVITY (Ages 3+) continued

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**Supplemental information:** This indicator is designed to allow for the description of the individual's ability to control their own behavior, including impulsiveness, hyperactivity and/or distractibility. If an individual has been diagnosed with Attention-Deficit/Hyperactivity Disorder (ADHD) and disorders of impulse control, this may be rated here. Individuals with impulse problems tend to engage in behavior without thinking, regardless of the consequences. A '3' on this indicator is reserved for those whose lack of control of behavior has placed them in physical danger during the period of the rating. Consider the individual's environment when rating (i.e., bored kids tend to be impulsive kids). ADHD is characterized by either frequently displayed symptoms of inattention (e.g., difficulty sustaining attention, not seeming to listen when spoken to directly, losing items, forgetful in daily activities, etc.) or hyperactivity or impulsivity (e.g., fidgety, difficulty playing quietly, talking excessively, difficulty waiting one's turn, etc.) to a degree that it causes functioning problems. (DSM 5-TR 2022, pg. 70)

DSM Criteria for **Attention-Deficit/Hyperactivity Disorder:** A persistent pattern of inattention and/or hyperactivity-impulsivity that interferes with function or development characterized by (1) and/or (2):

1. Inattention: 6 or more of the following symptoms for 6 months:
  - Often fails to give close attention to details or makes careless mistakes
  - Difficulty sustaining attention in tasks or play activities
  - Does not seem to listen when spoken to directly
  - Does not follow through on instructions and fails to finish tasks
  - Difficulty organizing tasks and activities
  - Avoids, dislikes, or is reluctant to engage in tasks that require sustained mental effort
  - Loses things necessary for tasks or activities
  - Easily distracted by extraneous stimuli
  - Forgetful in daily activities
2. Hyperactivity and Impulsivity: 6 or more of the following symptoms for 6 months:
  - Fidgets with or taps hands or feet or squirms in seat; leaves seat in situations when remaining seated is expected
  - Runs about or climbs where it is inappropriate
  - Unable to play or engage in leisure activities quietly
  - Often 'on the go' acting as if 'driven by a motor'
  - Talks excessively; interrupts or intrudes on others; blurts out an answer before a question has been completed
  - Has difficulty waiting his/her turn (DSM 5-TR, 2022, pg. 68-69)

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

[continues]

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## IMPULSIVITY/HYPERACTIVITY (Ages 3+) continued

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

- Being inattentive to details in play, activities of daily living or structured activities (e.g., makes developmentally unexpected accidents or mistakes)
- Having a hard time maintaining focus on activities or play
- Failing to attend to verbal requests/demands, especially when engaged in a preferred activity (e.g., caregiver needs to call the young child's name multiple times before the child notices)
- Getting derailed when attempting to follow multistep instructions and does not complete the activity
- Having a hard time executing age-appropriate sequential activities (e.g., getting dressed, following routines at childcare or home)
- Avoiding or objecting to activities that require prolonged attention (e.g., reading a book with a parent, or working on a puzzle)
- Losing track of things that are used regularly (e.g., favorite stuffed animal, shoes)
- Getting distracted by sounds and sights (e.g., sounds from another room or objects or activities outside the window)
- Seeming to forget what they are doing in common routine activities

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

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

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

#### Axis I

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

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## CONDUCT/ANTISOCIAL BEHAVIOR (Ages 6+)

This indicator rates the degree to which an individual engages in behavior that shows a disregard for and violation of the rights of others, such as aggression toward people and animals, destruction of property, deceitfulness or theft, or serious violation of rules (DSM 5-TR, p. 749). For children/youth under age 18, these behaviors may be consistent with the symptoms of a Conduct Disorder.

---

### Questions to Consider:

- Is the individual seen as dishonest? How does the individual handle telling the truth/lies?
  - Has the individual ever shown violent or threatening behavior towards others that resulted in an arrest?
  - Has the individual ever tortured animals?
  - Does the individual disregard or is unconcerned about the feelings of others (lack empathy)?
- 

### Ratings and Descriptions

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

No evidence of serious violations of others or laws.

---

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

History, suspicion, or some evidence of problems associated with antisocial behavior including but not limited to lying, stealing, manipulation of others, acts of sexual aggression, or violence towards people, property, or animals. The individual may have some difficulties in school, work, and/or home behavior. Problems are recognizable but not notably deviant for age, sex and community.

---

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

Clear evidence of antisocial behavior that impacts the individual's functioning in at least one life domain. This could include failure to obey laws, repeated lying, conning others, sexual aggression, or violence towards people, property, or animals. A child/youth rated at this level will likely meet criteria for a diagnosis of Conduct Disorder.

---

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

Evidence of a dangerous level of antisocial behavior that places individual or others at significant risk of physical harm due to these behaviors. This could include frequent episodes of unprovoked, planned aggressive or other antisocial behavior.

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NA Individual is younger than 6 years old. [continues]

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**CONDUCT (ANTISOCIAL BEHAVIOR) continued**

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**Supplemental Information:** This indicator describes the degree to which an individual engages in behavior in which the basic rights of others or major age-appropriate societal norms or rules are violated. Adults fail to conform to social norms with respect to lawful behavior and disregard the wishes, rights or feelings of others. They may repeatedly perform acts that are grounds for arrest (whether they are arrested or not), such as destroying property, harassing others, stealing, or pursuing illegal occupations. (DSM 5-TR, pg. 749)

DSM criteria for **Conduct Disorder:** A repetitive and persistent pattern of behavior in which the basic rights of others or major age-appropriate social norms or rules are violated as evidenced by the presence of 3 of the 15 criteria (from any category) in the past 12 months:

- Aggression to People and Animals: (1) often bullies, threatens, or intimidates others; (2) often initiates physical fights; (3) has used a weapon that can cause serious physical harm; (4) has been physically cruel to people; (5) has been physically cruel to animals; (6) has stolen while confronting a victim; (7) has forced someone into sexual activity.
- Destruction of Property: (8) has deliberately engaged in fire setting; (9) has deliberately destroyed others' property.
- Deceitfulness or Theft: (10) has broken into someone else's house, building, or car; (11) often lies to obtain goods or favors, or to avoid obligations; (12) has stolen items of nontrivial value without confronting a victim.
- Serious Violation of Rules: (13) often stays out at night despite parental prohibitions, beginning before age 13; (14) has run away from home overnight at least twice while living in parental or parental surrogate home; (15) is often truant from school, beginning before age 13. (DSM 5-TR 2022, pg. 530-531)

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## PSYCHOSIS (THOUGHT DISORDER) (Ages 6+)

This indicator rates the symptoms of psychiatric disorders with a known neurological base, including schizophrenia spectrum and other psychotic disorders. The common symptoms of these disorders include hallucinations (i.e., experiencing things others do not experience), delusions (i.e., a false belief or an incorrect inference about reality that is firmly sustained despite the fact that nearly everybody thinks the belief is false or proof exists of its inaccuracy), disorganized thinking, and bizarre/ idiosyncratic behavior.

---

### Questions to Consider:

- Does the individual exhibit behaviors that are unusual or difficult to understand?
  - Has the individual ever talked about hearing, seeing, or feeling something that was not actually there?
  - Has the individual ever done strange, bizarre, or nonsensical things?
  - Does the individual have strange beliefs about things?
- 

### Ratings and Descriptions

- |       |  |
|-------|--|
| 0     | <i>No evidence of any needs; no need for action.</i><br>No evidence of psychotic symptoms. Thought processes and content are within normal range.  |
| <hr/> |  |
| 1     | <i>Need or risk behavior that requires monitoring, watchful waiting, or preventive action based on history, suspicion, or disagreement.</i><br>Evidence of disruption in thought processes or content. Individual may be somewhat tangential in speech or evidence somewhat illogical thinking (age-inappropriate). This also includes an individual with a history of hallucinations but none currently. Use this category for individuals who are exhibiting some symptoms for schizophrenia spectrum and other psychotic disorders. |
| <hr/> |  |
| 2     | <i>Need is interfering with functioning. Action is required to ensure that the identified need or risk behavior is addressed.</i><br>Evidence of disturbance in thought process or content that may be impairing the individual's functioning in at least one life domain. Individual may be somewhat delusional or have brief intermittent hallucinations. Speech may be at times quite tangential or illogical.  |
| <hr/> |  |
| 3     | <i>Need is dangerous or disabling. Intensive and/or immediate action is required to address the need or risk behavior.</i><br>Clear evidence of dangerous hallucinations, delusions, or bizarre behavior. Behavior might be associated with some form of psychotic disorder that places the individual or others at risk of physical harm.   |
| <hr/> |  |
| NA    | Individual is younger than 6 years old. [continues]  |
- 

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**PSYCHOSIS (Ages 6+) continued**

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**Supplemental Information:** The common behaviors of psychosis that may be observed or reported include delusions (i.e., fixed beliefs that are not amenable to change in light of conflicting evidence), hallucinations (i.e., perception-like experiences that occur without an external stimulus and are not under an individual's control), disorganized thinking, disorganized speech (i.e., frequent derailment or incoherence of speech) and bizarre/idiosyncratic behavior (i.e., problems in goal-directed behavior). (DSM 5-TR, pgs. 101-109)

While a growing body of evidence suggests that schizophrenia can begin as early as age nine, schizophrenia is more likely to begin to develop during the teenage years. Even young children can have psychotic disorders, most often characterized by hallucinations. Posttraumatic stress disorder secondary to sexual or physical abuse can be associated with visions of the abuser when children are falling asleep or waking up. These occurrences would not be rated as hallucinations unless they occur during normal waking hours.

Consider a child/youth's age and developmental status when rating this indicator. An older child with an intellectual or developmental disability that has an imaginary friend would likely be rated a '0' in the absence of other indicators of psychosis.

**Note:** If a child/youth has a diagnosis that includes psychosis, but psychotic symptoms did not lead to the crisis or the crisis did not exacerbate psychotic symptoms, a rating of '1' would be appropriate for watchful waiting.

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## MANIA (AGES 6+)

This indicator identifies elevated/expansive mood, increase in energy, decrease in sleep, pressured speech, racing thoughts, and grandiosity that are consistent with the symptoms of mania. (DSM 5-TR)

---

### Questions to Consider:

- Does the individual have periods of feeling extremely happy/excited for hours or days at a time? Have periods of feeling very angry/cranky for hours or days at a time?
  - Does the individual have periods of time where they feel they don't need to sleep or eat? Have extreme behavior changes?
  - Is the individual's functioning impaired by emotional/mood problems?
- 

### Ratings and Descriptions

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

No evidence of hypomania, mania or manic behavior.

---

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

Individual has a history of manic behavior, or individual with some evidence of hypomania or irritability that does not impact the individual's functioning. Individual may be showing signs of beginning to cycle up.

---

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

Individual with manic behavior that is interfering with their functioning or those around them.

---

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

Individual with a level of mania that is dangerous or disabling. For example, the individual may be wildly over-spending, rarely sleeping, engaging in dangerous or extremely inappropriate behavior, or pursuing a special 'mission' that only they can accomplish. The manic episode rated here could include psychotic symptoms.

---

NA Individual is younger than 6 years old.

---

**Supplemental Information:** Mood in a manic episode is often described as euphoric, excessively cheerful, high or "feeling on top of the world." In some cases, the mood is of such a high infectious quality that it is easily recognized as excessive and may be characterized by unlimited and haphazard enthusiasm for interpersonal, sexual or occupational interactions. For example, the individual may spontaneously start extensive conversations with strangers in public. Often the predominant mood is irritable rather than elevated, particularly when the individual's wishes are denied or if the individual has been using substances. Rapid shifts in mood over a brief period of time may occur and are referred to as lability (i.e., the alteration among euphoria, dysphoria, and irritability). In children, happiness, silliness, and "goofiness" are normal in many social contexts; however, if these symptoms are recurrent, inappropriate to the context, and beyond what is expected for the developmental level of the child, they may meet the criteria of abnormally elevated mood. (DSM 5-TR, pgs. 143-144)

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## SUBSTANCE USE (Ages 6+)

This indicator describes problems related to the use of alcohol and illegal drugs, the misuse of prescription medications, and the inhalation of any chemical or synthetic substance by an individual. This rating is consistent with DSM Substance-Related and Addictive Disorders. This indicator does not apply to the use of tobacco or caffeine.

---

### Questions to Consider:

- Has the individual used alcohol or drugs on more than an experimental basis?
  - Do you suspect the individual has an alcohol or drug use problem?
  - Has the individual been in a recovery program for the use of alcohol or illegal drugs?
- 

### Ratings and Descriptions

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

Individual has no notable substance use difficulties at the present time.

---

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

Individual has substance use problems that occasionally interferes with daily life (e.g., intoxication, loss of money, reduced work/school performance, parental concern). History of substance use problems without evidence of current problems related to use is rated here.

---

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

Individual has a substance use problem that consistently interferes with the ability to function optimally but does not completely preclude functioning in an unstructured setting.

---

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

Individual has a substance use problem that represents complications to functional issues that may result in danger to self, public safety issues, or the need for detoxification of the individual.

---

NA Individual is younger than 6 years old. [continues]

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## SUBSTANCE USE continued

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**Supplemental Information:** As noted in the DSM 5-TR, the essential feature of a substance use disorder is a cluster of cognitive, behavioral, and physiological symptoms indicating that the individual continues using the substance despite significant substance-related problems.

The DSM 5-TR identifies the diagnosis of **Substance Disorder** based on a pathological pattern of behaviors related to the use of the substance:

- **Impaired Control:** substance taken in larger amounts or over a longer period of time; persistent desire or unsuccessful efforts to control substance use; great deal of time spent in activities to obtain substance; cravings to use the substance.
- **Social Impairment:** failure to fulfill major role obligations at work/school/home; persistent or recurrent social or interpersonal problems caused or exacerbated by substance use; social/occupational/recreational activities given up or reduced due to substance use.
- **Risky Use:** recurrent use in physically hazardous situations; use continued despite knowledge of having persistent or recurrent physical or psychological problem caused by substance use.
- **Pharmacological Criteria:** tolerance (e.g., need for increase in amount of substance to achieve desired effect; diminished effect with continued use of the same amount of substance); withdrawal (e.g., physiological symptoms that occur with the decreased use of a substance; individual is likely to use the substance to relieve the symptoms).

Specific descriptions of particular substance use disorders can be found in DSM 5-TR.

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# FUNCTIONING NEEDS

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## LIVING SITUATION

This indicator refers to how the individual is functioning in their current living arrangement, which could be with a relative, friend, shared housing situation, assisted living or nursing home, or children/youth living in a foster home, etc. This indicator should exclude respite, brief detention/jail, and brief medical and psychiatric hospitalization.

---

### Questions to Consider:

- Does the individual's behavior contribute to stress and tension in the home?
  - How are issues that arise between members of the household addressed?
  - Is the caregiver expressing a desire to have the child/youth removed from the home?
  - Is the individual at risk of being unable to remain in present living situation due to their behaviors?
- 

### Ratings and Descriptions

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

No evidence of problems with functioning in current living environment. Individual and caregivers or others living in the residence feel comfortable and safe dealing with issues that come up in day-to-day life.

---

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

Individual experiences problems with functioning in current living situation. Other residents, roommates, or caregivers express some concern about individual's behavior in living situation, and/or individual and others living in the residence, including caregivers, have some difficulty dealing with issues that arise in daily life.

---

- 2 *Need is interfering with functioning. Action is required to ensure that the identified need or risk behavior is addressed.*

Individual has problems in current living situation that impact their functioning. Individual has difficulties maintaining their behavior in this living situation, creating significant problems for others in the residence. Individual and others in the residence, including caregivers, have difficulty interacting effectively with each other much of the time.

---

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

Individual is at immediate risk of being unable to remain in present living situation due to problematic behaviors. Individual has difficulty interacting with others at home to the extent that risk of physical or psychological harm to others is likely. [continues]

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**LIVING SITUATION continued**

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**Supplemental Information:** Hospitals, shelters and detention centers do not count as “living situations.” If a child/youth is presently in one of these places, rate the previous living situation.

**Group homes and residential treatment centers are rated in this indicator.** Rating congregate care as a “living situation” is specific to the CAT: the purpose is to monitor this level of care for appropriateness for the child/youth during a crisis situation (e.g., is this level of care able to meet the child/youth’s needs?).

**Understanding the living situation in early childhood:** Because young children are in the beginning stages of developing self-control, challenging behaviors are common and expected in the years from birth through five. This process can lead to some difficult moments for both adults and children (ZTT, 2021). A child who engages in challenging behavior can influence family life at home and has a substantial impact on parents, siblings, and other members of the family. Studies focusing on the results of parenting a child with challenging behavior have found that families may feel increased levels of stress and isolation, as well as decreased levels of confidence. Supports that help to reduce challenging behaviors in young children are based in collaborative relationship with parents and family members (Doubet & Ostrosky, 2014).

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## FAMILY FUNCTIONING

This indicator refers evaluates and rates the individual's relationships with those who are in their family. It is recommended that the description of family should come from the individual's perspective (i.e. who the individual describes as family). In the absence of this information, consider biological and adoptive relatives and significant others with whom the individual is still in contact. When rating this indicator, take into account the relationship the individual has with their family as well as the relationship of the family as a whole.

---

### Questions to Consider:

- How does the individual get along with the family?
  - Are there problems/conflicts between family members?
  - Has there ever been any violence in the family?
  - What is the relationship like between the individual and their family members?
- 

### Ratings and Descriptions

- |       |  |
|-------|--|
| 0     | <i>No evidence of any needs; no need for action.</i><br>No evidence of problems in relationships with family members, and/or individual is doing well in relationships with family members.  |
| <hr/> |  |
| 1     | <i>Need or risk behavior that requires monitoring, watchful waiting, or preventive action based on history, suspicion, or disagreement.</i><br>History or suspicion of problems, and/or individual is doing adequately in relationships with family members, although some problems may exist. For example, some family members may have problems in their relationships with the individual. Arguing may be common but does not result in major problems. |
| <hr/> |  |
| 2     | <i>Need is interfering with functioning. Action is required to ensure that the identified need or risk behavior is addressed.</i><br>Individual's problems with parents, significant others, siblings, children and/or other family members are impacting their functioning. Frequent arguing, difficulty maintaining positive relationships may be observed.  |
| <hr/> |  |
| 3     | <i>Need is dangerous or disabling. Intensive and/or immediate action is required to address the need or risk behavior.</i><br>Individual's problems with parents, significant others, siblings, children and/or other family members are debilitating, placing them at risk. This would include problems of domestic violence, absence of any positive relationships, etc.   |
- 

**Supplemental Information:** For children/youth involved with child welfare, family refers to the person(s) fulfilling the permanency plan. Foster families should only be considered if they have made a significant commitment to the child/youth. Family Functioning should be rated independently of the problems the child/youth experienced or stimulated by the child/youth currently being assessed. According to Illinois law, domestic violence includes: hitting, kicking, threatening, harassing, or interfering with the personal liberty of another family or household member. [continues]

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**FAMILY FUNCTIONING continued**

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

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

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

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

**Axis II:** The Axis II – Caregiving Environment level can be cross walked with the CANS Action Levels for the Family indicator, at the clinician's discretion (see crosswalk below).

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

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

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## SOCIAL FUNCTIONING

This indicator describes social skills and relationships. It includes age-appropriate behavior and the ability to make and sustain relationships.

---

### Questions to Consider:

- Currently, how well does the individual get along with others?
  - Has there been an increase in conflicts with others? Does individual avoid social interactions?
  - Do they have unhealthy relationships?
  - Does the individual tend to change friends frequently?
- 

### Ratings and Descriptions

- 0 *No evidence of any needs; no need for action.*  
No evidence of problems and/or individual has age-appropriate social functioning.
- 
- 1 *Need or risk behavior that requires monitoring, watchful waiting, or preventive action based on history, suspicion, or disagreement.*  
There is a history or suspicion of problems in social relationships. Individual is having some difficulty interacting with others and building and/or maintaining relationships.  
**Ages 0-5:** Infants may be slow to respond to adults, toddlers may need support to interact with peers and preschoolers may resist social situations.
- 
- 2 *Need is interfering with functioning. Action is required to ensure that the identified need or risk behavior is addressed is required to ensure that the identified need is addressed.*  
Individual is having some problems with their social relationships that interfere with functioning in other life domains.  
**Ages 0-5:** Infants may be unresponsive to adults, and unaware of other infants. Toddlers may be aggressive and resist parallel play. Preschoolers may argue excessively with adults and peers and lack ability to play in groups even with adult support.
- 
- 3 *Need is dangerous or disabling. Intensive and/or immediate action is required to address the need or risk behavior.*  
Individual is experiencing significant disruptions in social relationships. Individual may have no friends or have constant conflict in relations with others or have maladaptive relationships with others. The quality of the individual's social relationships presents imminent danger to the individual's safety, health, and/or development.  
**Age 0-5:** Infants show no ability to interact in a meaningful manner. Toddlers are excessively withdrawn and unable to relate to familiar adults. Preschoolers show no joy or sustained interaction with peers or adults, and/or aggression may be putting others at risk
- 

**Supplemental Information:** A child/youth who socializes with primarily younger or much older individuals would be identified as having needs on this indicator. An individual who has conflictual relationships with peers also would be described as having needs. An isolated child/youth with no same age friends would be rated '3.' [continues]

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## SOCIAL FUNCTIONING continued

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

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

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

---

### Social Functioning Developmental Milestones

---

<b>By 3 Months</b>	<ul style="list-style-type: none"><li>• Smiles responsively (i.e., social smile)</li><li>• Imitates simple facial expressions (e.g., smiling, sticking tongue out)</li><li>• Looks at caregiver's face</li><li>• Coos responsively</li><li>• Localizes to familiar voices and sounds</li><li>• Shows interest in facial expressions</li><li>• Is comforted by proximity of caregiver</li></ul>
<b>By 6 Months</b>	<ul style="list-style-type: none"><li>• Imitates some movements and facial expressions (e.g., smiling, frowning)</li><li>• Engages in socially reciprocal interactions (e.g., playing simple back-and-forth games)</li><li>• Seeks social engagement with vocalizations, emotional expressions, or physical contact</li><li>• Watches face closely</li><li>• Responds to affection with smiling, cooing, or settling</li><li>• Recovers from distress when comforted by caregiver [continues]</li></ul>

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**SOCIAL FUNCTIONING continued**

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**By 9 months**

- Distinguishes between familiar and unfamiliar voices
- Shows some stranger wariness
- Demonstrates preference for caregivers
- Protests separation from caregiver
- Enjoys extended play with others
- Engages in back-and-forth, two-way communication using vocalizations and eye movement
- Mimics other's simple gestures
- Follows other's gaze and pointing

**By 12 months**

- Looks to caregiver for information about new situations and environments
- Looks to caregiver to share emotional experiences
- Responds to other people's emotions (e.g., displays somber, serious face in response to sadness in parent, smiles when parent laughs)
- Offers object to initiate interaction (e.g., hands caregiver a book to hear a story)
- Plays interactive games (e.g., peek-a-boo, patty-cake)
- Looks at familiar people when they are named
- Gives object to seek help (e.g., hands shoe to parent)
- Extends arm or leg to assist with dressing

**By 15 months**

- Seeks and enjoys attention from others, especially caregivers
- Shows affection with kisses (without pursed lips)
- Demonstrates cautious or fearful behavior such as clinging to or hiding behind caregiver
- Engages in parallel play with peers
- Presents a book or toy when they want to hear a story or play
- Repeats sounds or actions to get attention
- Enjoys looking at picture books with caregiver
- Initiates joint attention (e.g., points to show something interesting or to get others' attention)

**By 18 months**

- Shares humor with peers or adults (e.g., laughs at and makes funny faces or nonsense rhymes)
- Likes to hand things to others during play
- Engages in reciprocal displays of affection (e.g., hugs or kisses with a pucker)
- Asserts autonomy (e.g., "Me do")
- Reacts with concern when someone appears hurt
- Leaves caregiver's side to explore nearby objects or settings
- Engages in teasing behavior such as looking at caregiver and doing something "forbidden"
- When pointing, looks back at caregiver to confirm joint attention [continues]

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**SOCIAL FUNCTIONING continued**

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- By 24 months**
- Exhibits empathy (e.g., offers comfort when someone is hurt)
  - Attempts to exert independence frequently
  - Imitates others' complex actions, especially adults and older children (e.g., putting plates on a table, posture, gesture)
  - Enjoys being with other young children
  - Takes pride and pleasure in accomplishments
  - Primarily plays in proximity to young children; notices and imitates other young children's play
  - Responds to being corrected or praised

- By 36 months**
- Expresses affection openly and verbally
  - Shows affection to peers without prompting
  - Shares without prompts
  - Can wait turn in playing games
  - Shows concern for crying peers by taking action
  - Engages in associate play with peers (e.g., participate in similar activities without formal organization but with some interaction)
  - Shares accomplishments with others
  - Helps with simple household chores

- By 48 months**
- Pretends to play "Mom" or "Dad" or other relevant caregivers
  - Asks about or talks about caregiver when separated
  - Engages in cooperative play with other young children
  - Has a preferred friend
  - Expresses interests, likes, and dislikes

- By 60 months**
- Shows increased confidence associated with greater independence and autonomy
  - Wants to please friends
  - Emulates role models, real and imaginary
  - Values rules in social interactions
  - Participates in group activities that require assuming roles (e.g., Follow the Leader)
  - Modulates or modifies voice correctly depending on situation or listener (adult, another child, younger child) [continues]

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## SOCIAL FUNCTIONING continued

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### Axis I

Following a traumatic experience, a rating of ‘2’ or ‘3’ that represents a negative change in typical social functioning (e.g., decreased interest in social interactions) may be consistent with symptoms of **PTSD** (*see Adjustment to Trauma indicator*).

A rating of “2 or ‘3’ may be consistent with social-communication symptoms of **Autism Spectrum Disorder** (ASD) and **Early Atypical Autism Spectrum Disorder** (EAASD). DC 0-5 specifies three social-communication symptoms, including:

- Limited or atypical social-emotional responsivity, sustained social attention, or social reciprocity
- Deficits in nonverbal social-communication behaviors
- Peer interaction difficulties

A rating of ‘2’ or ‘3’ related to demonstration of fear/anxiety-based social functioning issues (freezing, withdrawing, hiding, avoiding, refusing to speak) in situations with unfamiliar people may be consistent with symptom of various anxiety disorders, including **Social Anxiety Disorder**, **Selective Mutism**, and **Inhibition to Novelty Disorder** (*see Anxiety indicator*).

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

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

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

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## DEVELOPMENTAL/INTELLECTUAL

This indicator describes the individual's development as compared to standard developmental milestones, as well as describes the presence of any developmental (motor, social and speech) or intellectual disabilities. It includes Intellectual Developmental Disorder (IDD) and Autism Spectrum Disorders. Rate the indicator depending on the significance of the disability and the related level of impairment in personal, social, family, school, or occupational functioning.

---

### Questions to Consider:

- Does the individual's growth and development seem age-appropriate?
  - Has the individual been screened for any developmental problems?
- 

### Ratings and Descriptions

- |       |  |
|-------|--|
| 0     | <i>No evidence of any needs; no need for action.</i><br>No evidence of developmental delay and/or individual has no developmental problems or intellectual disability.   |
| <hr/> |  |
| 1     | <i>Need or risk behavior that requires monitoring, watchful waiting, or preventive action based on history, suspicion, or disagreement.</i><br>There are concerns about possible developmental delay. Individual may have low IQ, a documented delay, or documented borderline intellectual disability (i.e., FSIQ 70-85). Mild deficits in adaptive functioning are indicated.  |
| <hr/> |  |
| 2     | <i>Need is interfering with functioning. Action is required to ensure that the identified need or risk behavior is addressed.</i><br>Individual has mild developmental delays (e.g., deficits in social functioning, inflexibility of behavior) causing functional problems in one or more settings and/or mild to moderate Intellectual Disability/Intellectual Disability Disorder. (If available, FSIQ 55-69.) IDD impacts communication, social functioning, daily living skills, judgment, and/or risk of manipulation by others. |
| <hr/> |  |
| 3     | <i>Need is dangerous or disabling. Immediate and/or intensive action is required to address the need or risk behavior.</i><br>Individual has severe to profound intellectual disability (FSIQ, if available, less than 55) and/or Autism Spectrum Disorder with marked to profound deficits in adaptive functioning in one or more areas: communication, social participation and independent living across multiple environments.   |
| <hr/> |  |
| NA    | Intellectual disability is suspected but not confirmed. A referral to psychological testing should occur prior to rating this indicator. [continues]   |
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**DEVELOPMENTAL/INTELLECTUAL continued**

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**Supplemental Information:** All developmental disabilities occur on a continuum; an individual with Autism Spectrum Disorder may be designated a '0', '1', '2', or '3' depending on the significance of the disability and the impairment. Learning disability is not rated on this indicator. An individual with suspected low IQ or developmental delays and who has not been previously diagnosed and/or assessed would be rated here and a referral for assessment would be recommended.

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

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

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

By 3 Months	<ul style="list-style-type: none"><li>• Follows people and objects with eyes</li><li>• Loses interest or protests if activity does not change</li></ul>
By 6 Months	<ul style="list-style-type: none"><li>• Tracks moving objects with eyes from side to side</li><li>• Experiments with cause and effect (e.g., bangs spoon on table)</li><li>• Smiles and vocalizes in response to own face in mirror image</li><li>• Recognizes familiar people and things at a distance</li><li>• Demonstrates anticipation of certain routine activities (e.g., shows excitement in anticipation of being fed)</li></ul>
By 9 Months	<ul style="list-style-type: none"><li>• Mouths or bangs objects</li><li>• Tries to get objects that are out of reach</li><li>• Looks for things they see others hide (e.g., toy under a blanket)</li></ul>
By 12 Months	<ul style="list-style-type: none"><li>• Watches the path of something as it falls</li><li>• Has favorite objects (e.g., toys, blanket)</li><li>• Explores objects and how they work in multiple ways (e.g., mouthing, touching, dropping)</li><li>• Fills and dumps containers</li><li>• Plays with two objects at the same time [continues]</li></ul>

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**DEVELOPMENTAL/INTELLECTUAL continued**

By 15 Months	<ul style="list-style-type: none"><li>• Imitates complex gestures (e.g., signing)</li><li>• Finds hidden objects easily</li><li>• Uses objects for their intended purpose (e.g., drinks from a cup, smooths hair with a brush)</li></ul>
By 18 months	<ul style="list-style-type: none"><li>• Enacts play sequences with objects according to their use (e.g., pushing a dump truck and emptying its cargo)</li><li>• Shows interest in a doll or stuffed animal</li><li>• Points to at least one body part</li><li>• Points to self when asked</li><li>• Plays simple pretend games (e.g., feeding a doll)</li><li>• Scribbles with crayon, marker, and so forth</li><li>• Turns pages of book</li><li>• Recognizes self in mirror</li></ul>
By 2 Years	<ul style="list-style-type: none"><li>• Finds things even when hidden under two or three covers or when hidden in one place and moved to another</li><li>• Begins to sort shapes and colors</li><li>• Completes sentences and rhymes from familiar books, stories, and songs</li><li>• Plays simple make-believe games (e.g., pretend meal)</li><li>• Builds towers of four or more blocks</li><li>• Follows two-step instructions (e.g., “Pick up your shoes and put them in the closet”)</li></ul>
By 3 Years	<ul style="list-style-type: none"><li>• Labels some colors correctly</li><li>• Plays thematic make-believe with objects, animals, and people</li><li>• Answers simple “Why” questions (e.g., “Why do we need a coat when it’s cold outside?”)</li><li>• Shows awareness of skill limitations</li><li>• Understands “bigger” and “smaller”</li><li>• Understands concept of “two”</li><li>• Enacts complex behavioral routines observed in daily life of caregivers, siblings, and peers</li><li>• Solves simple problems (e.g., obtains a desired object by opening a container)</li><li>• Attends to a story for 5 minutes</li><li>• Plays independently for 5 minutes [continues]</li></ul>

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**DEVELOPMENTAL/INTELLECTUAL continued**

By 4 Years	<ul style="list-style-type: none"><li>• Names several colors and some numbers</li><li>• Counts to five</li><li>• Has rudimentary understanding of time</li><li>• Shares past experiences</li><li>• Remembers part of a story</li><li>• Engages in make-believe play with capacity to build and elaborate on play themes</li><li>• Connects actions and emotions</li><li>• Responds to questions that require understanding of “same” and “different”</li><li>• Draws a person with two to four body parts</li><li>• Understands that actions can influence others’ emotions (e.g., tries to make others laugh by telling a joke)</li><li>• Waits for turn in simple game</li><li>• Plays board or card games with simple rules</li><li>• Describes what is going to happen next in a book</li><li>• Talks about right and wrong</li></ul>
By 5 Years	<ul style="list-style-type: none"><li>• Counts to 10 or more things</li><li>• Tells stories with beginning, middle, and end</li><li>• Draws a person with at least six body parts</li><li>• Acknowledges own mistakes or misbehaviors and can apologize</li><li>• Distinguishes fantasy from reality most of the time</li><li>• Names four colors correctly</li><li>• Follows rules in simple games</li><li>• Knows functions of every day household objects (e.g., money, cooking utensils)</li><li>• Attends to group activity for 15 minutes (e.g., circle time, storytelling)</li></ul>

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

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

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## MEDICATION COMPLIANCE

This indicator focuses on the level of the individual's willingness and participation in taking prescribed medications. For children/youth this includes providing reminders to them or their caregivers to maintain medication compliance.

---

### Questions to Consider:

- Has the individual ever had trouble remembering to take prescribed medication?
  - Has the individual ever refused to take prescribed medication?
  - Has the individual ever overused medication to get "high" or as an attempt to harm themselves?
- 

### Ratings and Descriptions

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

This level indicates an individual who takes any prescribed medications as prescribed and without reminders, or an individual who is not currently on any medication.

**Age 16+:** Individual takes medications as prescribed without assistance or reminders, or individual is not currently on any prescribed medication.

---

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

This level indicates an individual who will take prescribed medications routinely, but who sometimes needs reminders to maintain compliance. Also, a history of medication noncompliance but no current problems would be rated here.

**Age 16+:** Individual usually takes medications as prescribed but may intermittently stop, skip, or forget to take medications without causing instability of the underlying medical condition(s); they may benefit from reminders and checks to consistently take medications.

---

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

This level indicates an individual who is somewhat non-compliant. This individual may be resistant to taking prescribed medications or may tend to overuse their medications. They might comply with prescription plans for periods of time (1-2 weeks) but generally do not sustain taking medication in prescribed dose or protocol.

**Age 16+:** Individual takes medications inconsistently or misuses medications, causing some instability of the underlying medical condition; they may benefit from direct supervision of medication.

---

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

This level indicates an individual who has refused to take prescribed medications during the past 30-day period or an individual who has abused their medications to a significant degree (e.g., overdosing or over-using medications to a dangerous degree).

**Age 16+:** Individual does not take medication(s) prescribed for management of underlying medical conditions and their underlying medical conditions are not well controlled. An individual abusing their prescribed medications to a significant degree (e.g., overdosing or overusing medications to a dangerous degree) would also be rated here. [continues]

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## MEDICATION COMPLIANCE continued

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**Supplemental Information:** This rating includes all types of medication; however, given the nature of crisis services, problems with compliance with psychotropic medications are common needs. For younger children, the primary responsibility for medication compliance falls with caregivers. As youth transition to adulthood, they should assume greater personal responsibility for taking medications as prescribed.

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## FEEDING/ELIMINATION (Ages 0-5)

This indicator refers to all dimensions of eating and/or elimination. Pica would be rated here. **Note: Child must be older than 18 months in order to rate Pica.**

---

### Questions to Consider:

- Does the child have any unusual difficulties with urination or defecation (e.g., constipation)?
  - Does the child have any difficulties with breast or formula feeding?
- 

### Ratings and Descriptions

- |       |  |
|-------|--|
| 0     | <i>No evidence of any needs; no need for action.</i><br>Child does not appear to have problems with feeding or elimination.  |
| <hr/> |  |
| 1     | <i>Need or risk behavior that requires monitoring, watchful waiting, or preventive action based on history, suspicion, or disagreement.</i><br>History or evidence of some problem with feeding and/or elimination (e.g., picky eating).                   |
| <hr/> |  |
| 2     | <i>Need is interfering with functioning. Action is required to ensure that the identified need or risk behavior is addressed.</i><br>Child has problems with feeding and/or elimination that are interfering with functioning in at least one life domain. |
| <hr/> |  |
| 3     | <i>Need is dangerous or disabling. Intensive and/or immediate action is required to address the need or risk behavior.</i><br>Child's problems with feeding and/or elimination are debilitating or placing their development at risk without intervention. |
| <hr/> |  |
| NA    | Individual is 6 years old or older.  |
- 

**Supplemental Information:** Encopresis is an elimination disorder that involves repeatedly having bowel movements in inappropriate places after the age when bowel control is normally expected. Enuresis, more commonly called bed-wetting, is an elimination disorder that involves release of urine into bedding, clothing, or other inappropriate places. Both of these disorders can occur during the day or at night, can be voluntary or involuntary, and may occur together, although most often they occur separately.

**Note:** This combines two indicators from the IM+CANS 2024: Eating Disturbances and Elimination.

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**SCHOOL/PRESCHOOL/DAYCARE (Ages 0-21)**

This indicator rates the child/youth's experiences in educational settings and the child/youth's ability to get their needs met in these settings. This indicator also considers the presence of problems within these environments in terms of attendance, academic achievement, support from the school staff to meet the child/ youth's needs, and the child/youth's behavioral response to these environments.

---

**Questions to Consider:**

- What is the child/youth's experience in school?
  - Does the child/youth have difficulties with academics, social relationships, behavior, or attendance at school?
- 

**Ratings and Descriptions**

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

No evidence of problems with functioning in current educational environment.

---

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

History or evidence of problems in the educational environment that are not interfering with functioning. Child/youth may be enrolled in a special program.

---

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

Child/youth is experiencing difficulties maintaining their behavior, attendance, and/or progress in the educational environment.

---

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

Child/youth's problems with functioning in the educational environment place them at immediate risk of being removed from program due to their behaviors, lack of progress, or unmet needs.

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NA Individual is not in school due to age; or individual has received their GED or graduated from high school. [continues]

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**SCHOOL/PRESCHOOL/DAYCARE (Ages 0-21) continued**

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**Supplemental Information:** This indicator rates aspects of school attendance, behavior, and achievement. Problems in any one area are enough for a rating other than '0.' A rating of '3' would indicate a child/youth who is still having problems after special efforts have been made to address those challenges (e.g., problems in a special education class).

**Attendance:** If school is out for summer or a holiday break, rate the last 30 days in which attendance was expected. Non-attendance would be rated a '3.'

**Behavior:** Rate the behavior of the last 30 days that the child/youth was attending. Recent increases in school behavior problems would be rated a '2.' If the school placement is in jeopardy due to behavior (recent suspensions or expulsions), the rating would be '3.'

**Achievement:** A child/youth having moderate problems with achievement and failing some subjects, or recent declines in school performance, would be rated a '2.' A child/youth failing most subjects or who is more than one year behind their peers would be a '3.'

**Note:** If the child/youth is receiving special education services, rate the child's performance and behavior relative to their peer group. If it is planned for the child to be mainstreamed, rate the child's school functioning relative to that peer group.

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

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

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**SCHOOL/PRESCHOOL/DAYCARE (Ages 0-21) continued**

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

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

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## SLEEP (Ages 1+ years)

This indicator describes the individual's sleep patterns. This indicator is used to describe any problems with sleep, regardless of the cause, including difficulties falling asleep or staying asleep as well as sleeping too much. Both bedwetting and nightmares should be considered sleep issues.

---

### Questions to Consider:

- Does the individual appear rested?
  - Are they often sleepy during the day?
  - Do they have frequent nightmares or difficulty sleeping?
  - How many hours does the individual sleep each night?
- 

### Ratings and Descriptions

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

No evidence of problems with sleep. Individual gets a full night's sleep each night and feels rested.

---

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

Individual has some problems sleeping. Generally, individual gets a full night's sleep but at least once a week, problems arise. This may include occasionally awakening or bed wetting or having nightmares. Sleep is not restful for the individual.

---

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

Individual is having problems with sleep. Sleep is often disrupted, and individual seldom obtains a full night of sleep and doesn't feel rested. Difficulties in sleep are interfering with their functioning in at least one area of their life.

---

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

Individual is generally sleep deprived. Sleeping is almost always difficult, and the individual is not able to get a full night's sleep and does not feel rested. Individual's sleep deprivation is dangerous and places them at risk.

---

NA Individual is younger than 12 months old.

---

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

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**SLEEP (Ages 1+ years) continued**

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

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

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

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

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**PARENTAL/CAREGIVING ROLE (Ages 16+)**

This indicator focuses on an individual in any parental/caregiving role. The child/youth's caregiver(s) are rated elsewhere.

---

**Questions to Consider:**

- Is the individual in any roles where they care for someone else – parent, grandparent, young sibling, or their own child?
  - How well can the individual fill that role?
  - Does parenting responsibility impact the individual's life functioning?
  - Does the individual want to be more involved with parenting?
- 

**Ratings and Descriptions**

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

Individual has a parenting or caregiving role, and they are functioning appropriately in that role.

---

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

The individual has responsibilities as a parent/caregiver and occasionally experiences difficulties with this role.

---

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

The individual has responsibilities as a parent/caregiver, and either the individual is struggling with these responsibilities, or these responsibilities are currently interfering with the individual's functioning in other life domains.

---

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

The individual has responsibilities as a parent/caregiver and is currently unable to meet these responsibilities, or these responsibilities are making it impossible for the individual to function in other life domains. The individual has the potential of abuse or neglect in their parenting/caregiving role.

---

NA Individual is younger than 16 years old OR is not a caregiver/parent.

---

**Supplemental Information:** An individual with their own a child, or an individual responsible for the care of another family member (e.g., an elderly parent or grandparent) would be rated here. Include pregnancy as a parenting role. A parentified youth is rated in the Victimization/Exploitation indicator.

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## JOB FUNCTIONING/EMPLOYMENT (Ages 16+)

This indicator describes the performance of the individual in work settings. In addition to traditional employment, this can include vocational settings, supported employment, sheltered workshops, long-term volunteer experiences and internships. This performance can include issues of behavior, attendance or productivity.

---

### Questions to Consider:

- Is the individual currently employed? Do they have any struggles at work?
  - If the individual is unemployed, what was their last job? Are they looking for work?
  - Does the individual meet expectations at work? Do they have regular conflict with work? Do they arrive at work on time or having difficulty maintaining their work schedule?
- 

### Ratings and Descriptions

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

No evidence of problems in work environment. Individual is excelling in work environment.

---

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

Individual has a history of problems with work functioning, or individual may have some problems in the work environment that are not interfering with work functioning or other functional areas. An individual who is not currently working, but is motivated and is actively seeking work, could be rated here.

---

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

Individual is having some problems at work including disruptive behavior and/or difficulties with performing required work. Supervisors likely have warned individual about problems with their work performance. OR, although not working, the individual seems interested in doing so, but may have problems with developing vocational or prevocational skills.

---

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

Individual has problems at work related to attendance, performance, or relationships. Problematic work behaviors are placing the individual or others in danger, including aggressive behavior toward peers or superiors or severe attendance problems. Individual may be recently fired due to problematic behaviors or at very high risk of firing (e.g. on notice). OR, the individual has a long history of unemployment.

---

NA Individual is not currently working (unrelated to work behavior) or may not have plans to work; an individual who is younger than 16 years old is also rated here.

---

**Supplemental Information:** If the individual is receiving special vocational services, rate their performance and behavior relative to their peer group. If it is planned for the individual to work in the regular economy, rate their functioning compared to that peer group. Some individuals' lives may be impacted by their lack of desire to work which should be considered in rating this indicator.

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## CAREGIVER RESOURCES AND NEEDS

This section focuses on the needs of the caregiver(s) as they impact the ability to provide care for and support the individual. In general, it is recommended that the caregiver(s) with whom the individual is currently living be rated. If the child/youth has been placed temporarily, then focus on the caregiver to whom the child/youth will be returned. If it is a long-term foster care placement, then rate that caregiver(s). However, if the child/youth is currently in a temporary setting, then it may be more appropriate to rate the community caregivers where the child/youth will be placed upon discharge.

For dependent adults (i.e., adults with developmental or physical needs or cognitive limitations), caregiver refers to a parent(s) or other adult with primary care-taking responsibilities for the individual. This includes caregivers who manage the physical, medical and/or financial oversight of the dependent adult.

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

When rating multiple caregivers, the ratings should reflect the caregiver with the greatest need; so even if one caregiver doesn't have needs, an indicator's rating may be elevated to reflect the needs of the other caregiver.

If there is NO community caregiver, this section does not need to be completed and should be left blank.

---

## SUPERVISION

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

---

### Questions to Consider:

- Does the caregiver set appropriate limits on the individual?
  - Does the caregiver provide appropriate support to the individual to meet the caregiver's expectations?
  - Does the caregiver think they need some help with these issues?
- 

### Ratings and Descriptions

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

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

---

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

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

---

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

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

---

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

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

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## INVOLVEMENT WITH CARE

This indicator rates the caregiver's participation in the individual's care and ability to advocate for the individual.

---

### Questions to Consider:

- How involved is the caregiver in services for the individual?
  - Is the caregiver an advocate for the individual?
  - Would the caregiver like any help to become more involved?
- 

### Ratings and Descriptions

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

No evidence of problems with caregiver involvement in services or interventions for the individual, and/or caregiver is able to act as an effective advocate for the individual.

---

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

Caregiver is consistently involved in the planning and/or implementation of services for the individual but is not an active or fully effective advocate on their behalf. Caregiver is open to receiving support, education, and information.

---

- 2 *Need is interfering with functioning. Action is required to ensure that the identified need or risk behavior is addressed.*

Caregiver does not actively involve themselves in services and/or interventions intended to assist the individual.

---

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

Caregiver wishes for individual to be removed from their care.

---

**Supplemental Information:** This rating should be based on the level of involvement the caregiver(s) has in the planning and provision of child welfare, behavioral health, education, primary care, and related services.

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## CAREGIVER RESIDENTIAL STABILITY

This indicator rates the caregiver's current and likely future housing circumstances. It does not include the likelihood that the individual will be removed from the household.

---

### Questions to Consider:

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

### Ratings and Descriptions

- |       |  |
|-------|--|
| 0     | <i>No evidence of any needs; no need for action.</i><br>Caregiver has stable housing with no known risks of instability.   |
| <hr/> |  |
| 1     | <i>Need or risk behavior that requires monitoring, watchful waiting, or preventive action based on history, suspicion, or disagreement.</i><br>Caregiver has relatively stable housing but either has moved in the recent past or there are indications of housing problems that might force housing disruption. |
| <hr/> |  |
| 2     | <i>Need is interfering with functioning. Action is required to ensure that the identified need or risk behavior is addressed.</i><br>Caregiver has moved multiple times in the past year. Housing is unstable.   |
| <hr/> |  |
| 3     | <i>Need is dangerous or disabling. Intensive and/or immediate action is required to address the need or risk behavior.</i><br>Caregiver is homeless or has experienced homelessness in the recent past.  |
- 

**Supplemental information:** Stable housing is the foundation of intensive community-based services. A '3' indicates problems of recent homelessness. A '1' indicates concerns about instability in the immediate future: A family having difficulty paying utilities, rent or a mortgage might be rated as a '1.'

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## HEALTH/BEHAVIORAL HEALTH

This indicator refers to medical, physical, mental health and/or substance use problems that the caregiver(s) may be experiencing that prevent or limit their ability to provide care to the individual.

---

### Questions to Consider:

- How is the caregiver's health?
  - Do they have any health, mental health or substance use problems that limit their ability to care for the family?
- 

### Ratings and Descriptions

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

Caregiver is generally healthy.

---

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

Caregiver is in recovery from medical, physical, mental health or substance use problems, or has mild or controlled health problems that have the potential to complicate caregiving.

---

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

Caregiver has medical, physical, mental health or substance use problems that interfere with their caregiving role.

---

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

Caregiver has medical, physical, mental health or substance use problems that make it impossible for them to provide care at this time.

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**Supplemental Information:** *Note that this combines three indicators from the IM+CANS 2024: Medical/Physical, Mental Health, and Substance Use.*

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## **FAMILY STRESS**

This indicator describes the impact of managing the individual's behavioral and emotional needs on the family's stress level.

---

### **Questions to Consider:**

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

### **Ratings and Descriptions**

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

No evidence of caregiver having difficulty managing the stress of the individual's needs and/or caregiver is able to manage the stress of individual's needs.

---

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

There is a history or suspicion of family stress, and/or caregiver has some problems managing the stress of individual's needs.

---

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

Caregiver has notable problems managing the stress of individual's needs. This stress interferes with their capacity to provide care.

---

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

Caregiver is unable to manage the stress associated with individual's needs. This stress prevents caregiver from providing care.

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**EMPATHY WITH CHILDREN (Ages 0-21)**

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

---

**Questions to Consider:**

- Is the caregiver able to empathize with the individual?
  - Are there situations in which the caregiver is unable to empathize with the individual?
  - Is the caregiver's level of empathy impacting the individual and their development?
- 

**Ratings and Descriptions**

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

Caregiver is emotionally empathetic and attends to individual's emotional needs.

---

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

The caregiver can be emotionally empathetic and typically attends to the individual's emotional needs. There are times, however, when the caregiver is not able to attend to the individual's emotional needs.

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

The caregiver is often not empathetic and frequently is unable to attend to individual's emotional needs.

---

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

The caregiver has significant difficulties with emotional responsiveness. They are not empathetic and rarely attend to the individual's emotional needs.

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NA Individual is 22 years old or older.

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# PROTECTION

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## SAFETY

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

---

### Questions to Consider:

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

### Ratings and Descriptions

- |       |   |
|-------|---|
| 0     | <i>No evidence of any needs; no need for action.</i><br>Household is safe and secure. Individual is not at risk from others. OR individual does not have a caregiver  |
| <hr/> |   |
| 1     | <i>Need or risk behavior that requires monitoring, watchful waiting, or preventive action based on history, suspicion, or disagreement.</i><br>Household is safe but concerns exist about the safety of the individual due to history or others who might be abusive. |
| <hr/> |   |
| 2     | <i>Need is interfering with functioning. Action is required to ensure that the identified need or risk behavior is addressed.</i><br>Individual is in some danger from one or more individuals with access to the home.   |
| <hr/> |   |
| 3     | <i>Need is dangerous or disabling. Intensive and/or immediate action is required to address the need or risk behavior.</i><br>Individual is in immediate danger from one or more individuals with unsupervised access.  |
- 

**PLEASE NOTE: All referents are legally required to report suspected abuse or neglect to the appropriate authority.**

**Supplemental Information:** This indicator is rated differently for the IM-CAT compared to the IM+CANS. While the IM+CANS indicator captures lifetime history, **this indicator captures information that is relevant to the current crisis**; so while any experience with safety concerns with any caregiver is rated on the IM+CANS, **on the IM-CAT only abuse or neglect with current caregivers is rated.** If an individual has a history of safety concerns with current caregivers but is not currently at risk, this indicator would be rated a '1.'

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## FAMILY VIOLENCE

This indicator describes the presence of violence among family members in a household. Violence refers to physical fighting during which family members might get hurt. **Note: This indicator was previously called Marital/Partner Violence in the Home.**

---

### Questions to Consider:

- Does anyone in the family have conflict with one another? Does this conflict turn into physical altercations?
  - Have injuries occurred as a result of violent behavior?
- 

### Ratings and Descriptions

- |       |   |
|-------|---|
| 0     | <i>No evidence of any needs; no need for action.</i><br>There is no violent behavior in the family. Family gets along well and negotiates disagreements without physical altercations.  |
| <hr/> |   |
| 1     | <i>Need or risk behavior that requires monitoring, watchful waiting, or preventive action based on history, suspicion, or disagreement.</i><br>Family has a history of violent behaviors, but not in the past month. Or, family members engage in significant violent threats and intimidating behavior, but not physical violence. |
| <hr/> |   |
| 2     | <i>Need is interfering with functioning. Action is required to ensure that the identified need or risk behavior is addressed.</i><br>Family members have engaged in violent behaviors in the past month.  |
| <hr/> |   |
| 3     | <i>Need is dangerous or disabling. Intensive and/or immediate action is required to address the need or risk behavior.</i><br>Family members have engaged in frequent or very dangerous violent behavior in which at least one family member is at risk for significant injury or death.  |
- 

**Supplemental Information:** All families have conflict. Occasional arguments are not only normal but can be healthy if resolved eventually. Siblings who occasionally engage in aggressive ‘horseplay’ would not be rated here unless it escalates. Marital or partner violence can be a risk factor for abuse, so ratings of ‘2’ and ‘3’ require action. A ‘2’ might indicate that a call to child protection services is needed, while a ‘3’ might indicate that a call to police is necessary.

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