PECFAS®

Self-Training Manual

and Blank Scoring Forms

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MHS

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PECFAS® Self-Training Manual

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How to Use This Manual

The Preschool and Early Childhood Functional Assessment Scale® (PECFAS®) is used to assess degree of impairment in children of preschool age. It can be used with children as young as 3 years old and as old as 7 years old, in the case of children who are emotionally or developmentally delayed. The PECFAS® provides a rapid, visual profile of problem areas across settings.

The PECFAS® is a clinician-rated measure which can be used in both clinical and research settings to assess clinical progress or outcome. The clinician rates the client on the PECFAS® scale. It typically takes about 10 minutes. Essentially, the PECFAS® contains a "menu" (or choices) of behaviorally-oriented descriptions from which the rater chooses those that best describe the client. No specific interview or questionnaire needs to be administered to the client. The clinician rates the PECFAS® based on his/her knowledge of the client's functioning. Any source of information can be used. PECFAS® training sensitizes the clinician to the types of information needed (e.g., whether the child has been expelled from pre-school).

Impairment is defined as problems which interfere with the child's functioning in various life roles (e.g., as a learner, family member, etc). The child's most severe dysfunctional behavior during a specified time period, usually a one month or three month period, is rated. The time period to be used will be decided by your agency. The PECFAS® can be administered as often as practically useful. Rating the child upon entering the system (intake), upon exiting (discharge), and quarterly during the interim is the most typical pattern.

The PECFAS® is arranged in seven scales for rating the child: School/Daycare, Home, Community, Behavior Toward Others, Moods/Emotions, Self-Harmful Behavior, and Thinking. A total score is derived, for which there are general interpretive guidelines (see the first page of the PECFAS®). There are two optional scales for rating the child's caregivers on their ability to provide for the child's material and emotional needs.

A word of encouragement: The PECFAS® represents the child's problems in a way which makes sense to family members and managed care representatives. The PECFAS® should enhance your clinical work, rather than being one more burdensome form. It is quick and easy to use, yet yields information that can be very useful clinically. It is objective, has face validity, and is sensitive to client change. The PECFAS® contains a comprehensive list of behavioral descriptors for presenting problems for children. Rating impairment for each domain (e.g., the various scales, such as school), helps establish priorities in treatment. The PECFAS® profile sheet depicts the child's scores and can be used as a reference point for case reviews. The PECFAS® uses common language to describe real-life problems. Because of this, the PECFAS® is very useful when including the caregiver in treatment planning.

This manual is a self-study program which you can do entirely on your own. The materials are organized so that this manual is re-usable. Other materials, which are not re-usable, are contained in two accompanying handouts described below.

You will begin by reading the PECFAS® scale and the Instructions for Scoring the PECFAS®. The next task is to review the demonstration vignettes, which describe children ranging from mildly to severely impaired. Each demonstration vignette is followed by an answer key and profile form. The answer key includes the scale score, scale name, item number, and rationale for scoring. The profile form provides a

visual representation of the child's problems. When reviewing these practice vignettes, you will benefit the most by attempting to score them first, and then comparing your scores to the answers.

Next, you are asked to rate 16 vignettes on your own for the purpose of establishing reliability. The vignettes are contained in this manual. Blank scoring forms for recording your scores to these 16 vignettes are also contained in the manual. Additional blank scoring forms (FAS117) are available if you want to reuse the manual. For the purpose of rating these vignettes, you should rate the child's most severe level of dysfunction during the LAST 3 MONTHS.

The reason for establishing reliability on the PECFAS® is that everyone should use the same "rules" when using the PECFAS® in an applied setting. Different clinicians may rate the child at intake and at exit, and differences in ratings should reflect changes in the client, not variations in how the clinicians rate the PECFAS®. For example, if the intake rater was erroneously too "lenient" and the rater at discharge was erroneously too "harsh" in rating the child, it could appear that the child got worse while in treatment because of the variation in scoring. In order to ensure more accurate assessments, all users should do the same training so that the instrument is used in a standardized manner.

Admittedly, reading and thinking about the vignettes is a time investment. However, the realities of today's world include managed care (i.e., the need to continually justify intensity of treatment) and inclusion of parents as members of the treatment team. Increasingly, agencies have to choose a means of assessing impairment or need for treatment. Agencies which take the time and effort to standardize this process will likely be in a better position to advocate for their clients and their agency.

As a user of the PECFAS, you may also be interested in the following materials: (1) an interview for the PECFAS®, which is organized like the instrument and obtains all the information needed to rate the PECFAS (This was developed for research use but could be used for clinical purposes), (2) a screening interview which takes about ten minutes and can be used to screen for problems (i.e., used to determine whether a child needs a PECFAS evaluation by a professional), (3) an "upward" version of the PECFAS for children ages 7-17 years old, called the Child and Adolescent Functional Assessment Scale (CAFAS) and (4) a separate scale for assessing parental skills, referred to as the Caregiver Wish List.

You will find the PECFAS useful in supporting need for treatment and for documenting progress and outcome. If you have any suggestions or criticisms, please feel free to contact the author at (734) 769-9725.

Lessening the Clinician's Burden (and Benefiting Clients) - Is It Possible?

The PECFAS Form "at a Glance"

The PECFAS was designed for clinical use by professionals who are service providers. It should ease your burden, not increase it. Incorporate the PECFAS into routine clinical activities and required tasks by "dovetailing" it into current practices. The PECFAS scale itself focuses on problem behaviors to be addressed. The PECFAS scale is very useful in delineating treatment priorities, and it is a sensitive measure of change in functioning over time. Research has demonstrated that degree of impairment in functioning is likely the most sensitive measure of change.

In addition, identifying strengths and positively stated goals is critical to successful treatment. Thus, for each PECFAS scale, there is an accompanying list of characteristics which could be viewed as strengths or goals for any particular client. As an aid in coordinating a client's problem(s), strength(s), and goal(s), a treatment plan form appears in the last page of the PECFAS scale.

Glance through the PECFAS form, which follows this section. Notice that the first page of the form provides information on scoring and summarizing the results of the PECFAS. The second page is the PECFAS Profile for the child's subscales, which generates a picture of the child "at a glance". The subsequent pages present each subscale on a separate page. The top half of each page lists the PECFAS items for the subscale. The bottom third of each page has a list of "Strengths and Goals" which accompany the specific subscale. For example, strengths which can be demonstrated at school are listed on the same page as the School/Daycare subscale. There are seven youth subscales and two caregiver scales (which can be rated for the primary caregiver, noncustodial caregiver, and/or surrogate caregivers). The last two pages of the form are optional and are intended to be used to assist in treatment planning. Up to six problems can be delineated on this Treatment Plan form.

Rating the PECFAS® Scales

This is a brief summary of the instructions for rating the PECFAS. For a detailed set of guidelines, please refer to the "Preschool and Early Childhood Functional Assessment Scale: Instructions for Scoring" which is contained in this manual.

The PECFAS is used to assess a child's functional impairment, rated as severe, moderate, mild, or minimal/no impairment. If any one item listed under a level of impairment describes the child's functioning, the child qualifies for a rating at that level. You should indicate <u>all</u> items that apply at that impairment level. Do this by circling the number to the right of the item description. Do not circle any items that apply to lower levels. Rate the child's most severe level of dysfunction for the time period specified (e.g., last month or last three months).

1. For each scale begin your assessment by reviewing items in the SEVERE level. If any item describes the child's functioning, circle all items that apply in that level of impairment, and write the score "30" in the score box on the left.

2. If none of the items at the SEVERE level describe the child, proceed to the MODERATE level. If none of the items in the MODERATE level describe the child, proceed to the MILD level, and so on. If the child is described by <u>any</u> of the items in a level, then that level of impairment will apply to the child. Always start with the SEVERE LEVEL AND PROGRESSIVELY PROCEED TO THE MINIMAL/NO IMPAIRMENT LEVEL, STOPPING IF THE CHILD IS DESCRIBED BY ANY ONE OF THE ITEMS IN THAT PARTICULAR LEVEL.

3. If you believe that the child should be rated at a level of impairment where no items apply to the child, write the score in the score box, circle the number corresponding to the "EXCEPTION" box, and explain the reason for your rating in the space labeled "Explanation".

Using the PECFAS for Treatment Planning & Monitoring Progress over Time for Individual Clients

The PECFAS has 7 subscales which assess the child: School/Daycare, Home, Community, Behavior Toward Others, Moods/Emotions, Self-Harmful Behavior, and Thinking. For each subscale, the rater reads through a set of behavioral descriptions and endorses those that describe the child (e.g., expelled from preschool, which appears on the School/Daycare Scale). The item endorsements for each subscale determine the child's score on that subscale. The subscale scores are as follows: minimal or no impairment, 0; mild impairment, 10; moderate impairment, 20; & severe impairment, 30. The item endorsements can be mapped onto the PECFAS Profile, which yields a "clinical picture" of the child.

A. **Child's Needs**. The following information based on the seven PECFAS scales can be used to understand the child's treatment needs:

1. A list of endorsed items (e.g., expelled from preschool), which provides a comprehensive description of specific problematic behaviors and emotions.

2. Degree of impairment in different domains of functioning, as represented by the pattern of scores across the PECFAS scales: School/Daycare, Home, Community, Behavior Toward Others, Moods/Emotions, Self-Harmful Behavior, and Thinking. Relative strengths and weaknesses are apparent from the PECFAS Profile (e.g., severe impairment in School/Daycare, yet no impairment in Behavior Toward Others [i.e., a strength for this child]).

3. Risk behaviors demonstrated by the child (e.g., suicidal, aggressive behavior). These appear on the first page of the PECFAS form.

4. Overall dysfunction, as reflected in the PECFAS total score for the child. The total score is determined by totaling all seven subscales which assess the child, yielding a range from 0 to 210. The Caregiver scales are not included in the total for the child.

B. **Caregiver Needs**. In addition, the PECFAS provides information on Caregiver Resources. There are two caregiver scales: Material Needs and Family/Social Support. Conditions which may be related to impairment in the child's functioning can be recorded on these scales. Risks associated with low caregiver resources should be considered in treatment planning since these may need to be addressed as part of the child's care.

C. **Strengths & Goals**. For each PECFAS subscale, there are a list of associated items, which can be viewed as either a strength (i.e., child has the characteristic) or a goal (i.e., child does not yet have the characteristic but it is a goal in the child's individualized service plan), depending on the child being rated. For example, for the School/Daycare scale, "attends school regularly" can be regarded a strength or a goal. There is a list of strengths/goals for each PECFAS scale (i.e., the seven child subscales and the two caregiver scales).

D. **Treatment Plan**. An individualized treatment plan can be generated by specifying a plan of action for each PECFAS scale that indicates impairment. The last two pages of the PECFAS form provides a format for recording up to 6 problem areas. For each scale, the following can be specified:

Problems:
Goals:
Strengths:
Plan:

E. **Collaborating on Treatment/Service Decisions**. The services offered by the provider can be tailored to the child's and the family's needs. Used in conjunction with other tools for clinical assessment and decision making, the PECFAS can be very useful for making service decisions and collaborating on treatment. The PECFAS Profile and a treatment plan based on the information collected on the PECFAS form can be shared with the caregiver, the child (if appropriate), and other providers\agencies if necessary. If the caregiver or child disagrees with the problem items or the strengths or goals endorsed, the discussion which ensues should be helpful in clarifying the child's and family's treatment needs. The referring agency can use this information to clarify expectations with the provider. Likewise, the providers can review the referring agency's expectations to ensure that they are realistic and that they will have sufficient resources. Allocation of responsibility for the tasks to be undertaken in regard to both the child and the child's caregiver(s) can be clarified. The criterion by which therapeutic progress will be judged can be clearly stated (i.e., specific PECFAS scales, such as reduced scores on Moods/Emotions and Self-Harmful Behavior scales).

F. **Monitoring Treatment Over Time**. The PECFAS Profile can be used to track progress over time. For example, every three months, the treatment team (including the caregiver and the child [if appropriate]) can compare the child's scale scores to those obtained at intake. This review of how far the child has progressed can provide hope and encouragement.

PRESCHOOL AND EARLY CHILDHOOD FUNCTIONAL ASSESSMENT SCALE®

Name _____ Child ID # _____ Sex: ☐ boy ☐ girl

Today's Date _____ /_____ /_____ Admission Date _____ /_____ /_____ Date of Birth _____/_____/_____ Age _____
(optional)

Agency/Site ID # ___/___/___/___/___/___/___/___/___/___ Rater ID# ___/___/___/___/___/___/___/___/___/___

TIME PERIOD RATED:
☐ Last Month
☐ Last 3 Months
☐ Other _____

IN SCHOOL/DAYCARE:
☐ Yes
☐ No

RATER:
Name _____
☐ Case Manager (or team leader)
☐ Treating Therapist
☐ Intake Worker
☐ Non-Treating Clinician
☐ Lay Interviewer/Researcher
☐ Other _____

ASSESSMENT:
☐ Intake/Screening
☐ 3 mo ☐ 15 mo
☐ 6 mo ☐ 18 mo
☐ 9 mo ☐ 21 mo
☐ 12 mo ☐ 24 mo
☐ Exit from Services
☐ Change in Intensity of Service
☐ Other_____

CHILD'S LIVING ARRANGEMENT and/or RESIDENTIAL PLACEMENT (check all that apply):
☐ Family Home (with parent or legal guardian)
☐ Private Home with Other Relatives
☐ Private Home with Non-Relatives
☐ Out of Home
☐ Regular Foster Care
☐ Therapeutic Foster Care
☐ Group Home
☐ Psychiatric Group Home
☐ Psychiatric Inpatient
☐ Residential Treatment Center
☐ Drug and/or Alcohol Program
☐ Juvenile Detention/Jail/Correctional
☐ Youth Crisis Residential
☐ Other Residential Setting _____
☐ Other _____
☐ Unknown _____

SOURCES OF INFORMATION (check all that apply):

In-Person Contact with:
☐ Parent
☐ Child
☐ School/Daycare Personnel
☐ Foster (or surrogate) Parent
☐ Juvenile Justice, Police
☐ Social Welfare (Services)
☐ Mental Health Worker
☐ Public Health Worker
☐ Other _____

Telephone Contact with:
☐ Parent
☐ Child
☐ School/Daycare Personnel
☐ Foster (or surrogate) Parent
☐ Juvenile Justice, Police
☐ Social Welfare (Services)
☐ Mental Health Worker
☐ Public Health Worker
☐ Other _____

Review of Documents:
☐ School/Daycare
☐ Juvenile Justice, Police
☐ Social Welfare (Services)
☐ Mental Health
☐ Public Health
☐ Other _____

Rater Signature: My signature certifies that I have endorsed specific PECFAS® items which describe this child's behavior and which support the scores for each of the PECFAS subscales. This PECFAS form with endorsements is being retained in the case file.
Rater Signature:_____ Date:_____

INSTRUCTIONS: *Only persons who have established that they are reliable raters should rate the PECFAS®.* Be sure to rate the child's most SEVERE level of dysfunction for the time period being rated. The PECFAS is designed as a measure of functional status and should not be used as the sole criterion for determining any clinical decision, including need or eligibility for services, intensity of services, or dangerousness to self or others. Note that a list of strengths/goals follows each scale. Each characteristic can be viewed as a strength (i.e., child has the characteristic currently) or a goal (i.e., child does not yet have the characteristic but it is a goal in the child's individualized service plan). You may circle as many strengths and goals as you like to assist in developing a treatment plan. These items are separate from the PECFAS and do not affect the scoring of the PECFAS. The rater should sign this form (see above).

PECFAS® SCORING SUMMARY

SCALE SCORES FOR CHILD'S FUNCTIONING

SCHOOL/DAYCARE ROLE PERFORMANCE _____
HOME ROLE PERFORMANCE _____
COMMUNITY ROLE PERFORMANCE _____
BEHAVIOR TOWARD OTHERS _____
MOODS/EMOTIONS _____
SELF-HARMFUL BEHAVIOR _____
THINKING/COMMUNICATION _____

TOTAL FOR CHILD based on 7 Scales _____

SCALE SCORES FOR CAREGIVER'S RESOURCES

Primary_____ Other_____

MATERIAL NEEDS _____ _____
FAMILY/SOCIAL SUPPORT _____ _____

RISK BEHAVIORS:

Child's Functioning

☐ Has made a serious suicide attempt or is considered to be actively suicidal (118, 150-153) or possibly suicidal (154-156)

☐ Has been or may be harmful to others or self due to:
- ☐ Aggression:
  - ☐ at School (3,4)
  - ☐ at Home (33)
  - ☐ in the Community (63)
  - ☐ in Behavior in general (81)
- ☐ Sexual Behavior (62, 69, 82)
- ☐ Fire Setting (65, 70)

☐ Runaway Behavior (36)

☐ Psychotic or Organic symptoms in the context of severe impairment (162-169)

Caregiver Resourcefulness

☐ Child's needs far exceed caregiver's resources (195-205 or 234-244)

Explanation:_____

_____

_____

PECFAS® PROFILE: CHILD'S FUNCTIONING

Child's Name _____ **ID#** _____ **Rater** _____ **Date**____/____/____ **Site** _____

Level of Impairment	School/Daycare Role Peformance	Home Role Performance	Community Role Performance	Behavior Toward Others	Moods/ Emotions	Self-Harmful Behavior	Thinking/ Communication
SEVERE 30	1 ❍ 2 3 4 5 6 7 8 9	31 ❍ 32 33 34 35 36 37 38	59 ❍ 60 61 62 63 64 65 66	80 ❍ 81 82 83 84 85	114 ❍ 115 116 117 118 119 120 121 122	150 ❍ 151 152 153	162 ❍ 163 164 165 166 167 168 169
MODERATE 20	10 ❍ 11 12 13 14 15 16	39 ❍ 40 41 42 43 44 45	67 ❍ 68 69 70 71	86 ❍ 87 88 89 90 91 92 93 94	123 ❍ 124 125 126 127 128 129 130	154 ❍ 155 156	170 ❍ 171 172 173 174 175 176
MILD 10	17 ❍ 18 19 20 21 22	46 ❍ 47 48 49 50 51 52 53	72 ❍ 73 74 75	95 ❍ 96 97 98 99 100 101 102 103 104 105 106 107 108	131 ❍ 132 133 134 135 136 137 138 139 140 141	157 ❍ 158	177 ❍ 178 179 180 181
MINIMAL/NO 0	23 ❍ 24 25 26 27 28 29	54 ❍ 55 56 57	76 ❍ 77 78	109 ❍ 110 111 112	142 ❍ 143 144 145 146 147 148	159 ❍ 160	182 ❍ 183
COULD NOT SCORE	30 ❍	58 ❍	79 ❍	113 ❍	149 ❍	161 ❍	184 ❍

For each scale: (1) mark the item number(s) which correspond to those marked on the PECFAS form, (2) fill in the circle indicating severity level, (3) connect the circles.

Child's Name _____ ID# _____

	Severe Impairment *Severe disruption or incapacitation* **(30)**	**Moderate Impairment** *Major or persistent disruption* **(20)**	**Mild Impairment** *Significant problems or distress* **(10)**	**Minimal or No Impairment** *No disruption in functioning* **(0)**
SCHOOL/ DAYCARE Role Performance ☐	001 Asked to leave school/ daycare program due to behavior in school/daycare occurring during the rating period. 002 Refuses to attend school/ daycare program or has excessive absences. 003 Child viewed as potentially harmful to others because of child's actions or statements. 004 Harmed or made threat to hurt a teacher/peer/staff. 005 Unable to meet even minimum requirements for behavior in group settings in school/daycare. 006 Disruptive behavior (including poor attention or high activity level) persists despite special accommodations at school/daycare (e.g., special program, classroom or school). 007 Learning is notably below other children (i.e., at least one year behind), related to poor attention or high activity level, with the situation persisting despite special accommodations at school/daycare. 008 Learning is markedly below other children (i.e., at least one year behind), and is not due to an established learning problem (e.g., mental retardation).	010 Disobedience which results in repeated disruption to other children's activities or becomes known to supervisory staff because of severity and/or chronicity. 011 Inappropriate behavior resulting in disruption to others or becoming known to supervisory staff. 012 Frequently misses school/ daycare secondary to behavioral/ emotional problems (i.e., approximately once every two weeks or for several consecutive days). 013 Behavior is disruptive to the activities of other children and special accommodations are recommended or implemented (includes behavior due to poor attention or high activity level). 014 Does not achieve satisfactorily due to poor attention or high activity level; special accommodations are needed or implemented. 015 Learning is below average and is not due to an established learning problem (e.g., mental retardation).	017 Disobedience results in staff frequently bringing attention to problems or structuring child's activities so as to avoid predictable difficulties. 018 Inappropriate behavior results in staff frequently bringing attention to problems or structuring child's activities so as to avoid predictable difficulties. 019 Occasionally disobeys school/daycare rules, with no harm to others or to property. 020 Problems in school/ daycare with poor attention or high activity level are present but are not disruptive to other children's activities (can be managed O.K., with the child able to achieve satisfactorily). 021 Fails to listen, to follow instructions or routines, or to do activities/tasks.	023 Reasonably comfortable and competent at school. 024 Minor problems satisfactorily resolved. 025 Learning is average or above. 026 Learning is commensurate with ability and child is mentally retarded. 027 Learning is commensurate with ability and child has a known handicap (e.g., vision, hearing, speech, physical, etc.). 028 Behaves age-appropriately even though there are occasional temporary regressions due to the child's developmental stage or specific family circumstances.
	009 EXCEPTION	016 EXCEPTION	022 EXCEPTION	029 EXCEPTION
	Explanation:			COULD NOT SCORE: 030

Comments:

Strengths(S)/Goals (G) for School/Daycare Scale
(OPTIONAL: UNNECESSARY FOR PECFAS RATING)

S1 G1 Is permitted to attend school/daycare
S2 G2 Attends school/daycare regularly
S3 G3 Likes going to school/daycare
S4 G4 Behavior at school is devoid of aggressive acts or threats
S5 G5 Good behavior in classroom (not a problem)
S6 G6 Teacher in specialized classroom can manage behavior
S7 G7 Regular classroom teacher can manage behavior
S8 G8 Gets along okay with teachers
S9 G9 Enjoys praise from teachers
S10 G10 Easily follows adult guidance
S11 G11 Benefits from assistance when problems arise
S12 G12 Learning skills appropriate to age level
S13 G13 Stays on task (appropriate to age)
S14 G14 Feels good about performance in learning activities
S15 G15 Can transition from one activity to another
S16 G16 Is enthusiastic about favorite activities
S17 G17 Actively participates in learning activities
S18 G18 Likes to read or to be read to
S19 G19 Takes nap or rest as expected
S20 G20 Other_____

Child's Name _____ ID# _____

	Severe Impairment *Severe disruption or incapacitation* **(30)**	**Moderate Impairment** *Major or persistent disruption* **(20)**	**Mild Impairment** *Significant problems or distress* **(10)**	**Minimal or No Impairment** *No disruption in functioning* **(0)**
HOME Role Performance ☐	031 Child was placed outside of the home due to child's unmanageable or dangerous behavior in the home which occurred during the rating period. 032 Extensive management by others required in order for child to be maintained in the home. 033 High degree of supervision needed due to potentially dangerous behavior (e.g., head-banging, tries to hurt younger children, "plays" with electricity). 034 Child's behavior, while not necessarily dangerous, demands constant attention, and efforts to reduce the behavior have not been successful (e.g., destroys things, wanders away, extreme temper tantrums, screaming, crying). 035 Constantly clings to caregiver to the extent that caregiver's ability to work or carry out other roles is interfered with. 036 Leaves home with the intent to "run away." 037 At mealtimes, does not eat or refuses to eat so that child has to be fed.	039 Persistently uncooperative or disobedient, which interferes with doing routine care tasks for the child (e.g., getting dressed, taking a bath, brushing teeth, age-appropriate bowel and urine habits). 040 Persistently fails to do as told or to follow instructions. 041 Persistently refuses to carry out age-appropriate expectations (e.g., pick up toys, put things away). 042 Behavior is often adequate but there are periods, lasting several days, in which child is markedly disobedient or uncooperative. 043 Behavior is consistently demanding (i.e, child always on the go, child reacts very strongly if something happens that he/she does not like or if frustrated). 044 At mealtimes, does not eat or does not want to eat so that child has to be coaxed.	046 Frequently (but not always) won't follow reasonable rules and expectations within the home (e.g., going to bed on time), more than other children the same age. 047 Has to be "watched" or prodded in order to get him/her to do chores or comply with requests. 048 Often engages in behaviors which are frustrating to caregiver (e.g., purposeful dawdling, follows caregiver around). 049 Insists that caregiver do things for him/her that the child could do without help. 050 "Balks" or resists routines or taking instruction, but will comply if caregiver insists. 051 Upset if an adult is not paying attention or interacting with him/her. 052 Very finicky eater.	054 Typically cooperative in following reasonable rules and expectations within the home. 055 Minor problems satisfactorily resolved. 056 Behaves age-appropriately even though there are occasional temporary regressions due to the child's developmental stage or specific family circumstances.
	038 EXCEPTION	045 EXCEPTION	053 EXCEPTION	057 EXCEPTION
	Explanation:			COULD NOT SCORE: 058

Comments:

Strengths(S)/Goals (G) for Home Scale
(OPTIONAL: UNNECESSARY FOR PECFAS RATING)

S21	G21	Behavior at home is devoid of aggressive acts or threats
S22	G22	Does not use profanity toward others in home
S23	G23	Respectful of property in the home
S24	G24	Can be managed in the home with assistance
S25	G25	Can be managed in the home without assistance
S26	G26	Safe behavior even without close supervision
S27	G27	Accepts consequences for undesirable behavior
S28	G28	Reacts non-impulsively over disagreements
S29	G29	Seeks help from caregiver when needed
S30	G30	Willing to take help offered by caregiver
S31	G31	Accepts direction from caregiver
S32	G32	Will help do household "chores" when asked
S33	G33	Obeys rules routinely
S34	G34	Will accept routines (e.g., around bedtime, meals)
S35	G35	Night time routine (getting ready for bed) goes well
S36	G36	Easily relaxes and goes to sleep for nap or at night
S37	G37	Can be soothed and calmed when difficulties arise
S38	G38	Has a good appetite
S39	G39	Participates in family activities
S40	G40	Manages changes and transitions satisfactorily
S41	G41	Takes pride in being able to do some activities independently
S42	G42	Good behavior on home visits
S43	G43	Other_____

Child's Name _____ ID# _____

	Severe Impairment *Severe disruption or incapacitation* **(30)**	**Moderate Impairment** *Major or persistent disruption* **(20)**	**Mild Impairment** *Significant problems or distress* **(10)**	**Minimal or No Impairment** *No disruption in functioning* **(0)**
COMMUNITY Role Performance ☐	059 Associates or hangs around with older children who are likely involved with illegal activities or gang activities. 060 Does favors or tasks for older children who are likely involved with illegal activities or gang activities. 061 Has repeatedly stolen property or money outside the home and is aware that it is considered wrong to steal. 062 Does or attempts inappropriate sexual acts with children (i.e., as a perpetrator, not as a victim). 063 Committed acts that would likely result in confinement if child were older. 064 Deliberate and severe damage of property outside the home (e.g., school/daycare, car, building). 065 Deliberate firesetting with malicious intent.	067 On more than one occasion, committed acts that would be considered delinquent if child were older (e.g., vandalism, defacing property, threatening aggression, shoplifting other than minor items such as candy). 068 Often chooses to play with children who get into delinquent-like trouble. 069 Has been sexually inappropriate such that adults have concern about the welfare of other children who may be around the child unsupervised. 070 Repeatedly and intentionally plays with fire such that damage to property or person could result.	072 Minor problems not satisfactorily resolved (e.g., takes candy from store after having been previously corrected for doing so). 073 Sometimes plays with children who get into serious trouble. 074 Plays with fire on more than one occasion.	076 Does not negatively impact on the community. 077 Minor problems satisfactorily resolved.
	066 EXCEPTION	071 EXCEPTION	075 EXCEPTION	078 EXCEPTION
	Explanation:			COULD NOT SCORE: 079

Comments:

Strengths(S)/Goals (G) for Community Scale
(OPTIONAL: UNNECESSARY FOR PECFAS RATING)

S44	G44	No new illegal activity
S45	G45	No incidents of firesetting
S46	G46	No sexually inappropriate behavior
S47	G47	Avoids gang members and gang activities
S48	G48	Is trying to stay away from others who get into trouble
S49	G49	Plays with good kids
S50	G50	Wants to be a "good kid"
S51	G51	Is motivated to stay out of trouble
S52	G52	Keeps out of trouble (i.e., is "street smart").
S53	G53	Is not known in community for troublesome behaviors
S54	G54	Fulfills responsibilities related to juvenile justice, court, etc.
S55	G55	Accepts responsibility for misbehavior
S56	G56	Genuinely acknowledges how own behavior has hurt or negatively impacted others
S57	G57	Follows established laws and rules
S58	G58	Shows respect to others
S59	G59	Is a member of a prosocial club/group/educational program/athletic program
S60	G60	Has play activities which are alternatives to antisocial behavior
S61	G61	Has supportive relationships (outside of family)
S62	G62	Helps others willingly
S63	G63	Respectful of own cultural heritage/elders
S64	G64	Positively identifies with own cultural heritage
S65	G65	Participates in activities related to own cultural heritage
S66	G66	Participates in religious/spiritual activities (e.g., attends church)
S67	G67	Other_____

Child's Name _____ ID# _____

	Severe Impairment *Severe disruption or incapacitation* **(30)**	**Moderate Impairment** *Major or persistent disruption* **(20)**	**Mild Impairment** *Significant problems or distress* **(10)**	**Minimal or No Impairment** *No disruption in functioning* **(0)**
BEHAVIOR TOWARD OTHERS ☐	080 Behavior consistently inappropriate or bizarre. 081 Behavior so disruptive or dangerous that harm to others is likely (e.g., hurts or tries to hurt others, such as hitting, biting, throwing things at others, using or threatening to use a weapon or dangerous object). 082 Intentional inappropriate behavior of a sexual nature toward another child (as a perpetrator), and the behavior persists despite the child having been made aware of the inappropriateness. 083 Deliberately cruel to animals despite having been previously reprimanded for cruelty. 084 No age-appropriate peer interactions due to deficit in ability to relate to others; always plays alone; avoids interacting with other children.	086 Behavior frequently or typically inappropriate and causes problems for self or others (e.g., starts fights or arguments, is belligerent). 087 Inappropriate sexual behavior in the presence of others or directed toward others (e.g., deliberately displays or plays with sex parts), and behavior persists despite the child having been made aware of the inappropriateness. 088 Deliberately and persistently annoying to others; provokes conflict/problems. 089 Displays of anger or temper; angry outbursts (i.e., more than once a day). 090 Often mean or nasty to other people or animals. 091 Associates with other children who engage in activities in which others are harassed, bullied, etc. 092 Persistently antagonizes other children (e.g., grabs others' toys, purposefully knocks over or damages others' toys, bullies, teases, shoves). 093 Often plays alone even when there are opportunities for peer play; would rather be alone.	095 Unusually willful, quarrelsome, argumentative, or annoying to others. 096 Temper tantrums or outbursts if cannot get his/her own way, if frustrated, or if criticized. 097 Easily annoyed by others and responds more strongly than other children; quick-tempered. 098 Difficulties in peer interactions due to negative behavior (e.g., teasing, picks on others). 099 Immature behavior leads to poor interaction with peers. 100 Stays upset or overreacts to other children's teasing, etc. 101 Pouts, sulks, or acts stubborn a lot. 102 Has trouble sharing toys. 103 Very bossy in play with other children. 104 Excessive "rough and tumble" play. 105 Stays upset for unusually long periods after not getting his/her way. 106 Does not engage in typical recreational activities because of a tendency to be ignored or rejected by peers. 107 Does not engage in typical peer recreational activities because of being withdrawn or overly timid.	109 Relates age-appropriately to others. 110 Occasional problems are reasonably resolved. 111 Behaves age-appropriately even though there are occasional temporary regressions due to the child's developmental stage or specific family circumstances.
	085 EXCEPTION	094 EXCEPTION	108 EXCEPTION	112 EXCEPTION
	Explanation:			COULD NOT SCORE: 113

Strengths(S)/Goals (G) for Behavior Toward Others Scale

S68	G68	Is aware of behavior problems with other children and is working on this	S80	G80	Is able to control impulses
S69	G69	Is motivated to have more/better friends	S81	G81	Expresses anger through appropriate verbalizations or healthy physical or play activities
S70	G70	Has peer friendships which are age appropriate			
S71	G71	Can be fun to be with (e.g., jokes, witty, sense of humor)	S82	G82	Behaves appropriately in public places and at community events
S72	G72	Plays well with other children			
S73	G73	Can share toys	S83	G83	Shows respect to others
S74	G74	Can play by him/herself	S84	G84	Shows empathy towards others
S75	G75	Belongs to community clubs (e.g., scouts, drill corps, musical or dance groups, church fellowship)	S85	G85	Shows kindness to others
			S86	G86	Is gentle and caring with animals
S76	G76	Can quickly "get back to normal" after difficulties have been "smoothed over"	S87	G87	Has a good relationship with at least one caregiver
			S88	G88	Feels loved by at least one adult caregiver/parent figure (e.g. grandmother, aunt)
S77	G77	Is friendly and outgoing			
S78	G78	Asserts self in healthy ways	S89	G89	Has a good relationship with at least one sibling
S79	G79	Actively uses coping strategies to deal with difficult situations	S90	G90	Views home as nurturant/supportive
			S91	G91	Other_____

Child's Name _____ ID# _____

	Severe Impairment *Severe disruption or incapacitation* **(30)**	**Moderate Impairment** *Major or persistent disruption* **(20)**	**Mild Impairment** *Significant problems or distress* **(10)**	**Minimal or No Impairment** *No disruption in functioning* **(0)**
MOODS/EMOTIONS (Emotions = anxiety, depression, moodiness, fear, worry, irritability, tenseness, panic, anhedonia) ☐	114 Viewed as odd or strange because emotional responses are incongruous or inappropriate (unreasonable, excessive) most of the time. 115 Expresses marked distress upon being away from caregiver and cannot be consoled (stays highly upset). 116 If school-age, child has poor attendance (i.e., absent for at least one day per week on average) due to desire to be with caregiver, fearfulness, or anxieties. 117 Sadness or lack of usual expressiveness is associated with failure to do tasks or activities at school/daycare, OR marked disinterest in other kids, OR refusal/disinterest in eating. 118 Sadness or unhappiness is accompanied by suicidal wish. 119 Looks unhappy, sad, or very anxious most of the time; nothing seems to please or comfort the child. 120 Cries a lot and cannot be consoled, and with no physical explanation. 121 Emotional blunting (i.e., no or few signs of emotional expression; emotional expression is markedly flat).	123 Overreacts to being away from caregiver, but can eventually be consoled. 124 Extremely tense or fearful (e.g., overreacts to sounds or noises). 125 Worries excessively and persistently with disturbance in functioning manifested by at least one of the following: sleep problems, tiredness, poor concentration, irritability, muscle tension, or feeling "keyed up." 126 Sadness or unhappiness is persistent over time with disturbance in functioning in at least one of the following areas: sleeping, eating, concentration, energy level, or normal activities. If only irritability or anhedonia (i.e., marked diminished interest or pleasure in typical activities) is present, there should be disturbance in two or more areas. 127 Persistent self-criticism or feelings of worthlessness. 128 Has emotional flare-ups frequently, but not most of the time (e.g., sobbing uncontrollably, outbursts that are difficult to control or deflect). 129 Notable emotional restriction (e.g., has difficulty expressing strong emotions such as fear, hate, love).	131 Tends to be anxious, fearful, tense, or sad, with some related symptom present (e.g., nightmares, stomachaches, nailbiting, wakes up at night, has trouble getting to sleep). 132 Overreacts compared to other children; disproportionate expression of irritability, fear, or worries. 133 Easily distressed if makes mistakes (more than other children the same age). 134 Sad, withdrawn, hurt, or anxious if criticized; feelings are too easily hurt. 135 Sad (or depressed or anhedonic) or anxious in at least one setting for up to a few days at a time. 136 Never plays energetically or expresses joy or delight. 137 Too worried about neatness, cleanliness. 138 Child has nervous habits (e.g., scratching or twitching). 139 Frequent nightmares or awakenings (i.e., at least two times a week). 140 Overreacts to changes in schedule or routine.	142 Feels normal distress, but daily life is not disrupted. 143 Considers self to be an "OK" person. 144 Can express strong emotions appropriately. 145 Behaves age-appropriately even though there are occasional temporary regressions due to the child's developmental stage or specific family circumstances. 146 Child is generally happy. 147 Experiences of sadness and anxiety are age-appropriate.
	122 EXCEPTION	130 EXCEPTION	141 EXCEPTION	148 EXCEPTION
	Explanation:			COULD NOT SCORE: 149

Strengths(S)/Goals (G) for Moods/Emotions Scale
(OPTIONAL: UNNECESSARY FOR PECFAS RATING)

S92	G92	Can express strong emotions appropriately
S93	G93	Is able to express emotional needs appropriately
S94	G94	Shows a range of emotions (e.g., not flat affect)
S95	G95	Has self-awareness of emotional state/emotions
S96	G96	Shows interest in friends and activities
S97	G97	Has an appropriate understanding of "blame"; does not place too much blame on self
S98	G98	Feels good about self
S99	G99	Has a positive self-perception
S100	G100	Has a good sense of humor
S101	G101	Has a good/pleasant temperament
S102	G102	Has fun, enjoys self
S103	G103	Has healthy outlets for emotional feelings (consistent with culture)
S104	G104	Self-nurturing
S105	G105	Uses "self-talk" to manage mood/anxiety
S106	G106	Sleeps well at night
S107	G107	Shares feelings
S108	G108	Talks with an adult or older youth about nightmares, worries, or sadness
S109	G109	Uses distraction or play to manage mood/anxiety
S110	G110	Emotional reactions are consistent with "provoking" circumstances
S111	G111	No somatic complaints (e.g., stomachaches, headaches)
S112	G112	Attends school despite feelings
S113	G113	Participates in peer activities despite feelings
S114	G114	Can be away from caregivers without undue distress
S115	G115	Easily separates from caregiver when taken to school/ daycare
S116	G116	No suicidal wish or intent
S117	G117	Other_____

Child's Name _____ ID# _____

	Severe Impairment *Severe disruption or incapacitation* **(30)**	**Moderate Impairment** *Major or persistent disruption* **(20)**	**Mild Impairment** *Significant problems or distress* **(10)**	**Minimal or No Impairment** *No disruption in functioning* **(0)**
SELF-HARMFUL BEHAVIOR ☐	150 Non-accidental self-destructive behavior has resulted in or is likely to result in serious self-injury or self-harm (e.g., suicide attempt). 151 Seemingly accidental self-destructive behavior has resulted in or could likely result in serious self-injury (e.g., runs out in the path of a car, opens car door in moving vehicle), and child is aware of the danger. 152 Has a plan to hurt self, even if impractical or nonlethal.	154 Non-accidental self-harm, mutilation, or injury which is not life-threatening but not trivial (e.g., suicidal gestures or behavior without intent to die, cuts self). 155 Talks or repeatedly thinks about harming self, killing self, or wanting to die.	157 Repeated non-accidental behavior suggesting self-harm, yet the behavior is very unlikely to cause any serious injury (e.g., repeatedly pinching self or scratching skin with a dull object).	159 Behavior is not indicative of tendencies toward self-harm.
	153 EXCEPTION	156 EXCEPTION	158 EXCEPTION	160 EXCEPTION
	Explanation:			COULD NOT SCORE: 161

Comments:

Strengths(S)/Goals (G) for Self-Harmful Behavior Scale
(OPTIONAL: UNNECESSARY FOR PECFAS RATING)

S118	G118	No self-destructive actions
S119	G119	No suspicious "accidents"
S120	G120	Does not knowingly engage in dangerous behavior
S121	G121	No self-destructive talk
S122	G122	Shares feelings when experiences self-destructive urges or sad feelings
S123	G123	Uses coping strategies other than self-harm (e.g., "tuning out")
S124	G124	Uses appropriate outlets (e.g., pounding sand in sandbox)
S125	G125	Respects his/her body (e.g., no pinching, scratching purposefully)
S126	G126	Resists being abused/hurt
S127	G127	Avoids being sexually exploited
S128	G128	Eats well
S129	G129	Maintains adequate weight
S130	G130	Other_____

Child's Name _____ ID# _____

	Severe Impairment *Severe disruption or incapacitation* **(30)**	**Moderate Impairment** *Major or persistent disruption* **(20)**	**Mild Impairment** *Significant problems or distress* **(10)**	**Minimal or No Impairment** *No disruption in functioning* **(0)**
THINKING/ COMMUNICATION ☐	CANNOT ATTEND A NORMAL SCHOOL OR DAYCARE SITUATION, DOES NOT HAVE NORMAL PEER INTERACTIONS, OR CANNOT INTERACT ADEQUATELY IN THE COMMUNITY DUE TO ANY OF THE FOLLOWING: 162 Communications which are impossible or extremely difficult to understand due to incoherent thought or language. 163 Speech or nonverbal behavior is extremely odd and is noncommunicative (e.g., echolalia, idiosyncratic language). 164 Strange or bizarre behavior indicating an inability to distinguish fantasy from reality. 165 Most of the time is involved in aimless, nonpurposeful activity. 166 Refuses to talk or is selectively mute and this is not due to any known physical or sensory disability, speech impediment, or lack of familiarity with English. 167 Does not respond when spoken to and this is not due to any known physical or sensory disability, speech impediment, or lack of familiarity with English. 168 Repeats an idea, thought, or action over and over (e.g., repeatedly rocks body or head).	FREQUENT PROBLEMATIC BEHAVIOR OR DIFFICULTY IN INTERACTIONS WITH OTHERS; OR SPECIALIZED SETTING OR SUPERVISION NEEDED DUE TO ANY OF THE FOLLOWING: 170 Communications do not "flow," are irrelevant, or disorganized (i.e., more than other children of the same age). 171 Frequent and strange or odd behavior (e.g., eats non-food items, smears feces). 172 Apparent intermittent hallucinations that interfere with normal functioning. 173 Frequently involved in aimless, non-purposeful activity. 174 Preoccupying cognitions or fantasies with bizarre, odd, or gross themes. 175 Extremely limited in expressing self verbally and this is not due to any known physical or sensory disability, speech impediment, or lack of familiarity with English.	OCCASIONAL PROBLEMATIC BEHAVIOR, OR DIFFICULTY IN INTERACTIONS WITH OTHERS DUE TO ANY OF THE FOLLOWING: 177 Communications which are eccentric or use odd speech (i.e., more than other children of the same age). 178 Often expresses unnatural or strange ideas for his/her age. 179 Unusual perceptual experiences not qualifying as pathological hallucinations. 180 Limited in ability to express self verbally (i.e., more than other children of the same age), and this is not due to any known physical or sensory disability, speech impediment, or lack of familiarity with English.	182 Thought, as reflected by communication, is not disordered or eccentric when compared to other children of the same age.
	169 EXCEPTION	176 EXCEPTION	181 EXCEPTION	183 EXCEPTION
	Explanation:			COULD NOT SCORE: 184

Comments:

Strengths(S)/Goals (G) for Thinking Scale
(OPTIONAL: UNNECESSARY FOR PECFAS RATING)

S131	G131	Can communicate needs to others
S132	G132	Can express self adequately and clearly
S133	G133	Despite communication difficulties, tries to relate to others
S134	G134	Talks to others at an age-appropriate level
S135	G135	Responds socially to others at an age-appropriate level
S136	G136	General behavior is age appropriate
S137	G137	Good problem solving ability
S138	G138	Thinks logically
S139	G139	Has good understanding of personal circumstances
S140	G140	No hallucinations or delusions
S141	G141	Fantasies are "within normal limits" for age
S142	G142	Understands that thoughts cannot directly cause events to happen
S143	G143	Tries to control inappropriate thoughts, feelings, and impulses
S144	G144	Has age-appropriate self-care behaviors
S145	G145	Bathroom behavior and hygiene are age appropriate
S146	G146	Understands the need for medication
S147	G147	Other_____

CAREGIVER BEING RATED: PRIMARY FAMILY

Child's Name _____ ID#_____

Caregiver Being Rater | Relationship to Child | Informant | Child Placement

	Severe Impairment *Severe disruption or incapacitation* (30)	Moderate Impairment *Major or persistent disruption* (20)	Mild Impairment *Significant problems or distress* (10)	Minimal or No Impairment *No disruption in functioning* (0)
CAREGIVER RESOURCES Material Needs ☐	185 Child's needs for food, clothing, housing, medical attention, or neighborhood safety are not being met such that severe risk to health or welfare of child is likely.	187 Frequent negative impact on child's functioning OR a major disruption in the child's functioning due to child's needs for food, housing, clothing, medical attention, or neighborhood safety not being met.	189 Occasional negative impact on the child's functioning due to the child's needs for food, housing, clothing, medical attention, or neighborhood safety not being met.	191 Material needs are arranged for or adequately met so that there is no disruption in the child's functioning. 192 Able to use community resources as needed.
	186 EXCEPTION	188 EXCEPTION	190 EXCEPTION	193 EXCEPTION
	Explanation:			COULD NOT SCORE: 194
CAREGIVER RESOURCES Family/ Social Support ☐	195 Sociofamilial setting is potentially dangerous to the child due to lack of family resources required to meet the child's needs/demands. 196 Gross impairment in parental judgment or functioning (may be related to psychosis, substance abuse, severe personality disorder, mental retardation, etc.). 197 Caregiver is frankly hostile and/ or rejecting OR does not want child to return to the home. 198 Child is subjected to sexual abuse in the home by a caregiver. 199 Child is subjected to physical abuse or neglect in the home by a caregiver. 200 Child currently removed from the home for possible sexual abuse, physical abuse, or neglect. 201 Failure of caregivers to provide an environment safe from possible abuse to a child previously abused or traumatized. 202 Severe or frequent domestic violence takes place in the home. 203 Caregiver contributes to delinquency of child by being involved in unlawful behavior or approving of child being involved in potentially unlawful behavior. 204 Marked lack of parental supervision or consistency in care relative to the child's developmental age.	206 Child's developmental needs cannot be adequately met because child's needs/developmental demands exceed family resources. 207 Marked impairment in parental judgment or functioning (may be related to emotional instability, psychiatric illness, substance use, physical illness, criminal activities, or other impairing condition). 208 Family conflict is pervasive and continual (characterized by hostility, tension, and/or scapegoating, etc.). 209 Family members are insensitive, angry and/or resentful to the child. 210 Failure of caregiver to provide emotional support to child who has been traumatized or abused. 211 Domestic violence, or serious threat of domestic violence, takes place in the child's home. 212 Family not able to provide adequate supervision or consistency in care over time relative to the child's needs; no other supports compensate for this deficit.	214 Family not able to provide adequate warmth, security or sensitivity relative to the child's needs. Support from other sources outside the immediate family are unable to compensate for this inadequacy. 215 Frequent family arguments and/or misunderstandings resulting in bad feelings. 216 Family relations are characterized by poor problem solving, poor communication, or emotional insensitivity. 217 Family not able to provide adequate firmness relative to the child's needs; no other supports compensate for this deficit.	219 Family is sufficiently warm, secure, and sensitive to the child's major needs. 220 Parental supervision is adequate. 221 Even though there are temporary problems in providing adequate support to the child, there is compensation from the wider social support system.
	205 EXCEPTION	213 EXCEPTION	218 EXCEPTION	222 EXCEPTION
	Explanation:			COULD NOT SCORE: 223

Comments:

Strengths(S)/Goals (G) for Primary Family - See page 13

CAREGIVER BEING RATED: NON-CUSTODIAL FAMILY OR PARENT NOT LIVING IN CHILD'S HOME

Child's Name _____ ID#_____

Caregiver Being Rater | Relationship to Child | Informant | Child Placement

	Severe Impairment *Severe disruption or incapacitation* **(30)**	**Moderate Impairment** *Major or persistent disruption* **(20)**	**Mild Impairment** *Significant problems or distress* **(10)**	**Minimal or No Impairment** *No disruption in functioning* **(0)**
CAREGIVER RESOURCES Material Needs ☐	224 Child's needs for food, clothing, housing, medical attention, or neighborhood safety are not being met such that severe risk to health or welfare of child is likely.	226 Frequent negative impact on child's functioning OR a major disruption in the child's functioning due to child's needs for food, housing, clothing, medical attention, or neighborhood safety not being met.	228 Occasional negative impact on the child's functioning due to the child's needs for food, housing, clothing, medical attention, or neighborhood safety not being met.	230 Material needs are arranged for or adequately met so that there is no disruption in the child's functioning. 231 Able to use community resources as needed.
	225 EXCEPTION	227 EXCEPTION	229 EXCEPTION	232 EXCEPTION
	Explanation:			COULD NOT SCORE: 233

CAREGIVER RESOURCES Family/ Social Support ☐	234 Sociofamilial setting is potentially dangerous to the child due to lack of family resources required to meet the child's needs/demands. 235 Gross impairment in parental judgment or functioning (may be related to psychosis, substance abuse, severe personality disorder, mental retardation, etc.). 236 Caregiver is frankly hostile and/ or rejecting OR does not want child to return to the home. 237 Child is subjected to sexual abuse in the home by a caregiver. 238 Child is subjected to physical abuse or neglect in the home by a caregiver. 239 Child currently removed from the home for possible sexual abuse, physical abuse, or neglect. 240 Failure of caregivers to provide an environment safe from possible abuse to a child previously abused or traumatized. 241 Severe or frequent domestic violence takes place in the home. 242 Caregiver contributes to delinquency of child by being involved in unlawful behavior or approving of child being involved in potentially unlawful behavior. 243 Marked lack of parental supervision or consistency in care relative to the child's developmental age.	245 Child's developmental needs cannot be adequately met because child's needs/developmental demands exceed family resources. 246 Marked impairment in parental judgment or functioning (may be related to emotional instability, psychiatric illness, substance use, physical illness, criminal activities, or other impairing condition). 247 Family conflict is pervasive and continual (characterized by hostility, tension, and/or scapegoating, etc.). 248 Family members are insensitive, angry and/or resentful to the child. 249 Failure of caregiver to provide emotional support to child who has been traumatized or abused. 250 Domestic violence, or serious threat of domestic violence, takes place in the child's home. 251 Family not able to provide adequate supervision or consistency in care over time relative to the child's needs; no other supports compensate for this deficit.	253 Family not able to provide adequate warmth, security or sensitivity relative to the child's needs. Support from other sources outside the immediate family are unable to compensate for this inadequacy. 254 Frequent family arguments and/or misunderstandings resulting in bad feelings. 255 Family relations are characterized by poor problem solving, poor communication, or emotional insensitivity. 256 Family not able to provide adequate firmness relative to the child's needs; no other supports compensate for this deficit.	258 Family is sufficiently warm, secure, and sensitive to the child's major needs. 259 Parental supervision is adequate. 260 Even though there are temporary problems in providing adequate support to the child, there is compensation from the wider social support system.
	244 EXCEPTION	252 EXCEPTION	257 EXCEPTION	261 EXCEPTION
	Explanation:			COULD NOT SCORE: 262

Comments:

Strengths(S)/Goals (G) for Non-Custodial Family or Parent Not Living in Youth's Home - See page 13

CAREGIVER BEING RATED: SURROGATE CAREGIVER

Child's Name _____ ID#_____

Caregiver Being Rater _____ Relationship to Child _____ Informant _____ Child Placement _____

	Severe Impairment *Severe disruption or incapacitation* (30)	Moderate Impairment *Major or persistent disruption* (20)	Mild Impairment *Significant problems or distress* (10)	Minimal or No Impairment *No disruption in functioning* (0)
CAREGIVER RESOURCES Material Needs ☐	263 Child's needs for food, clothing, housing, medical attention, or neighborhood safety are not being met such that severe risk to health or welfare of child is likely.	265 Frequent negative impact on child's functioning OR a major disruption in the child's functioning due to child's needs for food, housing, clothing, medical attention, or neighborhood safety not being met.	267 Occasional negative impact on the child's functioning due to the child's needs for food, housing, clothing, medical attention, or neighborhood safety not being met.	269 Material needs are arranged for or adequately met so that there is no disruption in the child's functioning. 270 Able to use community resources as needed.
	264 EXCEPTION	266 EXCEPTION	268 EXCEPTION	271 EXCEPTION
	Explanation:			COULD NOT SCORE: 272
CAREGIVER RESOURCES Family/ Social Support ☐	273 Sociofamilial setting is potentially dangerous to the child due to lack of family resources required to meet the child's needs/demands. 274 Gross impairment in parental judgment or functioning (may be related to psychosis, substance abuse, severe personality disorder, mental retardation, etc.). 275 Caregiver is frankly hostile and/or rejecting OR does not want child to return to the home. 276 Child is subjected to sexual abuse in the home by a caregiver. 277 Child is subjected to physical abuse or neglect in the home by a caregiver. 278 Child currently removed from the home for possible sexual abuse, physical abuse, or neglect. 279 Failure of caregivers to provide an environment safe from possible abuse to a child previously abused or traumatized. 280 Severe or frequent domestic violence takes place in the home. 281 Caregiver contributes to delinquency of child by being involved in unlawful behavior or approving of child being involved in potentially unlawful behavior. 282 Marked lack of parental supervision or consistency in care relative to the child's developmental age.	284 Child's developmental needs cannot be adequately met because child's needs/developmental demands exceed family resources. 285 Marked impairment in parental judgment or functioning (may be related to emotional instability, psychiatric illness, substance use, physical illness, criminal activities, or other impairing condition). 286 Family conflict is pervasive and continual (characterized by hostility, tension, and/or scapegoating, etc.). 287 Family members are insensitive, angry and/or resentful to the child. 288 Failure of caregiver to provide emotional support to child who has been traumatized or abused. 289 Domestic violence, or serious threat of domestic violence, takes place in the child's home. 290 Family not able to provide adequate supervision or consistency in care over time relative to the child's needs; no other supports compensate for this deficit.	292 Family not able to provide adequate warmth, security or sensitivity relative to the child's needs. Support from other sources outside the immediate family are unable to compensate for this inadequacy. 293 Frequent family arguments and/or misunderstandings resulting in bad feelings. 294 Family relations are characterized by poor problem solving, poor communication, or emotional insensitivity. 295 Family not able to provide adequate firmness relative to the child's needs; no other supports compensate for this deficit.	297 Family is sufficiently warm, secure, and sensitive to the child's major needs. 298 Parental supervision is adequate. 299 Even though there are temporary problems in providing adequate support to the child, there is compensation from the wider social support system.
	283 EXCEPTION	291 EXCEPTION	296 EXCEPTION	300 EXCEPTION
	Explanation:			COULD NOT SCORE: 301

Comments:

Strengths(S)/Goals (G) for Surrogate Caregiver - See page 13

Strengths(S)/Goals (G) for Primary Family
(OPTIONAL: UNNECESSARY FOR PECFAS RATING)

S148	G148	Caregiver provides stable environment
S149	G149	Caregiver communicates clearly
S150	G150	Caregiver cooperates with agencies providing services to child
S151	G151	Caregiver encourages positive identification with cultural heritage
S152	G152	Caregiver reinforces desirable behaviors and ignores or gives consequences for undesirable behaviors
S153	G153	Caregiver is clear about behavioral expectations/values
S154	G154	Caregiver adheres to a daily routine
S155	G155	Caregiver sets realistic and age-appropriate goals for child
S156	G156	Family eats dinner together
S157	G157	Family talks about problems
S158	G158	Caregiver models prosocial behavior and talk
S159	G159	Caregiver models verbal problem solving skills
S160	S160	Caregiver provides nurturing/soothing/comforting home environment
S161	G161	Emotional support and physical protection is given to a child previously abused
S162	G162	Caregiver arranges for appropriate supervision/care of child when working or away from child
S163	G163	Caregiver is aware of when he/she needs help
S164	G164	Caregiver seeks help when his/her problem solving skills break down
S165	G165	Caregiver is caring in the face of difficult behavior from youth
S166	G166	Caregiver exercises good control when provoked
S167	G167	Caregiver tries to minimize negative impact of their own limitations
S168	G168	Caregiver tries to minimize negative impact of other family members on child (e.g., an abusing parent)
S169	G169	Caregiver is consistent and predictable in behavior toward child
S170	G170	Domestic abuse does not takes place
S171	G171	Caregiver seeks services for own concerns/problems
S172	G172	Child has extended family support
S173	G173	Child has adults outside the family who provide direction and guidance
S174	G174	Substance using caregiver is seeking services to deal with his/her own substance use
S175	G175	Other_____

Strengths(S)/Goals (G) for Non-Custodial Family or Parent Not Living in Youth's Home
(OPTIONAL: UNNECESSARY FOR PECFAS RATING)

S176	G176	Caregiver provides stable environment
S177	G177	Caregiver communicates clearly
S178	G178	Caregiver cooperates with agencies providing services to child
S179	G179	Caregiver encourages positive identification with cultural heritage
S180	G180	Caregiver reinforces desirable behaviors and ignores or gives consequences for undesirable behaviors
S181	G181	Caregiver is clear about behavioral expectations/values
S182	G182	Caregiver adheres to a daily routine
S183	G183	Caregiver sets realistic and age-appropriate goals for child
S184	G184	Family eats dinner together
S185	G185	Family talks about problems
S186	G186	Caregiver models prosocial behavior and talk
S187	G187	Caregiver models verbal problem solving skills
S188	G188	Caregiver provides nurturing/soothing/comforting home environment
S189	G189	Emotional support and physical protection is given to a child previously abused
S190	G190	Caregiver arranges for appropriate supervision/care of child when working or away from child
S191	G191	Caregiver is aware of when he/she needs help
S192	G192	Caregiver seeks help when his/her problem solving skills break down
S193	G193	Caregiver is caring in the face of difficult behavior from child
S194	G194	Caregiver exercises good control when provoked
S195	G195	Caregiver tries to minimize negative impact of their own limitations
S196	G196	Caregiver tries to minimize negative impact of other family members on child (e.g., an abusing parent)
S197	G197	Caregiver is consistent and predictable in behavior toward child
S198	G198	Domestic abuse does not takes place
S199	G199	Caregiver seeks services for own concerns/problems
S200	G200	Child has extended family support
S201	G201	Child has adults outside the family who provide direction and guidance
S202	G202	Substance using caregiver is seeking services to deal with his/her own substance use
S203	G203	Other_____

Strengths(S)/Goals (G) for Surrogate Caregiver
(OPTIONAL: UNNECESSARY FOR PECFAS RATING)

S204	G204	Caregiver provides stable environment
S205	G205	Caregiver communicates clearly
S206	G206	Caregiver cooperates with agencies providing services to child
S207	G207	Caregiver encourages positive identification with cultural heritage
S208	G208	Caregiver reinforces desirable behaviors and ignores or gives consequences for undesirable behaviors
S209	G209	Caregiver is clear about behavioral expectations/values
S210	G210	Caregiver adheres to a daily routine
S211	G211	Caregiver sets realistic and age-appropriate goals for child
S212	G212	Family eats dinner together
S213	G213	Family talks about problems
S214	G214	Caregiver models prosocial behavior and talk
S215	G215	Caregiver models verbal problem solving skills
S216	G216	Caregiver provides nurturing/soothing/comforting home environment
S217	G217	Emotional support and physical protection is given to a child previously abused
S218	G218	Caregiver arranges for appropriate supervision/care of child when working or away from child
S219	G219	Caregiver is aware of when he/she needs help
S220	G220	Caregiver seeks help when his/her problem solving skills break down
S221	G221	Caregiver is caring in the face of difficult behavior from child
S222	G222	Caregiver exercises good control when provoked
S223	G223	Caregiver tries to minimize negative impact of their own limitations
S224	G224	Caregiver tries to minimize negative impact of other family members on child (e.g., an abusing parent)
S225	G225	Caregiver is consistent and predictable in behavior toward child
S226	G226	Domestic abuse does not takes place
S227	G227	Caregiver seeks services for own concerns/problems
S228	G228	Child has extended family support
S229	G229	Child has adults outside the family who provide direction and guidance
S230	G230	Substance using caregiver is seeking services to deal with his/her own substance use
S231	G231	Other_____

OPTIONAL: TREATMENT PLAN

INSTRUCTIONS: Write in scale name. For the PROBLEM(S), GOALS(S), and STRENGTH(S), provide the PECFAS® item number and the item description. For the PROBLEM(S), you may want to elaborate on the details (e.g., smeared feces on bathroom wall on January 5, 2008). Under PLAN, you can provide details for accomplishing the specified goal.

Scale_____

	Item #(s)	Description
Problems		
Goals		
Strengths		
Plan		

Scale_____

	Item #(s)	Description
Problems		
Goals		
Strengths		
Plan		

Scale_____

	Item #(s)	Description
Problems		
Goals		
Strengths		
Plan		

Scale_____

	Item #(s)	Description
Problems		
Goals		
Strengths		
Plan		

Scale_____

	Item #(s)	Description
Problems		
Goals		
Strengths		
Plan		

Scale_____

	Item #(s)	Description
Problems		
Goals		
Strengths		
Plan		

Date	Signature	Title

The Preschool and Early Childhood Functional Assessment Scale®
Instructions For Scoring

The purpose of the PECFAS® is to measure impairment in day-to-day functioning, secondary to behavioral, emotional, psychological or psychiatric problems. The PECFAS was developed to use with children who are not yet enrolled in a full-time kindergarten program or in first grade. Depending on the child's emotional and cognitive developmental level, the PECFAS can be used with children ages 3 to 7 years old. It is rated by a practitioner or another trained rater. It is used to record the extent to which a child's mental health problems are disruptive to functioning in each of seven psychosocial areas. It also includes subscales to assess the extent to which the child's caregiver is able to provide for the needs of the child. The PECFAS provides a "snapshot" of the child's functional status at present and within the recent past. Any desired time frame can be used in rating the PECFAS (e.g., last month, last three months). The PECFAS user indicates the time period being rated on the first page of the PECFAS form.

The PECFAS is not based on any particular theory or model of psychopathology. Ratings are not intended to reflect the causes or dynamics underlying the child's problems or dysfunctions. The PECFAS profiles the degree of disruption in the child's current functioning regardless of the history, causes, or prognosis of the child's mental health problems.

Description of the PECFAS® Subscales

The seven psychosocial subscales that apply to the child are:

School/Daycare Role Performance	Ability to function satisfactorily in a group education or daycare environment
Home Role Performance	Extent to which child observes reasonable rules and performs age appropriate tasks
Community Role Performance	Respect for the rights of others and their property and conformity to laws
Behavior Toward Others	Appropriateness of child's daily behavior toward others, including adults and peers
Moods/Emotions	Modulation of the child's emotional life
Self-Harmful Behavior	Extent to which the child can cope without resorting to self-harmful behavior or verbalizations
Thinking/ Communication	Ability of child to use rational thought processes and communicate with others

The eighth and ninth subscales apply to the caregiving environment rather than the child. These subscales are not included in the total PECFAS score for the child.

Caregiver Resources: Material Needs	The extent to which the caregiver provides for the child's material needs (e.g., housing) such that there is no negative impact on the child's level of functioning; extent to which the neighborhood is safe for rearing children. The needs rated in this scale refer to the child's basic physical or material needs.
Caregiver Resources: Family/ Social Support	The extent to which the caregiver provides a home setting that is free of known risk factors (e.g., abuse, parental alcoholism) or provides for the child's developmental needs (e.g., emotional, social, etc.) given the child's individual needs and the caregiver's resources.

Description of the Levels of Impairment

To each of the subscales, the PECFAS applies a 4-level scoring system that is used to indicate the degree of dysfunction manifested in each area. The higher the score, the more severe the level of dysfunction. For each subscale, the rater determines the level of functioning, expressed in terms of degree of impairment.

Score ***Degree of Dysfunction or Impairment***

30 SEVERE IMPAIRMENT - *severe disruption or incapacitation*. There are significant problems or symptoms, some of which may cause concern about the welfare of the child or others around the child to such an extent that removal from the home, school, or community is necessary or special accommodations, arrangements or reassurances must be put in place. The child is functioning very poorly, relative to the performance expected for his/her age in the relevant life role (i.e., as a family member, etc.). The child finds it very difficult or impossible to perform important activities or to behave as expected.

20 MODERATE IMPAIRMENT - *major or persistent disruption*. This rating can be endorsed if the disruption is frequent or if disruption is only occasional but with major implications for the child's level of functioning. The child's functioning is negatively impacted or significantly interfered with. The child has difficulty with or finds it very difficult to do activities expected of him/her or to behave as expected (e.g., expectations at home, interacting with other children, obeying rules of conduct at daycare or home, etc.). Typically, the child is still able to continue functioning in a home and/or daycare setting.

10 MILD IMPAIRMENT - *significant problems and/or distress*. There are noteworthy problems or distress, but there is no major dysfunction or disturbance in or interference with functioning.

0 MINIMAL OR NO IMPAIRMENT - *no disruption of functioning*. This does not mean that the child is well adjusted; rather, it means that there is minimal or no impairment in the child's functioning as a result of behavioral, emotional, psychological, or psychiatric difficulties or disorders.

General Guidelines

1. Each subscale contains a menu of behavioral descriptions that are divided into the four levels of impairment. The rater reads a list of behavioral descriptors and marks those that apply to the child. The rater does <u>not</u> assign a score; rather, the items endorsed determine the score. The PECFAS forms need to be kept in the child's record so that item endorsements that support the subscale scores are always available for review. In addition, raters need to place their signature on the PECFAS forms to indicate that they selected the endorsed items. Note that the term "behavior" is used generically and can refer to actions, verbalizations, nonverbal gestures, etc. Specific instructions for each subscale are provided below.

2. Rate the child's functioning on every subscale. No subscale is left blank except in those rare occasions when the rater is unable to obtain enough information in an area to perform an accurate rating. Because a total score cannot be derived if any subscale scores are missing, it is critical to collect the information as needed to rate the child's current functioning.

3. Use a literal approach in judging behavioral criteria. That is, attend to the limited and specific meaning of each criterion item as it is defined and use only the information available to you in judging whether or not the problem is manifested. Rate the child's current functioning; do not infer that a problem exists on the basis of another problem, the underlying dynamics of the child's disorder, or the child's previous or current diagnostic group. Avoid stereotyping and generalizations. As much as possible, base your rating on what you have observed or what has been reported by the child or other informants.

4. Base your assessment on all information known to be true about the child at the time of the rating. Use all possible sources of information: the child, significant others, observers of the child, etc. If the child denies a problem's existence even though there is evidence otherwise, indicate that the problem is present. When a child is evaluated over time, it is preferable to use the same rater, method of obtaining information, and informants for each assessment. This is true no matter what assessment tool is being used. An interview that was designed specifically to obtain all of the information needed in order to rate the PECFAS (referred to as the *PECFAS® Interview:*

Parent Report) takes about 30 minutes and can be administered over the telephone or in person.

5. Rate the child at the *most severe* level of dysfunction occurring *at any time in the time period being rated* (e.g., last 30 days, last 90 days). The agency determines the time period to be rated. If the child was delayed in getting services, at intake you may need to rate him/her back to the time he/she was exhibiting the behavior that caused the referral.

6. Cultural competence involves being knowledgeable about the child's/family's culture. It is important to understand the cultural context of the behavior so you do not misinterpret behavior. Seek opinions of persons knowledgeable about the culture if in doubt. Try not to impose your own value judgments that may be heavily influenced by your age, sex, social class, or cultural background. However, do rate behaviors appearing in the PECFAS even if they are more common in some cultural contexts (e.g., aggression). To add context and balance to understanding the child's situation, you can add comments under "Exception" (described below) or in the summary on the PECFAS assessment (e.g., only aggressive when worried about mother's welfare). Be sure to rate the child's strengths because they can provide ideas for designing more effective interventions. However, still rate the target behavior! We want to intervene on the child's behalf.

7. The PECFAS provides criteria for rating the child on seven subscales, each referring to specific behaviors. As a result, most children probably will be rated as MINIMAL OR NO IMPAIRMENT on one or more of the subscales (even if they are rated severely impaired on another). For instance, some children with anxiety or depression symptoms do not exhibit disruptive behavior. Also, some children who have emotional or behavioral problems have no impairment in their thinking or communication processes.

8. Rate the child's current functioning without scoring more severely solely because the child is receiving services. The rating should accurately reflect the public performance of the individual. For example, do not rate as more impaired a high functioning child solely because the performance is thought to be related to outpatient psychotherapy or to medication. Services being received should only be considered when the subscale items refer to them. Additional guidelines for scoring children who are in residential care when rated are available in the *CAFAS Self-Training Manual*.

9. A list of strengths follows each PECFAS subscale. The rater chooses the strengths that apply to the child. These endorsements do not affect the child's score on the PECFAS instrument. This list of strengths is also used to select goals appropriate for the child.

Instructions for Determining the PECFAS® Score

The PECFAS is used to assess a child's functional impairment, rated as SEVERE, MODERATE, MILD, or MINIMAL OR NO impairment. If any one item listed under an impairment level describes the child's functioning, the child qualifies for the score at that level. You should mark <u>all items</u> that apply at that level, but you may stop with the items in the most dysfunctional level for which the child qualifies.

1. For each subscale, begin your assessment by reviewing items in the SEVERE level. If any item describes the child's functioning, circle its number as well as any other items that apply in that level. Write the score "30" in the box on the left and skip to the next subscale.

2. If the child does not qualify for a SEVERE rating, move right one column to the MODERATE category and review those items. If any apply, circle those item numbers, write the score "20" in the score box on the left, and skip to the next subscale.

3. If no items under MODERATE apply, move right one column to the MILD level. If any items apply, circle those item numbers, write the score "10" in the score box on the left, and skip to the next subscale.

4. If no item under MILD applies, move right one column to the MINIMAL OR NO IMPAIRMENT category, circle those item numbers that apply and write the score "0" in the score box.

5. If you believe that the child should be rated at a level of impairment where no items are circled, write the score in the score box, circle the corresponding "EXCEPTION" number, and explain the reason for your rating in the box labeled "Explanation." This option can be used for: (1) indicating behavior not described on the PECFAS, such as encopresis; or (2) overriding the severity level associated with a behavioral description. The latter should be done very cautiously. For example, consider the case of a

child who is in a classroom for children with behavioral disorders. At a meeting in late May, it is decided that he can be mainstreamed, but he will not change classrooms until the next fall to minimize disruptions to him. When evaluated in June, on this School subscale, the rater could score "Exception" under MILD IMPAIRMENT and, under "Explanation," write: "Per meeting 5/26, child can be placed in regular classroom." You can also use "Exception/Explanation" to add a note to put the child's behavior (which was indicated by an endorsed item) in context. For example, child's aggressive behavior was observed only after abrupt removal from the home.

6. If, under rare circumstances, there is insufficient information to rate the child on a subscale, circle the number corresponding to "Could Not Score" and provide the reason in the box labeled "Explanation." This is intended to be used only for the infrequent situations in which the rater is totally unable to rate the child based on lack of information.

Interpretation of the PECFAS®

The *Manual for Training Coordinators, Clinical Administrators and Data Managers* contains information on the clinical use and interpretation of the PECFAS.

1. The item endorsements generate a score for each subscale. The seven subscales assessing the child can be summed to yield a total score. Scores on the Caregiver subscales are not included in the total for the child. A scoring summary appears on the first page of the PECFAS form.

2. The PECFAS Profile, which appears on the second page of the PECFAS form, provides a visual representation of the child's scores across the subscales (i.e., the domains of functioning). The numbers on the Profile refer to the items on the PECFAS. The practitioner (1) marks the item number(s) that correspond to those marked on the PECFAS form for each subscale, (2) fills in the circle indicating severity level, and (3) connects the circles across the subscales to generate the profile. This can be very useful clinically when discussing the child in treatment team meetings and/or with the caregivers. Profiles for repeated assessments can be drawn on the same Profile form to illustrate change over time.

3. For each PECFAS subscale, there is a list of associated items, which can be viewed as either a strength (i.e., child has the characteristic) or a goal (i.e., child does not yet have the characteristic, but it is a goal for the child), depending on the child being rated. For example, for School/Daycare scale, "attends school/daycare regularly" can be regarded a strength or a goal. There is a list of strengths/goals for each PECFAS subscale (i.e., for the 7 child subscales and the 2 caregiver scales).

4. An individualized treatment plan can be generated by specifying a plan of action for each PECFAS subscale that indicates impairment. The last two pages of the PECFAS form provide a format for recording up to 6 problem areas. For each subscale, the following can be specified:
   Problems (from PECFAS items)
   Goals (from Goals/Strengths list)
   Strengths (from Goals/Strengths list)
   Plan (to be written by rater)

5. When generating the treatment plan, be sure to note whether the child is characterized by any of the risk behaviors (e.g., aggressive, suicidal) listed on the first page of the PECFAS form.

6. The services outlined on the treatment plan can be tailored to the child's and the family's needs. The PECFAS Profile and a treatment plan based on the information collected on the PECFAS form can be shared with the caregiver and the provider (if the child is evaluated before referral to a provider). If the caregiver disagrees with the problem items, strengths or goals endorsed, the discussion that ensues should be helpful in clarifying the child's and family's treatment needs. The referring agency can use this information to clarify expectations with the provider. Likewise, the provider can review the referring agency's expectations to ensure that they are realistic and that there will be sufficient resources. Allocation of responsibility for the tasks to be undertaken in regard to both the child and the child's caregiver(s) can be clarified. The criterion by which therapeutic progress will be judged can be clearly stated (i.e., on specific PECFAS subscales, such as reduced scores on Moods/Emotions and Self-Harmful subscales).

7. The PECFAS Profile can be used to track progress over time. For example, every three months the treatment team (including the caregiver) can compare the child's subscale scores to those obtained at intake. This review of how far the child has progressed can provide hope and encouragement. The *Manual for Training Coordinators, Clinical Administrators and Data Managers* describes outcome indicators that can be used to evaluate outcomes at the level of the

individual client while the child is still receiving treatment.

Specific Guidelines for the PECFAS® Subscales Assessing the Child

This section reviews every subscale, explaining the types of behaviors being rated in each subscale as well as definitions of terms. Defining terms is important even for well-known words (e.g., aggression) because it is important that all raters have the same internal reference when thinking about the same item on the PECFAS. Also, it is extremely important that, when rating the PECFAS, you attend to the words in the item that describe degree of impairment not just the words describing the type of problem. The term "typically" is used to mean that the child acts as described a lot or most of the time (i.e., chronic, persistent), whereas "frequently" or "often" is used to mean that the child acts as described more than other kids or more than expected for his/her age. Several items contain the words "age-appropriate" or "age-inappropriate," indicating that the child's behavior should be considered in light of the child's age. For example, what may be acceptable behavior for a 4-year-old will likely be considered unacceptable for a 7-year-old and vice versa.

For each subscale, the same format will be used to explain scoring rules: (1) the expectations for "normal" functioning for that domain are broken down into sub-areas (e.g., behavior, attendance, etc. for the School/Daycare subscale), (2) the text defines critical terms and explains the rationale underlying the scoring, and (3) a table is presented for each sub-area (e.g., attendance) so that you can easily see how the items differ across levels of impairment for each sub-area. Each table is organized with three columns: the level of severity of impairment (30, 20, 10), the item description in a condensed form, and the corresponding item number on the PECFAS. The following symbols are used in the tables: EX (Example); N/A (Not Applicable); / (or); ≥ (Equal to or more). In the tables, parentheses appearing around an item denote that an item with this exact wording does not appear on the PECFAS scale. You may need to use "Exception."

The first three subscales assess the extent to which the child fails to fulfill the roles most relevant to his or her place in society: at school or at daycare, in the home, and in the community. These role performance subscales assess impairment in the child's functioning relative to the extent to which the child can carry out normal, reasonable expectations given his/her age.

1. SCHOOL/DAYCARE ROLE PERFORMANCE

Expectations for School/Daycare	
Learning/Attention Problems	Learning is average or better OR Learning is commensurate with ability if has handicap or mental retardation Performs up to abilities
Attendance	Attends school/daycare regularly (as scheduled)
Behavior	Behaves age-appropriately

Problems in the School/Daycare area can be organized around: learning, attendance, and behavior problems. If school is currently not in session (e.g., summer vacation), rate the child's behavior for the most recent time period he/she was in school. If the child attended a summer school program, rate him/her on the behavior there. If a child is being home taught, consider the home environment as the school environment and the person educating the child as the teacher. Rate the child's behavior while being taught in that environment. Also, score behavior on the school bus on this subscale.

Poor Learning: The items describe the extent to which the child's learning of basic school readiness skills is behind other children (i.e., at least 1 year, below average, satisfactory). Also, at each impairment level, there are two items. One item specifically refers to poor attention or hyperactivity level as likely involved, whereas the other item does not. Typically preschoolers have not had the benefit of diagnostic testing to determine presence of learning problems. However, if testing has been done, and learning problems are known to be solely due to: (a) mental retardation or other serious and documented learning problems, (b) sensory deficits (e.g., hearing problems), or (c) physical disability or impairment, do not rate the child as impaired. The child should be rated on his/her functioning relative to his/her abilities. Note that under the MINIMAL OR NO IMPAIRMENT level, there are options that state that the child is performing academically at a level commensurate with abilities and the child is mentally retarded or has a known handicap. These options do not have to be used but are made available in the event that recording these challenges to learning may be helpful.

Poor Attendance: *School refusal* refers to the child staying home rather than going to school/daycare (when scheduled to attend). This could be due to a desperate or

strong desire to stay with parental figure(s), a fearfulness of school/daycare, depression, anxiety, or a reaction to experiencing a trauma. Score unexcused absences due to any reason except physical illness.

At the SEVERE level, the child is not attending school or a daycare program because he or she was asked to leave, refuses to attend, or has excessive absences.

At the MODERATE level, frequent absences are defined as at least "approximately once every two weeks or for several consecutive days." This is equivalent to being absent at least 10% of the time (i.e., 1 out of 10 school days).

Problematic Behavior: Most school and daycare settings are group settings, and, thus, the behavior of individual students cannot be permitted to interfere substantially with other children learning, playing, or napping.

Before describing the behavioral items appearing at each level of impairment for this subscale, relevant terms will be defined. The words *disobedience* and *inappropriate* are used in several PECFAS scales. *Disobedience* refers to the child's failure to do what he/she has been told or asked to do by a person in authority, such as parent or teacher (e.g., not doing a task/chore). It refers to directly carrying out a request or command. Of course, it is not disobedience if the request is illegal, of an abusive nature, entirely unreasonable, etc. *Inappropriate* refers to behavior that is not appropriate, acceptable, proper, or suitable for the circumstances (e.g., bullying). Inappropriate behavior is usually a behavioral excess (i.e., the presence of undesirable behavior rather than a deficit in desired behavior) and typically includes behaviors for which there are no specified rules because they are not seen as needed as it is not a typical form of misbehavior. For preschoolers, children may display inappropriate behavior that was modeled in another setting, and they may not realize that the behavior is inappropriate. Even so, this behavior should be rated because a plan aimed at replacing the inappropriate behavior with more appropriate behavior needs to be developed.

School and quality daycare provide a relatively standard set of expectations that are consistent with the child's developmental level. *Poor attention and high activity level (i.e., hyperactivity)* are usually defined within the context of functioning in school or at daycare. When determining whether poor attention and/or high activity level are present, school or daycare personnel are the best informants. Examples of inattention, taken from the *Diagnostic and Statistical Manual of Mental Disorders-Fourth Edition* (*DSM IV*; American Psychiatric Association[APA], 1994) include: has difficulty sustaining attention in tasks or during play activities, does not listen when spoken to, fails to finish work (not due to oppositional behavior or failure to understand instructions), has difficulty organizing tasks and activities, avoids schoolwork which requires sustained attention, is easily distracted, and is often forgetful. Examples of hyperactivity include: fidgets with hands or feet, leaves his/her seat in the classroom when remaining seated is expected, often runs about or climbs excessively in situations in which it is inappropriate, has difficulty quietly engaging in leisure activities, is often "on the go," and talks excessively. For the purposes of the PECFAS, the terms *poor attention* and *high activity* are used as behavioral descriptors (not as a disorder). There is no assumption or requirement that the diagnostic criteria regarding onset and duration of symptoms are met.

At the SEVERE level, the child cannot be maintained even with special accommodations. If the child has been placed in a specialized learning environment or is receiving specialized services and *is still a behavior problem*, score the child at the SEVERE level. This would apply to a child with ADHD (attention deficit/hyperactivity disorder) as well as a child who is noncompliant and disruptive.

The child can also be scored at the SEVERE level if he/she is out of school or daycare as a result of his/her "bad" behavior in school or daycare (i.e., biting other children). The child can be rated at the SEVERE level for the behavior related to removal from school. There are two items related to aggression: (1) being judged to be a potential threat to others because of potential aggressiveness, based on the child's actions or statements, and (2) having harmed someone or made a serious threat to harm someone. Sexually inappropriate behavior, which results in removal from school or daycare, can be rated as SEVERE.

If the child is out of school or daycare because he/she was asked to leave, endorse items describing the expulsion as well as items describing the behavior that led to the expulsion. In the example of a child who was asked to leave daycare for biting, items pertaining to expulsion and to the harmful potential would be scored. In the event that the behavior resulting in being asked to leave does not appear at the SEVERE level, circle the number for "Exception" and write the behavior in the "Explanation" box at the SEVERE level.

At the MODERATE level, the child's bad behavior results in persistent or repeated disruption of group activities. These children have generally become known to supervisory staff because their bad behavior is chronic or severe. Another indicator of MODERATE impairment

is that the classroom teacher or daycare staff thinks that special accommodations are needed (or have already been implemented). This situation may have resulted in the child's referral for mental health evaluation/services. If the child has been referred because of behavioral problems, rate the child at the moderate level because the school is finding the child difficult to manage or has concerns, even though the nature of problems may not have been identified yet. Please note that a child who is placed in a special school program because of behavior problems will at least be rated at the MODERATE level even if he/she is functioning well with these special accommodations.

At the MILD level, the classroom teacher or daycare staff can generally handle the child's bad behavior. The child should be causing more problems than is typical for child of the same age. This can be shown by: (1) the classroom/daycare staff bringing attention to the problems (e.g., by verbal reprimands, time-outs), (2) the classroom/daycare staff structuring the child's activities so as to avoid difficulties, such as having the child sit or play near staff, (3) the child occasionally disobeying the rules (more than other children), or (4) for child with attention or high activity level problems, the classroom/daycare staff being able to manage the child's behavior, which is not disruptive to other children.

	Learning/Attention Problems	**Item #**
30	Learning at least 1 year behind due to poor attention or high activity despite special accommodations	7
	Learning at least 1 year behind and is <u>not</u> known to be due to an established learning problem (e.g., mental retardation)	8
20	Achievement below average due to poor attention or high activity and special accommodations needed or implemented	14
	Achievement below average and is not due to an established learning problem	15
10	Attention problems or high activity levels are present but manageable.	20
	Fails to listen, follow instructions or routines, or do activities/tasks	21

	Attendance	**Item #**
30	Asked to leave during the rating perod due to behavior	1
	Refuses to attend (even if for "good" reason)	2
	Excessive absences	2
20	Frequently misses 10% = once every 2 weeks OR for several consecutive days	12
10	N/A	

	Problematic Behavior	**Item #**
30	Asked to leave school/daycare (for an extended time period) because of behavior during rating period	1
	Judged to be a potential threat due to actions or statements	3
	Harmed or made serious threat	4
	Unable to meet minimum requirements	5
	Still disruptive related to poor attention or hyperactivity, despite special accommodations	6
20	Persistent or repeated disruption of group activities	10,11
	Known to supervisory staff due to chronicity of problems	10,11
	Known to supervisory staff due to severity of problems	10,11
	Special accommodations are needed due to behavior problems related to poor attention or high activity level	13
10	Can be managed by classroom teacher/staff and teacher/staff brings attention to problems EX: by verbal reminder, negative consequences (i.e., time-out)	17,18
	Teacher/staff structures to prevent problems EX: child's seat is placed near staff	17,18
	Occasionally disobeys rules (more than other children) with no harm to property or people	19
	Attention or high activity problems present but not disruptive	20

Flow Chart for Behavior in School, Daycare or Childcare

30	Kicked out? Yes No → In alternative school or daycare setting? Yes No → In special program/setting & disruptive? Yes No ↓
20	Known to supervisory staff because of severity? Yes No → Known to supervisory staff because of chronicity? Yes No → In special program/ setting? Yes No → Special program/ setting recommended? Yes No ↓
10	Classroom/daycare staff identified child as behavior problem? Yes No ↓
0	

2. HOME ROLE PERFORMANCE

Expectations for Home	
Safety: Person & Property	Behaves in a safe manner Non-threatening, non-intimidating
Compliance: Rules, Routines, Chores	Follows household rules Follows expectations, routines (e.g., bedtime, picks up toys)
Non-Runaway Behavior	No runaway behavior
Eating/Mealtime	Eats age-appropriate foods without conflict

Compliance with routines and rules, following the requests of caregivers, and behaving in a way that does not jeopardize other household members are expectations within the home. In addition, behaviors indicating intent to run away from home are included in this subscale. Preschool children do not have the resources to be independent of caregivers nor to actually leave home. However, they may earnestly "try" to run away and engage in behaviors that are worrisome. Also, problematic eating behaviors, which are not due to known physical illness, are included on this subscale. Problems with eating, which are not uncommon in preschool children, are included in this subscale because typically it is at home that these problems are exhibited and are a source of conflict between parent and child.

Any behaviors that occur in the home or in any residential setting are scored on the Home subscale. "Household members" refer to other persons who share the home or residential setting. Preschoolers are seldom placed outside a home setting; however, for such situations, the rater should refer to the detailed guidelines for how to score children who spend some time in residential settings, outside of their home, which are published in the *CAFAS Self-Training Manual*.

The child is scored at the SEVERE level if, during the rating period, the child was removed from the home due to his/her "bad" behavior in the home. Other items describe the situation in which the child is living in the home but the child's behavior and activities require constant monitoring, close supervision, or extensive help from others in order for the child to remain in the home without compromising the safety or functioning of the household members (i.e., the child, caregivers, brothers and sisters [also called siblings], etc.).

Certainly aggressive and sexually inappropriate or provocative behavior in the home, which results in adults having to constantly monitor the behavior or activities of the child in order to ensure the safety of household members, would result in a score at the SEVERE level. There is also an item for children who have problems with separation to such an extent that the caregiver's ability to work or carry out other roles is impaired. At around 9 months of age, most children have strong reactions to being around strangers or being separated from caregivers, even for a little while. However, as the child matures, his/her tolerance for separations from the main caregiver increases such that the caregiver can carry out other life tasks (e.g., work) without the child being unduly distressed.

Also included at the SEVERE level is an item indicating earnest gesture at running away from home (i.e., child leaves home with the intent to "run away"). Only a situation in which the child clearly wants to be out of the home on a non-temporary basis should be scored here. At the SEVERE level for eating problems, the child refuses to eat and must be fed.

At the MODERATE level, the child is described as persistently uncooperative, disobedient, or refusing to carry out age-appropriate expectations. There is also an item describing children who are very demanding, such as children who are "hyper" to the extent they are always "on the go." Do not rate a child for noncompliance if a caregiver's requests are abusive or illegal. For eating problems, the child at the MODERATE level of impairment does not want to eat and has to be coaxed.

At the MILD level, the child is described as one who carries out expectations but requires prodding or being "watched" in order for the child to be consistently compliant. An item is included that indicates that the child will comply with the rules and expectations but the child often "balks". Intentional behavior, aimed at annoying or "harassing" the caregiver (e.g., taunts siblings; intentional dawdling), is also scored at the MILD level. Children who are frequently but not persistently disobedient are scored at this level. Also, very finicky eaters are rated at the MILD impairment level.

	 **Safety in the Home: Person & Property**	**Item #**
30	Not in the home (for an extended time period) due to "bad" behavior that occurred in the home in the rating period	31
	Potentially dangerous behavior; supervision needed	33
20	N/A	
10	N/A	

	 **Compliance: Rules, Routines, Chores**	**Item #**
30	Extensive management by others needed to be maintained in the home	32
	High degree of supervision due to potentially dangerous behavior	33
	Behavior demands constant attention (wanders away, extreme temper tantrums, destroys things)	34
	Efforts to reduce (bad) behavior are not successful	34
	Clings to caregiver, interfering with caregiver's ability to work, etc.	35
20	Persistent disobedience or uncooperativeness EX: bedtime, brushing teeth	39
	Persistent failure to follow rules or instructions	40
	Persistent refusal to meet age-appropriate expectations. EX: pick up toys	41
	Markedly disobedient for several days at a time (otherwise often adequate)	42
	Consistently demanding behavior (always "on the go")	43
10	Frequently fails to comply	46
	Has to be "watched" or prodded to get compliance	47
	Frequently frustrates caregiver. EX: purposeful dawdling, following caregiver	48
	Insists on caregiver's help for age-appropriate tasks	49
	Frequently "balks" or resists but will comply if caregiver insists	50
	Upset if an adult is not paying attention or interacting with him	51

	 **Runaway Behavior**	**Item #**
30	Leaves home with the intent to "run away"	36
20	N/A	
10	N/A	

	 **Eating/Mealtime**	**Item #**
30	Must be fed due to refusal to eat or not eating	37
20	Must be coaxed due to not wanting to or not eating	44
10	Very finicky about eating	52

3. COMMUNITY ROLE PERFORMANCE

Expectations for Community	
Obeys Laws	Obeys laws Does not put others at risk
Respects Property	Respects property of others or public property
Appropriate with Peers	Associates with "good kids" Avoids gang members and (older) children involved in illegal activities
Refrains from Particularly Offensive Acts	Refrains from: Inappropriate sexual behavior Fire-setting (anywhere – even in the home)

Laws exist in order to establish the rules that all persons are expected to obey so that the community at large can feel comfortable. Young children typically are not involved in illegal or delinquent acts. Thus, most children will be rated at the Minimal or No Impairment level. However, the scale is included in this version for young children because some children are engaged in these activities at a young age or are already modeling after older, delinquent youths.

Inappropriate sexual behavior is rated on this subscale. *Inappropriate sexual behavior* is defined as sexual behavior that violates social norms and is displayed publicly or is directed toward another person. Examples include exposing oneself in public or purposefully fondling oneself in front of another person. Do not score these items if the child's only role was as a victim (Burchard & Bruns, 1993). However, it is not uncommon for young children who are sexually abused to become perpetrators against even younger children.

Stealing property is rated as long as the child knew that stealing is wrong. Property damage outside the home and fire-setting refer to intentional acts; do not score accidents or acts solely due to carelessness. Damage to the belongings of household members or to the home (or agency, if child is in a placement) is rated on the Home subscale. However, if a police report is made, it would also be scored on the Community subscale.

You score the child on this subscale if there is good reason to believe the child is engaging in delinquent-like activities, based on reports by the child, caregiver, or other persons knowledgeable about the child. An example situation would be the case in which a caregiver is convinced that the child is shoplifting based on having seen goods in the child's room that were not purchased and for which there is no believable explanation. If the rater feels uncomfortable with scoring unconfirmed reports of delinquent-like behavior, the rater can endorse the relevant item as well as "Exception," citing in "Explanation" that it is an unconfirmed suspicion. It is important to rate delinquent behavior even without legal involvement because most acts are covert and undetected, and charges are often not pressed for a variety of reasons. Association with delinquent children is known to put a child at a greater risk for delinquency. Treatment will be different for children who are at-risk for delinquent-like behavior and, in particular, will include close parental monitoring.

At the SEVERE level, the child may be directly involved in delinquent-like acts (e.g., stealing) that could lead to confinement if older, or they may be associating with, or doing favors for, older children who are likely involved with illegal activities or gang activities. Score at the SEVERE level if child is mandated to receive court-ordered treatment or services for sexual, aggressive, or delinquent behavior.

At the SEVERE level, separate items refer to severe vandalism (i.e., property damage outside the home), repeated stealing, deliberate and malicious fire-setting (i.e., wanted to burn property or hurt a person), and inappropriate sexual behavior. To rate a young child on the community subscale for inappropriate sexual behavior, there should be evidence to suggest that the child is at risk for abusing other children or that the behavior is viewed as very odd or offensive by others.

At the MODERATE level, less serious delinquent-like behaviors are included, such as shoplifting or defacing property. These behaviors are described as occurring on more than one occasion and would be considered delinquent if older. Another item describes the child as choosing playmates and friends who get into delinquent-like trouble. Fire-setting at this level is characterized by "repeatedly and intentionally plays with fire, such that damage to property or person could result." Inappropriate sexual behavior at this level results in adults being concerned about the safety of other children if they are around the child while unsupervised.

At the MILD level, comparatively minor and less frequent behaviors are included. Minor problems that are not resolved satisfactorily are described at this level as well as sometimes associating with children who get into serious trouble. Playing with matches or fire on more than one occasion appears at this level. Fire-setting in any setting, including home, is included on the Community subscale because it presents a potential severe risk to the community.

	Obeys Laws	Item #
30	Committed acts that would result in confinement if older	63
20	Committed acts (>1) that would be considered delinquent if older (e.g., shoplifting)	67
10	Minor problems not resolved satisfactorily (i.e., repeats minor act after told it was wrong/illegal). EX: stealing candy	72

	Respects Property	Item #
30	Repeatedly stole property or money outside the home	61
	Deliberate & severe damage to property outside home	64
20	Committed acts (>1) that would be considered delinquent if child were older. EX: vandalism	67
10	Minor problems not satisfactorily resolved (i.e., repeats minor vandalism or after previously being corrected for doing so)	72

	Appropriate Peers	Item #
30	Associates or hangs around with older children who are likely involved in illegal or gang activities	59
	Does favors or tasks for older children who are likely involved in illegal or gang activities	60
20	Often chooses to play with children who get into delinquent-like trouble	68
10	Sometimes plays with children who get into serious trouble	73

	Sexual Misconduct/Mistrust	Item #
30	Does or attempts inappropriate sexual acts with children (N/A if victim only)	62
20	Sexually inappropriate such that adults have concern about welfare of other children who may be around the child unsupervised	69
10	N/A	

	Fire-setting Behavior	Item #
30	Deliberate fire-setting with malicious intent	65
20	Repeatedly & intentionally plays with fire such that damage to property or person could result	70
10	Plays with fire on more than one occasion	74

4. BEHAVIOR TOWARD OTHERS

Expectations for Behavior Toward Others	
Free of Unusually Offensive Behaviors	Able to interact with people and animals Meets expectations for behavior (i.e., not aggressive, bizarre, or sexually provocative)
Interactions Free of Negative, Troublesome Behaviors	Has age-appropriate skills for relating to peers and adults

The intent of this subscale is to assess patterns of behavior that are social or interpersonal in nature. Rate the child's behavior toward peers (other children), caregivers, other adults or persons in the community, siblings, and animals (if cruel to animals). Because it is not unusual for siblings to argue or have conflict, you would only score behavior with siblings on this subscale if it was atypical and characterized by emotionally abusive or dangerous behavior. For items referring to quality of interpersonal interactions, generally one looks for a *pattern of behavior*.

Inappropriate sexual behavior is rated on this subscale (see Community subscale guidelines for definitions). The rater must be careful in rating these items dealing with sexual activity because children in this developmental stage (4 through 7 years old) are learning about their bodies and are learning the "rules" about proper behavior (even if it doesn't make sense to them). It is not uncommon for children to explore bodies with other children (e. g., play "doctor"). In order to rate the child on these items of a sexual nature, the child's behavior, given the child's age and the circumstances, should be seen as inappropriate to most people. Note that the two items dealing with sexual behavior specify that the behavior should be directed toward another child (for SEVERE) or displayed in public or directed toward others (for MODERATE). Do not rate for behaviors done privately (i.e., by oneself). It is not uncommon for children who have been abused themselves to act out these behaviors with other children and for this behavior to persist despite educating the child. Example behaviors include sexualized play (e.g., mimicking movements suggesting sexual intercourse) or making provocative gestures or remarks. Thus, it can be a major problem for children in foster care, etc. because adults do not feel comfortable allowing the child to be with other children while unsupervised.

Physical cruelty to animals is included in this subscale. To be considered animal cruelty, the actions must be intentional (excluding sport hunting), although the animal

does not necessarily have to have been killed or injured as a result of the cruelty (Burchard & Bruns, 1993).

When rating "rough and tumble" behavior, it is important to get details. Relevant issues include:

- Was there a difference in size or age (i.e., one child could easily be hurt by the other)?
- Was the initiation of the activity mostly mutual (i.e., both children wanted to "horse play"?
- Did the activity break up on its own or was intervention from others needed?
- Was anyone hurt?
- Was anyone genuinely scared, surprised, or alarmed?

At the SEVERE level, the child may be perceived as consistently bizarre. An example would be a severely impaired autistic child who primarily interacts with inanimate objects and has no understandable verbalizations. Also scored at this level is a child who is potentially so dangerous that *harm to others is likely*. The child may have been sexually inappropriate toward another child, or he/she may have been deliberately and severely cruel to animals. Extreme social isolation/withdrawn behavior also appears at this level. However, it is typical for children to engage in "parallel play" at this age, meaning they play in the company of other children but may not play cooperatively (e. g., taking turns).

At the MODERATE level, the child may be considered to be frequently or typically inappropriate. The child may have been sexually inappropriate, or he/she may have been frequently mean to animals or other people. Numerous items refer to behaviors that characterize problematic relationships with adults, such as inappropriate behavior, acting spiteful (i.e., purposefully annoying), and having angry outbursts directed toward others. Impairment in relationships with peers (i.e., other children of about the same age) are described in other items. Having interactions with peers that are predominantly negative (e.g., grabbing, teasing), associating with "bullies," or preferring social isolation are all examples of impairment in peer relations described on this subscale.

Items at the MILD level describe various ways in which a child is experienced as being difficult, including: pouting or sulking a lot, getting upset if frustrated or criticized, easily annoyed, staying upset for an unusually long time, and being quick-tempered. Items describing relationship with peers include: is overly timid, is very bossy, has trouble sharing, engages in excessive "rough and tumble" play, tends to be ignored or rejected by peers, demonstrates immature behavior, and irritates peers.

	 **Unusually Offensive Behaviors**	**Item #**
30	**Bizarre Behavior** Consistently bizarre or inappropriate. EX: an autistic child who has no social verbalizations and whose behaviors are experienced as unpredictable and scary to other children	80
	Aggressive Behavior So disruptive or dangerous that harm to others is likely (i.e., hurts or tries to hurt others, such as hitting, biting, throwing things at others, using or threatening to use a weapon or dangerous object)	81
	Sexual Behavior Inappropriate behavior of a sexual nature toward another child (despite having been told that behavior is inappropriate)	82
	Cruelty/Meanness Deliberately cruel to animals	83
20	**Aggressive Behavior** Behavior frequently & typically inappropriate causing problems for self or others. EX: starts fights, aggressively grabs toys from other children	86
	Sexual Behavior Persistently inappropriate sexual behavior in the presence of others or directed toward others. EX: deliberately plays with sex parts, provocative gesturing and posturing toward others	87
	Cruelty/Meanness Frequently mean or nasty to other people Frequently mean or nasty to animals	90 90
10	N/A	

	Negative, Troublesome Interactions	Item #
30	No age-appropriate peer interactions due to deficit in ability to relate to others	84
	Always plays alone	84
	Avoids interacting with other children	84
20	**Defiant**	
	Behavior frequently & typically inappropriate causing problems for self or others. EX: belligerence	86
	Hostile	
	Deliberately & persistently annoying to others	88
	Deliberately provokes conflicts or problems	88
	Anger	
	Displays of anger or temper; angry outbursts	89
	Problems Specifically with Peers	
	Associates with children who engage in bullying or harassment of others	91
	Persistently antagonizes other children (e.g., bullies, grabs toys, teases, shoves, purposefully knocks over or damages others' toys)	92
	Prefers to be alone or play alone even when there are opportunities for peer play (atypical for age)	93
10	**Child is Difficult**	
	Unusually quarrelsome, argumentative or annoying to others	95
	Temper tantrums or outbursts if cannot have or do something, if frustrated, or if criticized	96
	Quick-tempered, easily annoyed by others & responds more strongly than other children	97
	Pouts, sulks, or acts stubborn a lot	101
	Stays upset for unusually long periods after not getting own way	105
	Problems Specifically with Peers	
	Difficulties in peer interactions due to negative behavior (e.g., teasing, bullying)	98
	Immature behavior leads to poor interaction with peers	99
	Stays upset or overreacts to other children's teasing, etc.	100
	Has trouble sharing	102
	Very bossy in play with others	103
	Excessive "rough and tumble" play	104
	Does not engage in typical recreation activities because ignored or rejected by peers	106
	Does not engage in typical recreation activities because overly timid or withdrawn	107

5. MOODS/EMOTIONS

Expectations for Moods/Emotions	
Depression	Depression, sadness, moodiness or irritability may be experienced but is short-lived and is managed so as to prevent extended negative impact
Anxiety	Anxiety, fears, worries, tenseness or panic feelings may be experienced but are managed so as to prevent extended negative impact
Regulation of Emotional Expressiveness	Free of clinically high or low levels of reactivity
Non-Bizarre Emotional Reactions	Others do not experience the child as having bizarre moods

The moods and emotions included in this subscale could be described as "internalizing" symptoms. "Externalizing" symptoms such as anger and hostility are *not* rated on this subscale. Anxiety may be expressed as fear, worry, tenseness or panic in this subscale. Indications of anxiety can be manifested in several contexts, including: anxiety when not physically near caregivers, excessive anxiety and worries, intense fear, and other manifestations that developed in response to being exposed to a traumatic event (e.g., in which there was actual or threatened death or serious injury).

Depression may be expressed as sadness, moodiness, feelings of worthlessness, irritability, fatigue, hopelessness, despair, or anhedonia. *Anhedonia* is defined as a markedly diminished interest or pleasure in all, or nearly all, activities most of the day, nearly every day. When a person feels anhedonic, he/she has markedly less interest in doing things that he/she usually does (e.g., playing games). In a preschool child, this might be observed as lack of pleasure or joy in things in which the child had previously taken delight (e.g., favorite foods, favorite cartoons, social interactions with familiar persons, familiar fun rituals or "jokes," etc.).

Moodiness and irritability are not uncommon. However, when there is disruption of the activities of daily life, impairment in functioning is suggested. Areas of functioning that may be disrupted by anxiety, depression, and their related expressions include: sleep, eating (i.e., disinterest, finicky eater, refusal), energy level (i.e., feels tired), concentration, and enjoyment of normal activities. "Normal" activities of daily living would include activities that are typical for the individual child (e.g.,

playing Legos, collecting stickers or cards, playing dress up or fantasy play, going to the park, etc.).

In order to endorse an item under either anxiety or depression, there should have been a *change* in the child's functioning. For example, the child used to be able to sleep okay, but a change has taken place and now the child has trouble sleeping. Following this logic, a child with Attention Deficit-Hyperactivity Disorder (ADHD) who has poor concentration would not qualify as depressed based solely on this behavior because the child's problems with attention should reflect a change to "count" towards depression (i.e., the child previously had better or satisfactory attention span). However, in order to rate the child, it is *not* a requirement that this change must have taken place within the rating period. In other words, the onset of depression, for example, may be prior to the rating period.

Some preschool children show classic signs of depression or anxiety, while, for other children, poor regulation of emotional expression is observed. Variability in mood is normal for young children, and, compared to older children, they can react strongly to changes in their environment. Thus, it is important to compare the child to other children about the same age. When poor regulation is observed in young children, the reason for it may not be known until after considerable work with the child or the family, although sometimes it is clearly related to known trauma or loss of loved ones. Of the items that reflect on this dysregulation, some describe very high reactivity and others describe markedly low levels of emotional responsiveness.

A child may be scored at the SEVERE level if his/her emotional expressions are incongruous (with what the child is saying or with reality) or inappropriate most of the time, and, as a result, others view the child as odd or strange. This type of behavior can be observed, for example, in a child with autism or psychosis.

Also scored at the SEVERE level is a child who is depressed *and* has suicidal *intent*. *Suicidal intent*, defined as a *genuine* desire to die, is scored at this level. Note that sometimes a child really wants to die but makes a suicidal attempt that is not very lethal (i.e., not likely to result in death). Young children can talk of wishing they were dead (i.e. suicidal wish), however, because of their age, they have few opportunities or resources for acting on their wishes. Score on the basis of the child's motivation (i.e., wish to be dead) rather than on lethality of the method.

For depressed mood (in the absence of suicidal intent) and anxiety to be scored at the SEVERE level, a child's overall functioning must be significantly impaired due to either depressed mood or anxiety, worrying, etc. Evidence of this high degree of impairment would be seen in academic or social roles, such as: absences from school (on average, at least one day a week); poor performance or not able to complete schoolwork or daycare activities (e.g., a craft project); or social withdrawal (i.e., does not want to play with friends or does not want to visit a friend at his/her house); or refusal/disinterest in eating.

Two items at the SEVERE level refer to separation anxiety. One item states that the child expresses marked distress (i.e., acts upset, panicky, cries, extremely withdrawn) upon being away from his/her parent figure to attend school, visit friends, etc. Another item describes excessive absences from school/daycare (on average, at least one day a week) due to a desire to be with the caregiver.

At the MODERATE level, the different contexts for the expression of moods are discussed separately. There is one item that is concerned with depression, another that specifically addresses general anxiety or being overly anxious or worried, and one that is concerned with manifestations of separation anxiety. The MODERATE item concerned with depression requires: (1) depressed mood or sadness that is persistent (stable over time, experienced at least half of the time) and (2) the individual exhibits some disturbance in functioning in at least <u>one</u> of the following areas: concentration, sleeping (i.e., either too much or too little sleep; problems falling asleep or staying asleep; early morning awakening), eating (i.e., an increase or a decrease in appetite), energy level (i.e., fatigue or loss of energy), or enjoying normal activities (i.e., play activities, responsiveness in social interactions, etc.). When depressed mood or sadness is not directly observed, then symptoms of *irritability* or *anhedonia* can be signs of depression in children (i.e., depression is inferred). When irritability or anhedonia are observed (but not depression or sadness), then disturbance in at least *two* or more of the above mentioned areas of functioning are required. This is a more stringent standard because some children may be irritable or anhedonic without being depressed. For example, children with a behavior disorder may become irritable only when they do not get their way, with no other evidence of depression.

In the item on generalized anxiety, requirements to meet the criteria for the item include: (1) child's worries are excessive (i.e., too much given the situation, out of proportion), (2) persistent (i.e., stable over time; worries at least half of the time), and (3) there is some disturbance in functioning manifested by at least one of the following: sleep problems (i.e., too little or too much, restless sleep,

difficulty falling asleep or staying asleep; early morning awakening), tiredness (i.e., easily fatigued), poor concentration, irritability, muscle tension, or feeling "on edge" (restless, "keyed-up"). "Feeling on edge" is not the same as hyperactivity; it is more like how one feels when one is easily startled or notices everything due to "hyper-alertness" (i.e., hypervigilance).

The item at the MODERATE level concerned with separation anxiety is for children who are very worried about being away from their parent or primary caregiver. However, at this level, these children can eventually be consoled. Also at the MODERATE level are extreme fear or tenseness related to anxiety and persistent self-criticism or feelings of worthlessness.

At the MILD level, emotional states may be disproportionate or easily evoked. They may be observed in one setting for several days (but not longer), and they may be accompanied by relatively mild symptoms, such as stomachaches or nightmares. The child's emotions are less intense and relatively short-lived. At the MILD level, low levels of impairment may be present (i.e., teacher reduces complexity of instructions for a child whose anxiety results in the child asking the teacher for reassurance even when the assignment is done correctly).

Three items on this subscale are concerned with dysregulation of emotional expressiveness in the direction of less responsiveness. These behaviors are sometimes observed in children who have been victims of abuse or have suffered a trauma (e.g., witnessing violence, natural disaster). Children who have been abused or traumatized can express feelings in a variety of ways, however, it is not uncommon for them to have trouble expressing feelings at all. Thus, items are included for this very purpose. At the SEVERE level of impairment, there is an item called *emotional blunting* that refers to the child having few or no signs of emotional expression (i.e., flat emotionally). At the MODERATE level, *emotional restriction* (i.e., substantially reduced intensity of emotional expression) is described as having difficulty expressing strong emotions such as fear, hate, love, etc. To score these items, the rater needs information from informants other than the child (e.g., the caregiver) to document that the child's emotional expression during the interview is not specific to the situation (e.g., the interview), represents a definite change from how the child used to be, and was associated with abuse or trauma. This is a particularly important point when interviewers are from a different cultural or ethnic subgroup than the child being interviewed. At the MILD level, an item refers to a child not expressing joy or playing energetically. This item may also describe a mildly depressive mood in children.

Other items describe the other end of the continuum – highly reactive children who cannot be readily comforted. High reactivity, or agitation, may be seen in very young children, in children with a reactive temperament, or, in some cases, in abused children. These children often overreact emotionally and cannot be consoled (at the SEVERE level) or are difficult to console (at the MODERATE LEVEL). At the SEVERE level, two items describe high reactivity. The first describes a child with anxious or depressed mood who cannot be comforted or pleased. The second describes a child who cries a lot (with no physical explanation) and cannot be consoled. At the MODERATE level is an item describing emotional "flare-ups" or marked changes in moods that are generally intense and abrupt and are meant to reflect *abnormal* variability. This item is intended to capture relatively affective instability or reactivity of mood related to anxiety and depression. At the MILD level are items depicting a reactive child who overreacts relative to children his/her age or has frequent nightmares or awakenings.

	 **Depression, Sadness**	**Item #**
30	Depression with failure to do school/daycare activities (e.g., play, crafts, etc.)	117
	Depression with refusal to eat/disinterest in eating	117
	Depression with social incapacitation = marked disinterest in other children	117
	Depression with suicidal intent (regardless of lethality)	118
	Looks unhappy or sad most of the time; nothing seems to please or comfort the child	119
20	Depression is persistent (i.e., half the time) with difficulty in one or more: Sleep problems Eating problems Difficulties concentrating Energy level Normal activities = anhedonia	126
	Irritability or anhedonia with 2 or more: Sleep problems Eating problems Difficulties concentrating Energy level Normal activities = anhedonia (if irritability only)	126
	Persistent self-criticism, feelings of worthlessness	127
10	Often sad, with related symptoms. EX: nightmares, stomachaches	131
	Disproportionate irritability	132
	Sad, withdrawn or hurt if criticized	134
	Sad, depressed or anhedonic in at least one setting for up to a few days at a time	135
	Never plays energetically or expresses joy or delight	136

	 **Anxiety or Separation Anxiety, Fear, Worry, Panic, Tenseness**	**Item #**
30	Marked distress when separated from caregiver and cannot be consoled	115
	Fear, anxieties, or desire to be with caregiver leads to poor attendance at school or daycare (absent ≥1 day/week on average)	116
	Looks very anxious most of the time; nothing seems to please or comfort the child	119
20	Overreacts to being away from caregiver but can be eventually consoled	123
	Extremely tense or fearful (e.g., overacts to noises)	124
	Worries persistent and excessive, with 1 or more: Sleep problems Tiredness Difficulty concentrating Irritability Muscle tension Feeling on edge ("keyed-up")	125
10	Tends to be anxious, fearful, with related symptom. EX: nightmare, stomachaches, trouble with sleep	131
	Disproportionate fears, worries	132
	Easily distressed if makes mistakes	133
	Anxious if criticized	134
	Anxious in at least one setting for a few days at a time	135
	Too worried about neatness, cleanliness	137
	Child has nervous habits (e.g., scratching or twitching)	138

	 **Poor Regulation of Emotional Expression** ▪ **High Reactivity** ▪ **Less Responsiveness**	**Item #**
30	**High Reactivity** Looks unhappy, sad, or anxious most of the time; nothing seems to please or comfort the child Cries a lot (with no physical explanation) and cannot be consoled **Less Responsive** Emotional blunting = no or few signs of emotional expression; emotional expression is markedly flat	 119 120 121
20	**High Reactivity** Has emotional flare-ups frequently but not most of the time (e.g., sobbing uncontrollably, outbursts that are difficult to control or deflect) **Less Responsive** Notable emotional restriction = has difficulty expressing strong emotions such as fear, hate, love	 128 129
10	**High Reactivity** Overreacts compared to other children; disproportionate expression or irritability, fear, or worries Frequent nightmares or awakenings (≥2 times/week) Overreacts to changes in schedule or routine **Less Responsive** Never plays energetically or expresses joy or delight	 132 139 140 136

	 **Bizarre Emotional Reactions**	**Item #**
30	Viewed as odd or strange because emotional responses are incongruous (unreasonable, excessive) most of the time. EX: laughs oddly when apparently sad. EX: "has no mood" that others can relate to (as seen in autism)	114
20	N/A	
10	N/A	

6. SELF-HARMFUL BEHAVIOR

Expectations for Self-Harmful	
No Self-Harmful Behavior	Child is free from desires and attempts to hurt him/herself Child can cope without resorting to self-harmful behavior or verbalization

A separate subscale is provided for recording self-harmful behavior because this type of behavior may occur in the absence of manifest depression. Self-harmful behavior refers to non-accidental behavior that could result in harm to self, such as suicidal behavior or gestures and self-mutilation. *Harming oneself* refers to causing pain or injury to oneself. The modifier "*non-accidental*" is used because the act could be clearly intentional or, in younger children, done without much awareness. *Suicidal intent* is defined as a genuine desire to die, while *lethality* refers to the likelihood of dying, given the method chosen to inflict self-injury.

Younger children often have few highly lethal means available to them. Thus, it is important to inquire about the true intent of their actions. Also, younger children may not make any spontaneous verbalizations about wanting to hurt themselves, yet their intent could have been to cause self-harm. An example would be a child who purposely opens the door of a moving vehicle, with the intent of falling out and hurting him/herself. The term "*seemingly non-intentional*" self-destructive behavior is used to describe this type of behavior. Careful interviewing of the child reveals their feelings of hopelessness, not wanting to live anymore, or not "caring" whether they live or die. Do *not* score acts if the child was truly unaware of the potential danger, if the child was truly "kidding around," or if the act was really accidental.

At the SEVERE level, the child may have engaged in self-destructive behavior that could have resulted in serious self-injury. Examples include: a clear suicide attempt and possible life-threatening acts **OR** non-life-threatening acts **AND** the child wanted to die. Thus, you score at the SEVERE level if there is suicidal intent (i.e., really wants to die), regardless of lethality of method. If the self-harmful behavior is accompanied by suicidal intent or incapacitating depression, then the appropriate item listed under the Moods/Emotions subscale should be marked as well. Also rated at the SEVERE level is the child who has a clear plan to hurt him/herself.

At the MODERATE level, children are scored if they have talked or repeatedly thought about wanting to die or to harm themselves. While less common in preschool

children, children who may have engaged in self-harming, non-trivial behaviors (which are not life-threatening) can also be scored at this level. This is sometimes seen in older children who are known to self-mutilate. In these cases, the treatment team has decided that hospitalization for suicide risk is not indicated (unless atypical circumstances occur).

At the MILD level, behaviors are included that are very unlikely to result in harm and could be regarded as trivial or superficial (e.g., superficial scratches, pinching self). These behaviors are repeatedly performed and seem to imply a desire to harm oneself. Often these types of behaviors are done without much awareness (as if a habit).

On this subscale, you can rate behaviors that are extremely dangerous if psychiatric hospitalization for them is typical (e.g., head-banging as sometimes seen in autism or with organicity; anorexia; or dangerous behavior as sometimes seen in psychosis or organicity [i.e., the child does not realize the danger of acts]).

	 **Self-Harmful Behavior**	**Item #**
30	Non-accidental self-destructive behavior – potential for or did self-injury EX: Suicide attempt with intent to die EX: Persistent head-banging	150
	Seemingly non-intentional self-destructive behavior – potential for or did self-injury & child aware of the danger (for a younger or inarticulate child making suicidal attempts, may use unsophisticated or incompetent methods) EX: Opens car door in moving vehicle EX: Runs out in the path of a car if street smart	151
	Has a clear plan to hurt self, even if impractical or non-lethal	152
	Has a genuine desire to die (suicidal intent, regardless of whether an attempt was made & regardless of lethality of method)	152
20	Non-accidental self-harm, mutilation, or injury which is non-life-threatening & non-trivial EX: suicidal gestures without intent to die	154
	Talks about harming self, killing self, or wanting to die	155
	Thinks about harming self, killing self, or wanting to die	155
10	Repeated non-accidental behavior suggesting self-harm, yet behavior is very unlikely to cause any serious injury EX: repeatedly pinching self EX: scratching skin with a dull object	157

7. THINKING/COMMUNICATION

Expectations for Thinking/Communication	
Communications	Communications are logical and coherent
Perceptions	Perceptions (i.e., what you see, hear, feel, smell, taste) are based in reality
Cognitions	Cognitions (thinking) are based in reality

The main intent of this subscale is to identify children who have problems in thinking or in understanding what is happening around them. Because thoughts are not observable, inferences about thinking processes are typically made from a person's communications (or lack thereof) with others. Young children are still developing communication and abstract thinking skills. Items should therefore only be endorsed if the child is clearly functioning differently and more poorly than other children of the same age. Do not rate children as impaired on this scale if they have a known thinking/communication problem due solely to physical or sensory disability, speech impediment (i.e., articulation problem), or lack of familiarity with the English language. Also, a child who has documented mental retardation, and whose behaviors and thinking are similar to non-behaviorally disordered children with mental retardation, would not be scored on this subscale.

However, given that this scale is for preschool children, it is likely that, for most children, their rating on the PECFAS will be done at the time of first contact with professionals in mental health or allied fields, such as speech or occupational pathology. For these preschool children with communication problems, the diagnostic workup, which could determine whether their problems are due solely to physical or sensory deficits, etc., will not have been done yet. In fact, their scores on the Thinking subscale will likely be helpful in justifying the needed diagnostic or consultative sessions. In the situation in which the rater has identified communication or thinking problems and does not know whether they are the result of physical problems, etc., the rater should endorse the items on this subscale that describe the child's behavior. To indicate that a diagnostic workup is needed, the rater can also endorse "Exception" in the same column, and under "Explanation," write in "Evaluation needed to determine cause" or "Evaluation needed to rule in/out…"

This subscale has a slightly different structure than the others. At the beginning of each level of impairment, there is a statement describing the extent of impairment observed at the level (e.g., cannot attend a normal school

or daycare situation, etc.), followed by numerous behavioral descriptions of types of impairment (e.g., non-communicative speech, bizarre behavior). The rater decides if the extent of impairment applies to the child being rated, and, if so, chooses one or more of the listed behaviors for that level. At each severity level, the child must meet criteria for degree of impairment and for type of behavior. Various types of behaviors included in this subscale are: disorganized thinking; communication as it reflects problems in thinking or gross inability to communicate ideas; bizarre or very odd behavior (e.g., hand-flapping or fantasies); and impaired sensory perceptions due to psychiatric illness (e.g., hallucinations).

The impairment requirements for each level of severity are given in the following table. Remember that these impairment criteria are necessary but not sufficient because an item below the impairment criteria must also be endorsed (i.e., an impairment criterion and another item below it at the same level of severity are both endorsed).

	 **Thinking: Impairment Requirements**
30	Cannot attend a normal school or daycare situation, OR Does not have normal peer interactions, OR Cannot interact adequately in the community
20	Frequent problematic behavior or difficulty in interaction with others, OR Specialized setting or supervision needed
10	Occasional problematic behavior, OR difficulty in interactions with others

Some of the behaviors assessed in this subscale can be easily identified (e.g., inability to communicate, hallucinations, delusions, bizarre fantasies, etc.). However, distortions in thinking, as evidenced by obsessions or suspicions, may be much harder to rate for very young children. As a consequence, the focus of this subscale is to assess more obvious problems in thinking that interfere with the child's functioning and would be considered "pathological."

The following definitions and related guidelines for rating the different severity levels, mostly taken from the *DSM IV* (APA, 1994), are offered:

Echolalia refers to repeating words of others in a meaningless fashion.

Flight of ideas refers to a nearly continuous flow of accelerated speech with changes from topic to topic.

Incoherence refers to lack of logical or meaningful connection between words, phrases, sentences; excessive use of incomplete sentences; excessive irrelevancies or abrupt changes in subject matter; idiosyncratic word usage; distorted grammar.

Hallucinations are sensory perceptions that occur without external stimulation of the relevant sensory organ. Hallucinating typically involves an experience of hearing or seeing things that are not there. The individual may or may not recognize that he/she is having a false sensory experience. Do *not* rate as hallucinations if the sensory perceptions are: due to physical illness; related to religious or cultural beliefs; or experienced during sleep (i.e., dreaming). As a general guideline, for younger children, do not rate as hallucinations sensory experiences that occur: while dreaming, upon falling asleep, or upon awakening from sleep. “Non-pathological” hallucinations appear at the MILD level, which include unusual sensory experiences, which the child understands are "not real" at the time and occur when the child is apprehensive or very anxious. An example of a hallucination at the MILD level would be a child reporting seeing things around bedtime.

Delusions are false personal beliefs based on incorrect conclusions about external reality. They are firmly held in spite of what almost everyone else believes and in spite of what appears to be obvious proof to the contrary. The belief is not one ordinarily accepted by other members of the child's culture or subculture (e.g., it is not an article of religious faith).

Selective mutism is the persistent failure to speak in specific social situations (e.g., at school, with playmates) where speaking is expected, despite speaking in other situations. Do not score if selective mutism is limited to the first month of school.

Children who are essentially non-communicative to persons who do not know him/her well, as appropriate for their age, are scored at the SEVERE level. Do not rate on this subscale if the communication problems are solely due to: documented physical disability, speech impediment or articulation problems, hearing impairment, or lack of familiarity with English. Also at the SEVERE level are children who seem strange or bizarre to others due to delusions or hallucinations.

At the MODERATE level, the child has to have *either* frequent difficulty in communication or behavior (that is inappropriate for his/her age), OR be in need of a specialized setting or supervision. Children at the MODERATE level may have disorganized

communications or may have hallucinations (which can interfere with functioning but do not make the person seem bizarre). At the MODERATE level, there is also an item for preoccupying cognitions or fantasies with bizarre, odd, or gross themes. These recurrent thoughts or ruminations are typically bothersome to daycare staff or others who recognize that the ideas expressed are very unusual compared to other children of the same age. Frequent aimless, non-purposeful behavior also appears at the MODERATE level.

At the MILD level, the child has occasional difficulty in behavior or in interactions with others. Items at the MILD level include: eccentric or odd communications, limited ability to express self verbally, unnatural or strange ideas, and unusual perceptual experiences that are not "pathological" (i.e., do not interfere with current functioning and do not predict poor functioning in the future). Limited ability to express self verbally is included because sometimes the poor communication skills of very young children appear to be related to behavior problems. For example, the child acts "wild" whenever he feels embarrassed or scared. These items would be used for children who have impaired behavioral functioning and who have very poor verbal self-expression yet for whom no specific disability has been identified to account for the problem. Often it takes some time to determine if young children have impaired thinking processes apart from other problems.

	Odd Communications	**Item #**
30	Communications which are impossible or extremely difficult to understand due to incoherent thought or language Speech or nonverbal behavior is extremely odd & is non-communicative (echolalia, idiosyncratic language)	162 163
20	Communications do not "flow," are irrelevant, or are disorganized (i.e., more than other children of the same age)	170
10	Eccentric or odd speech (e.g., impoverished, digressive, vague) relative to other children of the same age	177

	Apparent Faulty Sensory Perceptions	**Item #**
30	Inability to distinguish fantasy from reality indicated by strange or bizarre behavior	164
20	Apparent intermittent hallucinations that interfere with normal functioning	172
10	Unusual perceptual experiences that are not pathological hallucinations. EX: sees wolves before going to sleep but knows they are not real	179

	Odd Cognitions	**Item #**
30	N/A	
20	Preoccupying cognitions or fantasies with bizarre, odd, or gross themes, given child's age	174
10	Often expresses unnatural or strange ideas for his/her age	178

	Non-Purposeful or Odd Behaviors	**Item #**
30	Most of the time involved in aimless, non-purposeful activities Repeats an idea, thought, or action over and over (e. g., rocking)	165 168
20	Frequent and strange or odd behavior (e.g., eats non-food items, smears feces) Frequently involved in aimless, non-purposeful activities	171 173

	Limited Communication	**Item #**
30	Refuses to talk or is selectively mute (and not due to documented physical or sensory disability, etc.) Does not respond when spoken to (and not due to documented physical or sensory disability, etc.)	166 167
20	Extremely limited in expressing self verbally (and not due to documented physical or sensory disability, etc.)	175
10	Limited in ability to express self verbally (more than other children of the same age) (and not due to documented physical or sensory disability, etc.)	180

Specific Guidelines for the PECFAS® Subscales Assessing the Caregiver

There are two Caregiver Scales: Material Needs and Family/Social Support. In these two categories, the caregiver is rated, not the child. Scores for these two scales should not be added to the score generated for the child on the previously described subscales.

For the Caregiver scales, the rater is asked to specify: the informant (i.e., the person who provided the information), the name of the caregiver being rated, and the caregiver's relationship to the child (e.g., biological mother, non-custodial parent, foster mother). Rating the caregiver can be problematic in some situations (e.g., the child has recently been placed in a temporary living condition (e.g., foster care) but was living with his/her parent before the placement, or the parents are divorced and the situations in the two homes are reportedly very different. Since these types of living arrangements are not uncommon for children who receive services, you may want to rate different caregivers on separate scales.

Forms for three caregivers are provided for the PECFAS: (1) Primary Family – the parent(s) who are rearing the child or with whom the child lives most of the time (e.g., biological parent, adoptive parent, where the child was before treatment and where the child will return [e.g., the grandmother's home]), (2) Non-custodial Caregiver – a parent(s) who has a psychological impact on the child yet is non-custodial or is not living in the same home as the child, and (3) Surrogate Caregiver – surrogate parent(s) (i.e., person(s) substituting as parent(s), such as foster parent(s)). Use of the Non-custodial or Surrogate Caregiver forms is optional. Two procedural decisions need to be made by the user (i.e., the agency). One is which Caregiver scales should be completed, and, if more than one caregiver is rated over time, how changes in caregiver's relationship to the child are to be handled. When tracking a caregiver over time, there are two approaches: (1) always score the same <u>person</u> on the same form (e.g., always score the mother on the "Primary Family" form); or (2) always score according to <u>function</u> (e.g., If the child was living with the mother at intake, score her on the "Primary Family" form. Then, later, if the child moved into the father's home, the father would be scored on the "Primary Family" form.)

When rating the "Primary Family," do not rate other persons living in the household who do not have major parental responsibilities or impact on the child (e.g., a grandmother who lives with the caregivers). Also, if there are two parental figures in the primary family and they differ in impairment in parental functioning (e.g., one is an alcoholic and the other is not as impaired), then the rating given on the scale should reflect the greater level of impairment (e.g., the higher impairment of the alcoholic). Also, it is important to recognize that, when informants report on caregivers other than themselves, they may not be accurate.

Note that these scales do not necessarily reflect on how "good" or "bad" a parent is. Receiving a score at the SEVERE, MODERATE, or MILD level can mean simply that the child's needs are greater than the resources available to the caregiver. For example, a parent's wages may be so low that the only home he/she can afford is in a high crime area that is unsafe for the children. Another example would be a single parent who has difficulty providing for an autistic child because he/she has several children and a low-wage job.

1. CAREGIVER RESOURCES: MATERIAL NEEDS SCALE

Expectations for Material Needs	
Material Needs	Caregiver provides food, shelter, clothing, and medical care for the child such that child's functioning and development of skills are not impeded.

Material needs include food (i.e., balanced diet), housing (i.e., a home that is free from major safety hazards, provides adequate privacy), clothing (i.e., appropriate for the weather), medical attention (i.e., immunizations, care when sick), dental care, and safety (i.e., live in a neighborhood that is reasonably safe; street violence and drug dealing are not immediately present or common). It is crucial to understand that the rating in this scale indicates the extent to which the caregiver has difficulties in providing for the child such that there is a negative impact on the child's functioning. Note that a family can be in a low-income bracket, yet the child's basic material needs are met. Obviously, a child's future options can be limited by growing up in a low-income home, however, this is not the same thing as not having one's basic material needs met. Also, a caregiver may not meet the child's needs for reasons other than insufficient money. An example would be a mother whose drug usage interferes with providing nutritious food for the children.

Safety issues related to sexual abuse or physical abuse are not rated in this scale but rather in the Family/Social Support Scale.

	Caregiver Material Needs	Item #
30	Child's needs are not being met such that severe risk to health or welfare of child is likely	185
20	Frequent negative impact on child's functioning OR a major disruption in child's functioning because needs are not being met	187
10	Occasional negative impact on the child's functioning because needs are not being met	189

2. CAREGIVER RESOURCES: FAMILY/SOCIAL SUPPORT SCALE

Expectations for Caregiver Family/Social Support Scale	
Level of Resources Available	Caregiver can satisfactorily meet the special needs of the child without jeopardizing other family members
Parental Judgment and Functioning	Caregiver exercises good parental judgment so that he/she can provide a safe, secure, and healthy home environment in which the child's developmental needs can be met
Non-Abusive Environment	Caregiver protects the child from abuse or, if abuse occurs, provides the physical and emotional support the child needs
Supervised Home	Caregiver provides a home and adequate supervision of the child's activities (whether in or outside of the home)
Conflict Management	Family environment is free of domestic violence, hostility, or pervasive conflict

"Developmental needs" refers to the child's need to receive guidance and support, appropriate to his/her age, across various life spheres (e.g., social, emotional, academic, regulation of impulses, etc.). Another factor to consider is the support available from the extended family and the community. Temporary inability of the family to provide for the child could conceivably be compensated for by sources of social and emotional support other than the immediate family. As mentioned previously, caregivers who are not living in the same household can be rated on separate forms.

The first item at each severity level states that the child's needs are greater than the caregiver's resources. At the SEVERE level, the situation is potentially dangerous; at the MODERATE level, the child's developmental needs are not adequately met; and at the MILD level, adequate warmth, sensitivity, or security are not provided. These items do not imply parental dysfunction. The child's developmental needs may be inadequately addressed solely because the child's needs/demands exceed family resources. These items can be used when the parent(s) or family is not necessarily impaired, yet the child's needs cannot be met by the resources available. The family's resources are less than those needed to care for a child with special needs, resulting in extra burdens on the family. Examples of such children may include children with disabilities, developmental delays, pervasive developmental disorders (e.g., autism), severe attention deficit-hyperactivity disorder, etc.

Items referring to "impairment in parental judgment or functioning" appear at the SEVERE and MODERATE levels. For each level, examples of conditions that can be related to severe impairment (e.g., psychoses or substance abuse) and moderate impairment (e.g., emotional instability or substance use) are provided. These parental conditions are provided as a rough guideline. Endorsement of these items does not mean that the parent has one of the listed disorders. In fact, sometimes the rater may know that the parent's functioning is impaired but not know the source of the parent's dysfunction. The conditions listed are examples of ones that typically lead to a parent failing to engage in parenting activities in an appropriate and timely manner. These activities include providing nurturance and appropriate limits as well as encouragement and assistance in learning academic and other life skills. Also note that these items refer to impairment in parental judgment. Examples would include leaving a child in the care of an inappropriate person (e.g., drug user) or leaving a young child alone in the house.

At the SEVERE level, there is an item describing the caregiver as "hostile, rejecting," or, if the child is currently out of the home, does not want the child to "return to the home." This item is intended to rate caregivers who feel rejecting or hostile toward the child and/or do not look forward to the child returning if he/she is currently out of the home. The wording "return to the home" was specifically chosen. This item would not necessarily be endorsed if the parent indicated that at the present time he/she could not safely care for the child in his/her home or temporarily needed respite care. *Respite care* refers to an arrangement whereby the child and the caregivers have temporary "relief" from each other. It can take many forms, including the child spending

overnight(s) in another home (e.g., foster care) or a paraprofessional staying in the home overnight to attend to the child. Termination of parental rights would be rated at the severe level. The similar item at the MODERATE level refers to the caregiver as being insensitive, angry, or resentful of the child.

Inadequate supervision by the caregiver is reflected in items that refer to contributing to delinquent-like behavior at the SEVERE level and inadequate supervision, firmness, or consistency of care at the MODERATE and MILD level. "Supervision" refers to knowing or monitoring what the child is doing. Obviously, the type and extent of supervision expected of the caregiver varies depending on the child's age and developmental level.

Severe or frequent domestic violence (i.e., physical violence or serious threat of violence against a caregiver in the home) is scored at the SEVERE level, while presence of domestic violence or threat of it appears at the MODERATE level. Items reflecting poor management of family conflict (i.e., conflict is pervasive and continuous) are included at the MODERATE level, and items reflecting poor family relationships (e.g., frequent arguments) and poor family functioning (e.g., poor communication) are included at the MILD level. These items would also be scored if the conflict were marital.

Abuse of Child: Several items at the SEVERE level of impairment describe situations relevant to abuse. There are two items that specify "abuse by a caregiver": one for sexual abuse and the other for physical abuse or neglect. In addition, since the abuse may have happened before the time period covered by the PECFAS, there is an item that refers to the child being out of the home due to abuse or neglect. You should mark this item even if the abuse has not been substantiated, as long as the child is currently removed. Also, note that this item does not stipulate that the abuse was by a caregiver. Sometimes when an abused child is not removed from the home (or has been returned to the home), he/she receives little protection and/or support from the caregiver providing for him/her. The alleged perpetrator may even be in the home at times, resulting in the child feeling very unsafe. An item at the SEVERE level specifically describes this situation, in which the caregiver fails to provide a safe environment. In addition, at the MODERATE level of impairment, an item describes the situation in which a caregiver fails to provide emotional support to a child who has been abused. The alleged perpetrator could be a family member or someone outside of the immediate family (e.g., neighbor, friend of the family, cousin). If a caregiver was severely, emotionally abusive to a child who has been sexually abused (e.g., calling the child a "slut" or "bitch"), then the caregiver could be scored at the SEVERE level.

	 **Level of Resources Available**	**Item #**
30	Sociofamilial setting is potentially dangerous to the child due to lack of family resources required to meet the child's needs/demands. EX: Caring for a child with autism, other pervasive developmental disorder, or psychosis, with limited resources	195
20	Child's developmental needs cannot be adequately met	206
10	Family not able to provide adequate warmth, security, or sensitivity	214

	 **Parental Judgment and Functioning**	**Item #**
30	Gross impairment in parental judgment or functioning. EX: psychosis, substance abuse, severe personality disorder, mental retardation	196
	Caregiver is openly involved in unlawful behavior or contributes to or approves of child being involved in potentially unlawful behavior	203
20	Marked impairment in parental judgment or functioning. EX: emotional instability, psychiatric illness, substance use, physical illness	207
10	N/A	

	 **Supervised Home**	**Item #**
30	Caregiver does not want child to return to the home	197
	Marked lack of parental supervision or consistency in care. EX: Frequently does not know the whereabouts of child, does not know the child's friends	204
20	Not able to provide adequate supervision or consistency in care over time	212
10	Not able to provide adequate supervision, firmness, or consistency in care over time	217

	 **Non-Abusive Environment**	**Item #**
30	During the rating period, child is subjected to sexual abuse in the home by a caregiver	198
	During the rating period, child is subjected to physical abuse or neglect in the home by a caregiver	199
	Child currently removed from the home due to sexual abuse, physical abuse, or neglect. (Initiation of removal may have been prior to current rating period.)	200
	Failure of caregiver to provide an environment safe from possible abuse for a child who has been previously abused or traumatized. EX: Parent allows a friend, who has a history of sexual offending, to babysit child; allows abuser near the child when contraindicated	201
	Parents' rights terminated	Except.
20	Failure of caregiver to provide emotional support to child who has been traumatized or abused	210
10	N/A	

	 **Family Violence or Conflict Management**	**Item #**
30	Frankly hostile, rejecting to child	197
	Severe or frequent domestic violence	202
20	Domestic violence or serious threat of domestic violence	211
	Conflict is pervasive (across areas) and continual (chronic) EX: hostility, tensions, scapegoating	208
	Family members are insensitive, angry, and/or resentful to the child	209
10	Frequent family arguments and/or misunderstandings resulting in bad feelings	215
	Family relations are characterized by poor problem solving, poor communication, or emotional insensitivity	216

Notes About Scoring the Same Behavior on More than One Subscale

Generally, the rater decides which scale a behavior relates to and scores that scale accordingly. However, there are some behaviors, because of their strong quality, which have implications for more than one subscale or area of functioning. The more common examples of this situation are mentioned here.

Extremely aggressive behavior may be scored on the Behavior Toward Others subscale as well as any of the Role Performance subscales (i.e., School/Daycare, Home, or Community). Aggression in the school or home is <u>not</u> scored on the Community subscale unless it resulted in involvement of the police or legal system or diversion to other services. Aggression in the neighborhood or in the larger community would be scored on the Community subscale.

Sexual assault, or inappropriateness, would be scored on the Behavior Toward Others subscale as well as on any of the Role Performance subscales (i.e., School/Daycare, Home, or Community). If the child's sexually aggressive behavior resulted in exclusion from school, daycare, or childcare settings during the rating period, then the School/Daycare subscale would be scored at the SEVERE level. If the child's sexually inappropriate behavior took place in the home, resulting in removal or the need for constant monitoring in the home during the rating period, then the Home subscale would be scored at the SEVERE level. Sexually inappropriate behavior would be scored on the Community subscale if there was legal involvement (including court ordered treatment), or if legal involvement was purposefully avoided and the child diverted to mental health or social services.
Most children with pervasive and seriously impairing disorders (e.g., Autism, other pervasive developmental disorders, Schizophrenia, Schizotypal Personality Disorder) would likely receive a high impairment score on at least Thinking, Behavior Toward Others and probably School/Daycare as well as potentially other subscales.

Children who are not attending school, or are not in daycare or childcare settings due to fearfulness, a strong desire to stay with parental figure(s), or because of trauma suffered at school or daycare would be scored on the School/Daycare subscale and on the Moods/Emotions subscale. A very depressed child may also be rated on the School/Daycare subscale due to absences or poor performance.

Important Notes About Scoring the PECFAS® When Children are in Residential Care

It is much less common for young children between the ages of 4 and 7 to be placed in residential care than older children. Instructions for scoring children when in residential care are therefore included in the *CAFAS Self-Training Manual*.

ADDITIONAL SCORING CRITERIA FOR CHILD WITH SPECIAL NEEDS OR IN SPECIAL PROGRAMS

Supplementary scoring criteria for specific conditions are available in the *Manual for Training Coordinators, Clinical Administrators, and Data Managers.* Of particular relevance to preschoolers are the suggested items (and severity levels) that are given for children with developmental delays and for children displaying inappropriate sexual behaviors.

If you have any questions or suggestions for improving these instructions, please feel free to contact the author.

Vignettes® to Demonstrate Scoring

Case vignettes are presented. Each vignette is followed by a completed scoring form and profile. The vignettes provided describe disguised case summaries.

The scoring form is organized so that it provides space to record the following information for each scale: severity score (e.g., 30), item number from the PECFAS® items (e.g., 156), and Rationale for the scoring (e.g., expelled from preschool for biting other children).

In the cases where a non-custodial caregiver should also be rated, scoring lines for both caregivers are included on the form.

#1 — TIFFANY

Background

Tiffany is a 4-year-old girl. Tiffany has always lived with her grandmother as her primary caregiver. Her biological mother left the household soon after she was born, leaving Tiffany to be raised by her grandmother. In the past month, Tiffany's grandmother has been admitted to the hospital for a serious heart condition. Tiffany is staying with her aunt while her grandmother is in the hospital.

School/Daycare

Tiffany's preschool teacher states Tiffany is generally a delightful and affectionate child who gets along well with the other children in the class. Her teacher mentioned that since Tiffany's grandmother has been in the hospital, Tiffany seems a little more subdued and has begun sucking her thumb. The teacher says she has tried to give Tiffany some additional attention to get her through this difficult time in her life.

Home

The aunt reports Tiffany is behaving well at home. The aunt is trying to keep Tiffany's routine as normal as possible, despite the grandmother's absence. Tiffany frequently asks when her grandmother will be coming home, and at night wants to snuggle up in her grandmother's favorite chair. Her aunt also noticed Tiffany has begun to suck her thumb again, a habit Tiffany had stopped last year. The aunt gets a little worried because Tiffany is such a picky eater. This was a problem even before her grandmother became ill. She eats only small quantities of food, and is quite particular about what she will and won't eat. The aunt has decided not to make a big deal out of this with Tiffany, but she states it does concern her at times.

Community

Tiffany spends time with the other children in the neighborhood at the local playground. She likes to play on the swings and in the sandbox. Tiffany also really enjoys weekly trips to the library. Prior to her grandmother's illness, Tiffany and her grandmother went to the library. Tiffany's aunt continues this tradition.

Behavior Toward Others

Tiffany has several friends at school and in the neighborhood. She has one particular "best friend" at school, Sarah, who also lives close by. The aunt has noticed Tiffany seems to want to play a little closer to home since the grandmother has gone into the hospital, but she still seems to like having children over and seems to enjoy herself at home and at the playground. She and Sarah spend many afternoons with their dolls and stuffed animals.

Moods/Emotions

Even though Tiffany seems to be doing okay, the aunt is concerned because for one or two days in a row, Tiffany can seem quite sad and "inside herself". The aunt says this mood seems to pass and Tiffany appears "back to her old self" for a few weeks, but then the mood sets in for a day or two again. The aunt asked the teacher if she has noticed this, but the teacher feels Tiffany seems to be generally doing all right at school.

Self-Harmful Behavior

Repeatedly in the past month, Tiffany has gotten very upset and begun pinching herself. She says she does this because she is a "bad girl who made grandma sick and tired". These incidents are upsetting to Tiffany's aunt.

Thinking/Communication

Tiffany is a very verbal child who is not shy about stating her opinion. She enjoys asking questions and giving her impressions about things that are important to her. Tiffany began to talk at an early age, and this has always been a source of pride to her family. The grandmother often referred to Tiffany as "my little chatterbox".

(For this exercise, rate aunt as primary caregiver.)

Caregiver Resources: Material Needs

Tiffany's aunt was able to move into the grandmother's home in order to care for Tiffany. The grandmother's medical bills are mostly covered and the aunt is able to continue working at her job nearby.

Caregiver Resources: Family/Social Support

The aunt states although she is willing to help out during this crisis, she is worried about what will happen in the long term if the grandmother remains unable to care for Tiffany. She states that although she loves Tiffany "as an aunt", she does not want to take on her child-rearing full time. Perhaps for this reason, she finds it hard to reassure Tiffany when Tiffany becomes upset about her grandmother being in the hospital. Tiffany asks, "Who will be my Mommy, if grandma doesn't come home?" The aunt says she resents being asked these questions and has told Tiffany not to act like such a baby and not to say such things. Tiffany does not appear to have supports outside the immediate family to help her with these concerns.

Vignette # 1 Vignette Name Tiffany Age 4 Rater's Name _____

Scale Score	Scale	Item No.	Rationale for Scoring
0	School/Daycare	028	Doing well at daycare. Temporary regression due to specific family circumstances (grandmother in hospital).
10	Home	052	Picky eater. Eats small quantities of food. Aunt is concerned.
0	Community	076	Does well in the community.
0	Behavior Toward Others	109	Positive and age-appropriate interactions with others.
10	Moods/Emotions	135	Sad in at least one setting (home) for a few days at a time.
10	Self-Harmful Behavior	157	Repeatedly pinching self, stating that she is doing it because she is "a bad girl".
0	Thinking/ Communication	182	Able to express her thoughts well. Verbal child.
	Primary Caregiver Resources:		
0	Material Needs	191	Aunt working. Medical bills mostly covered. No negative financial impact.
20	Family/Social Support	209	Aunt reports current difficulty responding to child's emotional needs regarding grandmother's illness and future caretaking arrangements; resents being in this position and appears insensitive to the child's concerns about who will care for her.

PECFAS PROFILE: CHILD'S FUNCTIONING **Child's Name** Tiffany **ID#**_____

For each scale, mark the item number(s) which corresponds to those marked on the PECFAS form and fill in the circle indicating severity level. A profile is yielded by connecting the filled circles.

Level of Impairment	School/Daycare Role Performance	Home Role Performance	Community Role Performance	Behavior Toward Others	Moods/Emotions	Self-Harmful Behavior	Thinking
SEVERE 30	1 2 3 4 ○ 5 6 7 8 9	31 32 33 34 ○ 35 36 37 38	59 60 61 62 ○ 63 64 65 66	80 81 82 ○ 83 84 85	114 115 116 117 ○ 118 119 120 121 122	150 ○ 151 152 153	162 163 164 165 ○ 166 167 168 169
MODERATE 20	10 11 12 13 ○ 14 15 16	39 40 41 42 ○ 43 44 45	67 68 69 ○ 70 71	86 87 88 89 ○ 90 91 92 93 94	123 124 125 126 ○ 127 128 129 130	○ 154 155 156	170 171 172 ○ 173 174 175 176
MILD 10	17 18 19 ○ 20 21 22	46 47 48 49 50 51 52 53	○ 72 73 74 75	95 96 97 98 99 100 101 ○ 102 103 104 105 106 107 108	131 132 133 134 135 136 137 138 139 140 141	157 158	○ 177 178 179 180 181
MINIMAL/NO 0	23 24 25 26 27 28 29	54 55 56 57 ○	76 77 78	109 110 111 112	142 143 144 145 146 147 148 ○	○ 159 160	182 183
COULD NOT SCORE	30 ○	58 ○	79 ○	113 ○	149 ○	161 ○	184 ○

For each scale, mark the item number(s) which corresponds to those marked on the PECFAS form and fill in the circle indicating severity level. A profile is yielded by connecting the filled circles.

#2 - ALISON

Background

Alison is a 5-year-old girl. Her mother brought Alison in for a mental health evaluation because Alison's parents have separated and Alison is experiencing some school difficulties. Alison and her mother have recently moved in with an aunt in order to save money.

School/Daycare

Alison started kindergarten this year and had seemed to be making a good adjustment to school. However, since Alison's parents separated, Alison has been occasionally disobeying school rules. Initially, the teacher thought the behavior was related to the parents' separation, but the behavior has persisted.

Home

Alison's mother says Alison has been very clingy lately. She used to enjoy playing with her Barbies and stuffed animals. Now, when Alison is home, she wants to mostly sit by her mother. She becomes distressed when she is not in the same room as her Mom. In the past, Alison slept in her own room. At her aunt's, she shares a room with her mother. At bedtime she refuses to go to bed alone; instead she insists her mother come to bed with her. This interferes with her mother's daily roles and evening routines. Alison asks daily when they can go back to their old house and when her Daddy will come back. These questions are disturbing to her mother because she doesn't know what to say. Alison complains she is sick several times per week and asks if she can stay home from school. This upsets her mother because in the past Alison really seemed to enjoy school.

Community

Alison mostly stays indoors. She does not currently spend much time outside or in the community.

Behavior Toward Others

Alison will play with other children if coaxed to do so, but she tends not to engage in typical recreational activities with other children because she is timid.

Moods/Emotions

The mother states Alison's personality has "changed completely" since the separation. "Alison used to be my 'Susie Sunshine'. Now she often looks like the wind has been knocked out of her and she cries quite a bit at school and at home. Her teacher and I are able to console her, and she has periods of being okay, but she has seemed persistently sad for quite some time." Her mother reports Alison used to be a "good sleeper". However, for the past several months, she seems to have a hard time sleeping.

Self-Harmful Behavior

Alison used to be described as a brave and assertive youngster. Now, if she gets even a little scratch, or another child bumps into her, she bursts into tears.

Thinking/Communication

Alison is asking frequent questions about where her father is and when he might be coming back. She says she doesn't want to go to school because her Daddy left when she started to go school. Alison is concerned her father might have come back to their old house and won't be able to find her and Mommy because they have moved.

Caregiver Resources: Material Needs

The family has suffered a loss of income due to the separation. They have moved in with Alison's aunt in order to save money. Alison's mother is hoping she will be able to obtain child support when the divorce process is finalized. Alison's aunt has always been a supportive family member, and says they can stay with her as long as they need to.

Caregiver Resources: Family/Social Support

Alison's mother thinks that she, herself, might be experiencing some depression related to the sudden separation. (She found out her husband was seeing another woman). She feels uncertain how to discuss these "adult matters" with Alison, so she has mostly tried to change the subject when Alison asks about her father. Alison's aunt is very angry with Alison's father. It is all she can do to not tell Alison what a jerk her father is being. She says she has a "hard time helping Alison with her sad feelings because she is so angry about the whole situation". Alison's teacher has suggested a "Divorce Support Group" at school, but Alison's mother does not think Alison is ready to handle this.

Vignette # 2 Vignette Name Alison Age 5 Rater's Name _____

Scale Score	Scale	Item No.	Rationale for Scoring
10	School/Daycare	019	Occasionally disobeys school rules.
30	Home	035	Constantly clingy. Needs to be in same room as mom. Interfering with mother's routines.
0	Community	076	Doesn't negatively impact community.
10	Behavior Toward Others	107	Mother describes child as timid (i.e., does not engage in typical recreational activities).
20	Moods/Emotions	126	Sadness persists over time.
0	Self-Harmful Behavior	159	No report of self-harm.
0	Thinking/ Communication	182	Thoughts do not appear disordered.
	Primary Caregiver Resources:		
0	Material Needs	191	Despite loss of income due to separation, family is able to stay with supportive relative.
10	Family/Social Support	214	Due to own distress, mother not able to be responsive to child's emotional needs. Aunt is not able to compensate due to her own anger.

PECFAS PROFILE: CHILD'S FUNCTIONING **Child's Name** Alison **ID#**_____

For each scale, mark the item number(s) which corresponds to those marked on the PECFAS form and fill in the circle indicating severity level. A profile is yielded by connecting the filled circles.

Level of Impairment	School/Daycare Role Performance	Home Role Performance	Community Role Performance	Behavior Toward Others	Moods/Emotions	Self-Harmful Behavior	Thinking
SEVERE 30	1 2 3 4 5 ○ 6 7 8 9	31 32 33 34 35 36 37 38	59 60 61 62 ○ 63 64 65 66	80 81 82 ○ 83 84 85	114 115 116 117 ○ 118 119 120 121 122	150 ○ 151 152 153	162 163 164 165 ○ 166 167 168 169
MODERATE 20	10 11 12 13 ○ 14 15 16	39 40 41 42 ○ 43 44 45	67 68 69 70 ○ 71	86 87 88 89 ○ 90 91 92 93 94	123 124 125 126 127 128 129 130	○ 154 155 156	170 171 172 ○ 173 174 175 176
MILD 10	17 18 19 20 21 22	46 47 48 ○ 49 50 51 52 53	72 ○ 73 74 75	95 96 97 98 99 100 101 102 103 104 105 106 107 108	131 132 133 134 135 ○ 136 137 138 139 140 141	○ 157 158	177 ○ 178 179 180 181
MINIMAL/NO 0	23 24 25 26 27 ○ 28 29	54 ○ 55 56 57	76 77 78	109 110 111 ○ 112	142 ○ 143 144 145 146 147 148	159 160	182 183
COULD NOT SCORE	30 ○	58 ○	79 ○	113 ○	149 ○	161 ○	184 ○

For each scale, mark the item number(s) which corresponds to those marked on the PECFAS form and fill in the circle indicating severity level. A profile is yielded by connecting the filled circles.

#3 - PETER

Background

Peter is a 5-year-old boy. He lives with his mother and grandparents. His mother reportedly is an alcoholic and drank heavily throughout the pregnancy. Peter has not seen his father since he left the family when Peter was one year old.

School/Daycare

Peter has been having a lot of trouble at day care related to his disruptive behavior. His teachers state he is an irritable child with a very low frustration tolerance. He has aggressive outbursts where he has attacked other children and the day care staff. He also makes frequent threats against other students and his day care providers. He frequently will raise his fist in a threatening manner if he doesn't get what he wants.

Home

Peter frequently engages in unsafe and out-of-control behavior at home. His mother states when she tries to discipline Peter, he will run out of the house and is often gone for hours. When she confronts him about this, Peter states he hates her and he wants to go live with his dad. His mother says several times a month Peter leaves the house, saying he is running away. She has found him many blocks away and is angry that he crossed busy streets. His mother stated, "I can't believe he is pulling this stuff at five years old. What will he be like as a teenager?"

Community

Peter's mother stated Peter generally plays with children his own age who are "good kids". Sometimes, however, he has spent time with children who get into serious trouble in the neighborhood. His family says they try to steer him away from "bad influences". The older children are not into illegal or gang activities, but they do get into serious trouble.

Behavior Toward Others

Peter frequently hurts other people, both at home and at day care. His mother reports he constantly pushes, punches, and kicks other children. If the other child does not do what Peter wants, he will lash out physically. Both his mother and day care providers are very concerned about this behavior.

Moods/Emotions

Peter's teachers report he seems "very tense, nervous, and irritable" most of the time. His mother reports Peter seems to have a very low tolerance for "anything going wrong", and frequently seems like he is in a "bad mood". She stated, "No matter what we do, Peter doesn't like it. Nothing seems to make him happy or feel good."

Self-Harmful Behavior

Peter's daycare providers have been very concerned about him, because many times when they have tried to stop Peter's aggressive outbursts, he has threatened to kill himself. At first they thought he was simply repeating something he heard from older children, but they have become alarmed at his frequency of such statements. When his daycare provider explored with him about an actual plan to harm or kill himself, he didn't seem to have one. However, she stated he does seem to be thinking about killing himself quite frequently.

Thinking/Communication

Both Peter's mother and daycare provider state that frequently Peter seems "out of touch with reality". They say he is completely "caught up" with a very aggressive TV character, insisting he is that character. His daycare provider states he has strange, bizarre behavior. He seems unable to sort out what is real and what is fantasy. She stated, "I know it is normal for children to pretend a lot, but Peter acts so caught up in his own fantasy world that it is very hard for staff or other children to break in. There are serious questions about if Peter is able to continue to attend daycare here. His bizarre behavior gets in the way of him being able to interact normally with his peers."

Caregiver Resources: Material Needs

Peter and his mother live with her parents. They stay in the basement, which has its own separate entrance. His mother hopes they will be able to move out on their own someday. She states, "I'd like my own space. I'd rather have our own place, but it will be a while before that happens."

Caregiver Resources: Family/Social Support

Peter's mother has had recent involvement from protective services because she does not seem to be providing enough supervision for Peter. Peter is frequently seen out in the neighborhood very late at night. His mother reportedly said to a child protection worker, "I don't know what you want me to do, if Peter doesn't come home when it gets dark, I figure that is his problem." It was the worker's impression Peter's mother had been drinking at the time of the interview. The daycare providers report they often smell alcohol when Peter's mother comes to the school. They have driven the family home on several occasions due to concerns about Peter riding with his mother while drunk. This has been reported to children's services several times.

Vignette # 3 Vignette Name Peter Age 5 Rater's Name _____

Scale Score	Scale	Item No.	Rationale for Scoring
30	School/Daycare	004	Aggressive outbursts resulting in attacking other children and staff (kicks, punches, pushes).
30	Home	036	Leaves home several times per month stating he is "running away". Mom finds him blocks away.
10	Community	073	Mostly plays with children his own age who are "good kids". Sometimes plays with children who get into serious trouble.
30	Behavior Toward Others	081	Child will physically "lash out" (punches, kicks, and pushes) if he does not get his way with others.
30	Moods/Emotions	119	Teachers report child looks "very tense, nervous, irritable". Mother reports "nothing seems to make him feel good or happy".
20	Self-Harmful Behavior	155	Frequently thinking about killing himself. Threatened to kill self on several occasions.
30	Thinking/ Communication	164	Teacher reported strange and bizarre behavior indicating an inability to distinguish between reality and fantasy.
	Primary Caregiver Resources:		
0	Material Needs	191	Family lives with maternal grandmother in basement. No indication of disruption in child's functioning.
30	Family/Social Support	196	Gross impairment in parental judgment (staff report mother driving child while under the influence of alcohol), multiple reports to Children's Protective Services due to lack of appropriate care and supervision

PECFAS PROFILE: CHILD'S FUNCTIONING **Child's Name** Peter **ID#**_____

For each scale, mark the item number(s) which corresponds to those marked on the PECFAS form and fill in the circle indicating severity level. A profile is yielded by connecting the filled circle.

Level of Impairment	School/Daycare Role Performance	Home Role Performance	Community Role Performance	Behavior Toward Others	Moods/Emotions	Self-Harmful Behavior	Thinking
SEVERE 30	1 2 **3** 4 5 6 7 8 9	31 32 33 34 35 **36** 37 38	59 60 61 62 63 64 65 66	80 **81** 82 83 84 85	114 115 116 117 118 **119** 120 121 122	150 151 152 153	162 163 **164** 165 166 167 168 169
MODERATE 20	10 11 12 13 14 15 16	39 40 41 42 43 44 45	67 68 69 70 71	86 87 88 89 90 91 92 93 94	123 124 125 126 127 128 129 130	**154** **155** 156	170 171 172 173 174 175 176
MILD 10	17 18 19 20 21 22	46 47 48 49 50 51 52 53	72 **73** 74 75	95 96 97 98 99 100 101 102 103 104 105 106 107 108	131 132 133 134 135 136 137 138 139 140 141	157 158	177 178 179 180 181
MINIMAL/NO 0	23 24 25 26 27 28 29	54 55 56 57	76 77 78	109 110 111 112	142 143 144 145 146 147 148	159 160	182 183
COULD NOT SCORE	30	58	79	113	149	161	184

#4 - ANDREW

School/Daycare

Andrew is a 6-year-old boy. Andrew's teacher has suggested Andrew get special assistance because he is having a hard time in school. His teacher told his mother Andrew is having trouble being successful with his schoolwork because he is so "hyper". He makes impulsive mistakes with his work and has a difficult time sitting still. His teacher stated, "I try to be patient with Andrew and give him extra attention and reminders, but Andrew is very distracted and this has begun to affect how he is performing in class."

Home

Andrew's mother said that Andrew is consistently "bouncing off the walls" at home. She stated Andrew is very hyperactive at home and rarely sits down long enough to focus on anything. The exception is that he watches TV. Otherwise, he is "flying around the apartment, getting into everything" which really makes his siblings angry. Andrew's mother described him as being like "Taz," (the cartoon character who spins like a tornado.) His mother stated, "When Andrew was younger, we had to lock him in his room at night. His behavior is consistently demanding."

Community

Andrew reportedly does spend quite a bit of time playing with other children in the neighborhood. His mother stated the kids play "normal kid games" and Andrew does not get into trouble in the community while playing with his friends.

Behavior Toward Others

Andrew's mother stated he gets along with other people pretty well except he frequently gets really angry and "blows up". Andrew's face reportedly gets very red, and he screams angrily at the top of his lungs. His mother gave the example of Andrew screaming at his brother for touching the TV while he was watching a show. These outbursts happen quite frequently, about 7-10 times per week. His teacher sees these behaviors less frequently, but has been concerned at how "intense" Andrew gets when he is angry or frustrated.

Moods/Emotions

Andrew's mother and teacher agree he does not seem like a "happy child". His teacher stated that Andrew seems to have "low self-esteem" and frequently says things like, "I'm stupid". His teacher said he has to be careful how he talks to Andrew because Andrew, "Takes things the wrong way and seems to feel like I am attacking him when I am just making a suggestion. I don't think Andrew feels good about himself; he is his own worst enemy. He really seems to feel like he is worthless and is very critical of himself."

Self-Harmful Behavior

Andrew has stated on several occasions, he thinks his family would be happier if he "wasn't here". At first his teacher brushed off the comment, but when Andrew repeatedly voiced these feelings, Andrew was sent to the school counselor. Based on Andrew's comments, the counselor became quite concerned that Andrew was thinking a lot about killing himself. He didn't necessarily have a specific plan, but thoughts of harming himself did seem to be on his mind frequently.

Thinking/Communication

Both the school counselor and Andrew's teacher feel Andrew's thinking can get quite confused. Frequently, Andrew bounces from one subject to another, and how he got from one place to another is not really clear. His teacher

stated, "I sometimes find Andrew's thoughts very difficult to follow. His thoughts jump around; it is hard to follow his train of thought." Andrew's mother has reported similar concerns at home.

Caregiver Resources: Material Needs

Andrew and his family have had to move frequently due to being evicted for non-payment of rent. Over the last few years, the family has spent time in homeless shelters and lived out of their car for awhile. Andrew has attended five schools since beginning kindergarten. The housing situation, and not having enough money, has been an ongoing problem and has had frequent negative impact on the children.

Caregiver Resources: Family/Social Support

Andrew's mother has a serious alcohol problem, and it is suspected Andrew and his brother were exposed to alcohol prenatally. She has come to school meetings drunk, and at times has become verbally abusive toward school staff. Andrew said his mother is often "passed out" when he gets home from school. The teacher stated that, although Andrew's mother says she is concerned about Andrew, his mother does not follow through on any plans made to help Andrew's performance. Andrew's Mom seems like she is "out of it most of the time". At school, Andrew said his mother sometimes locks him and his brother out of the house so "she can drink her beer".

Vignette # 4 Vignette Name Andrew Age 6 Rater's Name _____

Scale Score	Scale	Item No.	Rationale for Scoring
20	School/Daycare	014	Having trouble at school because of high activity level.
20	Home	043	Constantly "bouncing off the walls". Hyperactive at home, can't focus on anything.
0	Community	076	No problems reported.
20	Behavior Toward Others	089	Frequently gets really angry and "blows up"; screams at top of lungs 7-10 times per week.
20	Moods/Emotions	127	Andrew seems like an "unhappy child". Persistent self-criticism and feelings of worthlessness.
20	Self-Harmful Behavior	155	Andrew stated that he thinks his family would be happier if he wasn't there. School counselor concerned because Andrew frequently thinks about suicide.
20	Thinking/ Communication	170	Andrew's thoughts difficult to follow; frequently jumps from subject to subject without clear association.
	Primary Caregiver Resources:		
20	Material Needs	187	Unstable housing situation has resulted in frequent moves, school changes, and family living out of their car. Money problems have had frequent negative impact on children.
30	Family/Social Support	196	Suspected prenatal exposure to alcohol. Locks children out of home in order to drink; comes to school meetings drunk.

PECFAS PROFILE: CHILD'S FUNCTIONING **Child's Name Andrew ID#_____**

For each scale, mark the item number(s) which corresponds to those marked on the PECFAS form and fill in the circle indicating severity level. A profile is yielded by connecting the filled circles.

Level of Impairment	School/Daycare Role Performance	Home Role Performance	Community Role Performance	Behavior Toward Others	Moods/Emotions	Self-Harmful Behavior	Thinking
SEVERE 30	1 2 3 4 5 6 7 8 9 ○	31 32 33 34 35 36 37 38 ○	59 60 61 62 63 64 65 66 ○	80 81 82 83 84 85 ○	114 115 116 117 118 119 120 121 122 ○	150 151 152 153 ○	162 163 164 165 166 167 168 169 ○
MODERATE 20	10 11 12 13 14 15 16 ●	39 40 41 42 43 44 45 ●	67 68 69 70 71 ○	86 87 88 89 90 91 92 93 94 ●	123 124 125 126 127 128 129 130 ●	154 155 156 ●	170 171 172 173 174 175 176 ●
MILD 10	17 18 19 20 21 22 ○	46 47 48 49 50 51 52 53 ○	72 73 74 75 ○	95 96 97 98 99 100 101 102 103 104 105 106 107 108 ○	131 132 133 134 135 136 137 138 139 140 141 ○	157 158 ○	177 178 179 180 181 ○
MINIMAL/NO 0	23 24 25 26 27 28 29 ○	54 55 56 57 ○	76 77 78 ●	109 110 111 112 ○	142 143 144 145 146 147 148 ○	159 160 ○	182 183 ○
COULD NOT SCORE	30 ○	58 ○	79 ○	113 ○	149 ○	161 ○	184 ○

For each scale, mark the item number(s) which corresponds to those marked on the PECFAS form and fill in the circle indicating severity level. A profile is yielded by connecting the filled circles.

#5 - ANN

School/Daycare

Ann is a 7-year-old girl. Although Ann appears to have average to above average intelligence, she is having a difficult time following classroom routines. Her teacher reports that Ann is having a difficult time following instructions in the classroom. She frequently appears to be "off task" and not performing activities along with the rest of the class. On Ann's papers and progress report, Ann's teacher has made several comments that Ann does not listen during class.

Home

Ann lives at home with her parents and two younger siblings. Her mother stated that Ann is a loving child but that it can be very difficult to get her to do things around the house. Her mother stated, "She sometimes resists household routines, so I must force her to comply. It is almost not worth it to ask her to do anything. Sometimes if I ask her to pick up her toys or clean up her room, she will take hours to get started. She whines, complains, and stalls. I make her do it anyway but it is hardly worth it. She gets along pretty well with her brother and sister. They have the usual arguments and fights but nothing out of the ordinary."

Community

Ann's father stated that a couple of weeks ago, Ann was found with a small toy that neither of her parents could remember buying for her. When she was asked where it came from, initially she said that she found it outside. When her parents pressed her, she admitted taking it from the store. Her father took her back to the store and made her both return and pay for the item. She also apologized to the store manager. Her father stated that Ann seemed to have learned her lesson and there have been no further incidences.

Behavior Toward Others

Ann has friends at school and in the neighborhood. However, her teacher reported that she is having some significant peer problems. Her teacher stated, "Ann is not one of my kinder students; in fact, she is often down right mean. She tends to be cruel to other students and then acts really surprised when they get angry with her. She is part of a group of children that often torments some of my more vulnerable students. I have talked to Ann about the importance of kindness but I think it goes in one ear and out the other. She continues to be nasty. I have raised this issue at a meeting with her parents as well."

Moods/Emotions

Ann's parents state that they don't think that Ann has any big problems with her moods. Her Dad stated, "I don't think that Ann is the most relaxed child in the world, but then we aren't the most relaxed family in the world. Ann can tend to be high strung at times but generally we feel she is doing OK in terms of her mood. She is not one of those totally moody and crabby children." Her parents did mention that Ann seems to be a restless sleeper and comes to their bed several times per week, complaining of scary dreams.

Self-Harmful Behavior

Ann's parents denied that Ann had any suicidal thoughts or behaviors. In fact they were shocked by the question. Her mother stated, "I didn't realize that children as young as Ann would ever think about suicide or try to harm themselves. How sad!" When questioned closely, Ann's parents stated that Ann on many occasions has unwound paper clips and used them to scratch lines on her skin, particularly on her arms, legs, and stomach. Her parents thought this was odd and have tried to limit this behavior.

Thinking/Communication

Both Ann's parents and teacher state that Ann is a smart and verbal child. Her teacher stated, "Although I don't always like what Ann has to say, I don't think that she has any trouble getting her point across." Her parents concur with this opinion. In interviews, Ann presented as a bright child who was able to discuss several aspects of her life.

Caregiver Resources: Material Needs

Ann's parents report that they have had some money problems over the last several years, which have had an occasional negative impact on the family. Her mother stated, "we have had to move and at times had to stay in very cramped quarters with my relatives. As recently as 2 months ago, we were temporarily in a bad situation where we didn't know where the next meal was coming from and I couldn't afford shoes for the children. This is not usual. That was definitely a low point in our lives. My husband and I both felt bad about not being able to fully provide for our family."

Caregiver Resources: Family/Social Support

Ann's parents both stated that the family has been very tense lately. Ann's father stated, "My wife and I haven't gotten along for a long time. We have been arguing even more than usual lately. She blames me for our money problems and I feel that she should be looking harder for work. Having to move frequently has also been difficult." During the evaluation process, much family conflict was observed. Ann's parents frequently interrupted each other and disagreed with each other's perceptions. They appeared hostile towards each other and frequently blamed each other for Ann's current difficulties.

Vignette # 5 Vignette Name Ann Age 7 Rater's Name _____

Scale Score	Scale	Item No.	Rationale for Scoring
10	School/Daycare	021	Problems with listening and following classroom routines.
10	Home	050	Sometimes resists household routines but will comply if mother insists.
0	Community	077	One shoplifting incident that appears to have been satisfactorily resolved.
20	Behavior Toward Others	090	Often mean and nasty toward others.
10	Moods/Emotions	139	Awakened by scary dreams several times per week.
10	Self-Harmful Behavior	157	Child has scratched self with paper clip on her arms "on several occasions."
0	Thinking/ Communication	182	Child is described as bright, verbal, and able to get her thoughts across.
	Primary Caregiver Resources:		
20	Material Needs	189	Family reports financial problems with major negative impact on the family, including not knowing whether they will have enough food.
20	Family/Social Support	208	Significant family conflict between mother and father. Parents appeared hostile and blaming towards each other.

PECFAS PROFILE: CHILD'S FUNCTIONING **Child's Name** Ann **ID#**_____

For each scale, mark the item number(s) which corresponds to those marked on the PECFAS form and fill in the circle indicating severity level. A profile is yielded by connecting the filled circles.

Level of Impairment	School/Daycare Role Performance	Home Role Performance	Community Role Performance	Behavior Toward Others	Moods/Emotions	Self-Harmful Behavior	Thinking
SEVERE 30	1 2 3 4 5 6 7 8 9 ○	31 32 33 34 35 36 37 38 ○	59 60 61 62 63 64 65 66 ○	80 81 82 83 84 85 ○	114 115 116 117 118 119 120 121 122 ○	150 151 152 153 ○	162 163 164 165 166 167 168 169 ○
MODERATE 20	10 11 12 13 14 15 16 ○	39 40 41 42 43 44 45 ○	67 68 69 70 71 ○	86 87 88 89 90 91 92 93 94 ●	123 124 125 126 127 128 129 130 ○	154 155 156 ○	170 171 172 173 174 175 176 ○
MILD 10	17 18 19 20 21 22 ●	46 47 48 49 50 51 52 53 ●	72 73 74 75 ○	95 96 97 98 99 100 101 102 103 104 105 106 107 108 ○	131 132 133 134 135 136 137 138 139 140 141 ●	157 158 ●	177 178 179 180 181 ○
MINIMAL/NO 0	23 24 25 26 27 28 29 ○	54 55 56 57 ○	76 77 78 ●	109 110 111 112 ○	142 143 144 145 146 147 148 ○	159 160 ○	182 183 ●
COULD NOT SCORE	30 ○	58 ○	79 ○	113 ○	149 ○	161 ○	184 ○

For each scale, mark the item number(s) which corresponds to those marked on the PECFAS form and fill in the circle indicating severity level. A profile is yielded by connecting the filled circles.

Vignettes® for Establishing Reliability

To complete this section, you will need the "Blank Scoring Forms" for recording your scores. These forms may appear at the end of this manual (on perforated "tear out" pages) or may be a separate handout entitled "Blank Scoring Forms" that should accompany this Self-Training Manual.

The "Blank Scoring Forms" are organized so that you can provide the following for each vignette for each scale: severity score (e.g., 30), item number from the PECFAS© (e.g., 001), and rational for the scoring (e.g., kicked out of daycare after threatening to choke another child). The scoring form must contain the rationale for each subscale in order to be scored for reliability.

Rate the child's most severe level of dysfunction during the last 3 months.

After your reliability is checked by the training coordinator, you should compare your scores to the answer key so you can better understand any scoring weaknesses.

#1 - POLLY

School/Daycare

Polly is a 6-year-old girl. Polly's mother describes her daughter as a satisfactory student. However, Polly's mother is concerned because she has received several notes from Polly's teacher stating Polly has a poor attention span. Polly seems to daydream a lot in school. Her teacher stated, "Polly often will have her head down on her desk or be staring out the window. Polly is not disruptive but I'm concerned that she does not seem to have a very long attention span. Polly enjoys taking care of the classroom pets (a rabbit and some goldfish), and is always the first one to volunteer when it is time to feed the animals."

Home

Polly's mother states, Polly is generally pretty well behaved at home. "We have not noticed that she seems inattentive, but we don't put a lot of demands on Polly. She is the youngest, and our house is pretty laid back." Polly is very attached to the family dog and spends a lot of time taking her dog out for a walk or teaching her dog how to do tricks, such as shaking hands. Polly's mother stated Polly does have some annoying habits, particularly when it comes to food. In the past, Polly would refuse to eat anything except peanut butter and jelly sandwiches or macaroni and cheese. "We used to get into huge battles about what she ate, or rather what she wouldn't eat. Now Polly will eat, but she is very picky about what she will and won't eat. I find this annoying. It also really bugs her father. We were raised to eat what was on our plates."

Community

Polly has not gotten into trouble in the community. She spends time with her best friend in the neighborhood. Her friend sleeps over almost every weekend.

Behavior Toward Others

Polly's teacher states the other kids at school pick on Polly a lot. They say she "acts like a baby". She sucks her thumb and talks "baby-talk" when she gets upset. Some of the students try to be nice to Polly, but her teacher stated that Polly's behaviors seem to "turn them off". Polly's one friend in the neighborhood has some of the same immature behaviors. This seems to help the girls get along with each other. Polly's mother is glad she has a friend.

Moods/Emotions

Polly's teacher stated that generally Polly does not seem like a sad child, but she does seem to worry quite a bit. Her mother brings her to school each day. Polly frequently cries when it is time for her mother to leave the school. Polly repeatedly asks where her mother will be and if she can call her during the day. The school and Polly's mother have come up with an agreement about not letting Polly call home during the day. Her teacher stated after about the first 15 minutes of school, Polly can be consoled and doesn't seem so upset about being away from her mother.

Self-Harmful Behavior

Polly has a very low tolerance for pain. If she slightly bumps her knee, she wails loudly. Sometimes she refuses to go outside to play because she is worried other children might bump into her or knock her down. Her mother does not feel these are realistic concerns.

Thinking/Communication

Polly has been tested by the speech therapist at school and has been found to have a speech delay. She is receiving speech therapy two times per week at school. Her speech therapist feels that Polly is making good progress. Her thoughts do not appear to be unusual or disordered.

Caregiver Resources: Material Needs

Polly's parents both work and feel they are able to support the family on their current salaries.

Caregiver Resources: Family/Social Support

Polly's mother stated she and her husband find Polly's picky eating and immature behavior to be frustrating. "We are not always as firm with her as we should be." They are worried about the reports from Polly's teacher that Polly seems distracted in school. Polly's mother stated, "Her father and I are not very consistent with Polly. My husband and I probably baby Polly too much."

#2 - TIM

Background

Tim, a 5-year-old boy, lives at home with his mother and two older sisters (ages 7 and 10). Tim and his sisters were temporarily placed in foster care last year due to neglect. They were returned to their mother six months ago after their mother successfully completed a substance abuse program. Tim's family is still receiving intervention and being monitored due to the history of child neglect.

School/Daycare

Tim attends a full-day Head Start program four days a week. His teacher reports he has been in her classroom for the past six months. Last year he had a lot of difficulties, but this year he has been making a good adjustment to school. He does a nice job of following classroom routines. His mother says Tim looks forward to going to school. He especially likes riding the school bus with the other kids.

Home

Tim's mother reports, "Six months ago, when Timmy first came back from being in the foster home, he was very hard to discipline. He would not listen to me or do what I said. It was like he was fighting each one of my rules. That behavior lasted for about one month. For the past 5 months, he has been behaving much better at home. He follows the rules pretty well now."

Community

In the past two months, Tim's sisters have told their mother many times, Tim is lighting matches and starting fires in the alley behind their house. Tim has continued this, even though his mother has explained to him how dangerous his behavior is.

Behavior Toward Others

Tim gets along pretty well with his siblings and with the children at school. His mother is concerned, however, because Tim frequently yells at the family dog. "Tim gets downright nasty to our puppy. He doesn't go after the dog or anything, but he absolutely screams at the poor thing." She also suspects that he is pinching the dog. When Tim's mother asked him why he was so mad at the dog, Tim said he yelled at the dog because the dog was a "bad boy."

Moods/Emotions

The mother says Tim seems worried a lot. “He worries too much about a lot of things, and even worries about things that seem ridiculous to me. For example, when we are on the bus, we might see an ambulance or a fire truck. Timmy gets really scared that our house is on fire. No matter how many times I tell him not to worry about it, he keeps right on worrying about it. Sometimes his worries seem to wear him out – he will get real tired and sometimes he will fall asleep even though it isn’t bedtime. The worrying is getting in his way of being a regular kid. It gets pretty annoying after a while."

Self-Harmful Behavior

Since Tim has come home from foster care, he sometimes scrapes his arms with a pushpin or a tack. His mother thinks this is a nervous habit he developed while he was away from her. He doesn't draw blood, but does frequently have scratches on his arms.

Thinking/Communication

The mother stated that about once a week, Tim has a hard time going to bed at night. He reports seeing a "big yellow dog, not the family puppy" in his bedroom. Tim tells his mother that he sees the dog and knows it cannot be real but still insists that he sees it. It seems unusual to mother, who has 3 older kids who never had this experience. He falls asleep after his mother or older sister comforts him and tucks him in.

Caregiver Resources: Material Needs

Tim's family does not have a lot of money. His mother works full time at a fast food restaurant. "It is touch-and-go a lot with the bills. I got into a lot of debt when I was using. Now we are trying to dig our way out and it is tight." The family has enough money for food, housing, and clothing, but, in the past month, Tim's mother felt she wasn't able to take Tim to the doctor when Tim had a fever. She stated, "We can't afford health insurance right now, and don't have enough money for a doctor's bill. Tim got better and I would have found a way to take him in if he got any sicker, but I don't feel very good about this."

Caregiver Resources: Family/Social Support

Last year, the children were removed from the home due to parental neglect. The children were returned after the mother completed substance abuse treatment and took parenting classes. Although most of the children's basic needs are being provided for, the children are without adult supervision for several hours after school. Neighbors have been concerned the children seem "on the loose" in the neighborhood after school. When asked about Tim's fire setting, his mother stated, "He doesn't do it that much and he isn't doing it in the house." The caseworker is extremely concerned about Tim's mother's continuing casual attitude toward supervising the children, especially in light of Tim's fire setting.

#3 - SAMANTHA

Background

Samantha is a 4-year-old girl. She lives with foster parents after being removed from her biological parents' home due to allegations of physical abuse and neglect. Samantha was quite small and thin when she came into foster care. The placing agency stated Samantha's biological parents didn't have a lot of money and often did not have food or heat at the house. She has been living with her foster parents for one year. A court case for terminating her biological parents' rights is pending. Samantha has biweekly, supervised visits with her parents. Samantha's foster parents hope to adopt Samantha, if that becomes possible.

School/Daycare

In the last three months, Samantha has been asked to leave previous daycare settings due to impulsive behaviors and frequent "temper fits," despite clear limits being set. In her third and current daycare setting, these behaviors have continued. Initially, her foster mother thought the first daycare setting was overreacting, but, after trying several different settings with similar types of behaviors being reported, the foster mother is getting very concerned about Samantha's behavior.

Home

Samantha's foster care mother states she cannot leave Samantha alone even for "one second"; Samantha must be constantly supervised. Samantha destroys things "in a heartbeat" and can't be trusted to stay in the yard. Once, while briefly unsupervised, Samantha peeled a large section of wallpaper off a wall. Her foster mother stated, "Even though my husband and I have had a lot of experience with foster children, we have not found a way to get Samantha to stop these behaviors. She basically has to be watched and supervised at all times because otherwise she will do something destructive. If I am not with her, I am worried she will tear the place up or go off someplace. My husband and I don't like her wrecking the house, and the few times she wandered off, it practically scared us to death."

Community

Although there has not been any severe damage, Samantha has defaced playground equipment with markers more than once at a public park her foster mother takes her to.

Behavior Toward Others

Her foster mother is most concerned about Samantha's frequent temper outbursts. If Samantha isn't able to get what she wants, she will angrily scream and throw herself on the floor. Many times a day, Samantha has these outbursts and she is very difficult to console.

Moods/Emotions

Samantha can be an exuberant child at times, but she frequently seems nervous, tense, and fearful. She is very startled by sudden movements and loud noises. Her foster mother said that, even though Samantha has been safe while living with her foster family for the last year, she still is jumpy and often seems scared.

Self-Harmful Behavior

Frequently in a tantrum, Samantha slaps herself in the face and pounds her fists on the hardest surface she can find (hardwood floor, wall, kitchen counter top). At these times she often states, "I am stupid and bad". This has resulted in bruises on her hands and face, but no broken bones or other serious injury. Her foster mother is concerned about

this behavior, and wants to be able to help Samantha stop it, but states that Samantha has never said that she wants to die. Her foster mother is worried, because Samantha injures herself, even though not seriously, but does not think Samantha is trying to kill herself.

Thinking/Communication

Samantha frequently talks about monsters. She is preoccupied with drawing pictures of these monsters – she draws them on her coloring book covers and on all of her work sheets at daycare. Other children notice her drawings and find them scary. Her teachers don't know what to make of it. Samantha will frequently talk about the monsters.

Foster Family
(Note: For this exercise, rate foster family as primary caregivers)

Caregiver Resources: Material Needs

The foster family has ample material resources.

Caregiver Resources: Family/Social Support

The foster family has close relatives and friends in the area. They are active members of a church where members rely on each other for spiritual and social support.

Biological Family
(Note: For this exercise, rate biological parents as non-custodial caregivers)

Caregiver Resources: Material Needs

Samantha's biological parents do not have very much money and have had a lot of difficulty in the past providing for themselves and their children. When the children were removed, there was no food in the house. These difficulties are still present. In the past month, both the heat and water were turned off due to non-payment and other problems (several of the pipes had frozen and burst and the family did not have money to repair the burst pipes).

Caregiver Resources: Family/Social Support

Samantha's biological family tends to be isolated. In addition to Samantha, several of the other children have been removed for substantiated allegations of physical abuse.

#4 - LATOYA

School/Daycare

LaToya is a 7-year-old girl. LaToya is reported to be an average student. When contacted, her teacher stated that LaToya was a quiet student who seemed to be mostly at grade level with her learning. LaToya has had some transient peer difficulties with several of the girls in her class. "There is the usual clique of girls that has little battles over who is whose best friend. LaToya has gotten involved in these sorts of squabbles, but I won't say it is out of the norm."

Home

LaToya's mother stated that ever since she and her husband separated, LaToya has "backtracked". "She has become needy and dependent, in a way that she wasn't before. She insists that I bathe her and dress her, things that she is perfectly able to do on her own. She still plays well alone and with her cousins when they're there – and is very independent, but as soon as I come into the room, she wants my help with every little thing." The mother says "the first few months (after the separation), I could understand it, but it's gone on now for almost a year".

Community

LaToya's mother reported that "after LaToya returned from another child's house about two months ago, the child's mother called me to say that some candy was missing from her daughter's room. I found it in LaToya's room. I confronted her about it. She admitted that she had wanted it and so she took it, even though she knows that when she did this once before, she couldn't watch TV for 2 nights. This is not a big deal, but I want LaToya to learn from her mistakes and stop doing this."

Behavior Toward Others

LaToya's father stated, "LaToya used to be a pretty outgoing kid. She has been having some problems with other children lately because she has become very thin-skinned. Any little thing bothers her and she will pout and sulk for hours."

Moods/Emotions

LaToya is reportedly easily upset. Both of her parents report that LaToya cries more than she used to and generally seems more anxious and tense. She is also having nightmares more frequently.

Self-Harmful Behavior

LaToya does not seem to currently have behaviors that indicate a tendency toward self-harm.

Thinking/Communication

LaToya's teacher reports that LaToya seems to be an average student and does not appear to be having difficulties in this area. Her thoughts, as reflected by her communication, do not seem disordered or odd compared to other children her age.

Caregiver Resources: Material Needs

Both of LaToya's parents seem to have adequate material resources. There do not appear to be difficulties in this area.

Caregiver Resources: Family/Social Support

LaToya's parents report that during the separation and divorce they had difficulty being as "tuned in" and supportive of LaToya as they had in the past. LaToya's father stated that it took him time to adjust to being a "single parent" when he had LaToya during visitations and LaToya's mother stated that she went through a period of depression. Both parents stated, however, that their large extended family was able to pick up the slack during those times. LaToya has a favorite aunt that she sees regularly and with whom she was able to talk over her feelings and concerns.

#5 - MARCUS

School/Daycare

Marcus is a 6-year-old boy. Marcus is having significant difficulties at school due to his impulsive behavior and over-activity. His teacher is very frustrated because Marcus is constantly running around the classroom and never settles down for more than a few seconds for an activity. His behavior is disruptive to the other students. At parent-teacher conferences, she discussed her concerns with Marcus' parents. She is recommending that Marcus be referred for some additional evaluation because he is so overactive and inattentive in the classroom.

Home

Marcus' parents state they were very worried about Marcus beginning school because he's a very demanding child at home. His parents state that as soon as Marcus could walk, he was running, and it seems like he has never slowed down. “Marcus is like one of those wind-up toys, but he never winds down. Very few activities capture his attention and he gets very upset when frustrated. He is always into something.”

Community

Marcus has set several fires over the past four months. Initially, his parents were not terribly concerned because Marcus' brother had also gone through a period of playing with matches. However, they are now worried because they feel they have been very clear that starting fires is dangerous and "not okay," and Marcus still has continued to set small fires. They do not feel Marcus is setting fires to purposely try to hurt someone or destroy property. His mother stated, "He just does it and doesn't think about the consequences. Of course, we are very worried about this because it is potentially dangerous."

Behavior Toward Others

Marcus reportedly has few friends at school or at home. His teacher states he is so impulsive and overactive, that he often plays alone. She stated, "Marcus gets so interested in his own activities, he doesn't bother playing with other children; he usually would rather be alone." His parents confirm this picture at home. His father stated, “He seems to prefer playing alone. Even when his cousins are over, he doesn’t usually join in."

Moods/Emotions

Marcus' mother stated, "We don't think Marcus is depressed.” However, she added that he sometimes seems nervous, and gave the example of him constantly biting his nails and twirling his own hair.

Self-Harmful Behavior

Marcus' parents and teacher do not report behavior indicating self-harm. Marcus' nail biting and hair twirling appear to be nervous habits, without intention to harm himself.

Thinking/Communication

Marcus' teacher stated, "Marcus isn’t one of my brightest students, but his thinking seems to be mostly on track. I believe it is mainly his over-activity that is getting him into trouble."

Caregiver Resources: Material Needs

Marcus' parents state they are not having difficulty in this area. They are able to provide adequately for Marcus' material needs.

Caregiver Resources: Family/Social Support

Marcus' parents state they are very frustrated with Marcus and worried about his behavior. His mother stated that even though his behavior is frustrating, she knew from a very early age that Marcus did not seem to be able to control how overactive he was. His father initially felt the family was not being strict enough with Marcus, but in the last year, he too has begun to realize Marcus may have a problem and is not purposely being bad.

#6 - JASON

Background

Jason, a 5-year-old boy, was placed into foster care one month ago due to allegations of neglect. Just prior to being removed, Jason set a serious fire at his home that killed a younger sibling. Jason has a history of fire setting. In the past, the fires had resulted in Jason's biological family being evicted from several apartment buildings. Jason currently remains in foster care.

School/Daycare

Jason has been expelled from four daycares in the past year due to disruptive and aggressive behavior. His most recent expulsion was just last week. The most recent daycare had a reputation for working with "difficult children". However, they were unable to manage Jason's aggressive behavior.

Home

His mother stated Jason has always been a "willful child". He was difficult to soothe when he was younger. She said Jason's father was very abusive toward her and the children. She particularly remembers one occasion where he hit her while she was holding Jason, causing Jason to fall out of her arms. She left Jason's father soon after this incident. The mother stated Jason has been obsessed with fire for several years. After the first fire, she was very careful to keep all matches and lighters hidden, but Jason was somehow able to find them and set additional fires. Jason has severe temper tantrums where he screams, hits, and kicks at anything within range. Jason's foster parents confirm that he has intense tantrums where he must be physically restrained to prevent him from hurting others. The foster family is very careful to keep lighters and matches away from Jason. However, recently the foster mother found Jason rolling up small pieces of paper and pushing them under the burners of the stove. They have also found bowel movements that Jason has hidden in closets and behind a radiator. The foster parents have received specialized training in managing children with severe behavioral disorders, but they find Jason's behavior very stressful and difficult to manage.

Community

Jason's fire setting has caused extensive damage to two previous dwellings, and has caused the death of a younger sibling. Jason has stated he likes starting fires and watching things burn up.

Behavior Toward Others

When Jason becomes upset or angry, he strikes out in an aggressive way and often needs to be physically managed. His foster mother is particularly concerned because she has seen Jason be aggressive even when he is not having a tantrum. When he thought no one was looking, she has seen him trip a younger child and laugh. Other children stay away from Jason because they are afraid of him. His foster mother reports Jason frequently hurts others by punching, kicking, and throwing things.

Moods/Emotions

Jason has a hard time regulating his emotions. His foster mother stated, "His feelings almost always appear to be either too much or too little related to the situation." The only time she has seen him laugh is after he has hurt someone or destroyed something at the house. Once his foster mother overheard him tell another child, “My baby brother burned up. My mom said it was my fault, but she is crazy." She thought it was very unusual that Jason laughed when he said this. Other children seem to think he is strange and don’t like to play with him.

Self-Harmful Behavior

Jason seems oblivious to pain. When he is in a rage, he sometimes bangs his head against the floor. His foster mother reported that recently, while restraining him, she stated, "I am not going to let you hurt yourself." Jason began screaming that he could hurt himself if he wanted to. Jason, on several occasions, has attempted to ride his bike down a hill into a busy intersection. His foster mother took his bike away when Jason said he didn't care if he got "smushed".

Thinking/Communication

Jason tells elaborate stories about "bad men" who fight "killer cops". He also frequently discusses ways children and animals could "get dead" such as being choked or suffocated with a pillow. His foster mother stated, "The topics he chooses to talk about are very gory." Jason's foster parents state Jason seems obsessed with violence. They try to distract him but he frequently returns to violent topics.

Biological Mother
(Note: For this exercise, rate biological mother as "primary caregiver".)

Caregiver Resources: Material Needs

Jason's mother is currently staying with her sister's family. She sleeps on a couch in living room. Jason's family lost most of their possessions during the house fire. His mother lost her job due to missed work. She is looking for employment. Frequently the family has been without housing or adequate food and clothing.

Caregiver Resources: Family/Social Support

Jason is not living with his mother due to allegations of neglect. Despite a known history of fire setting, Jason's mother was not able to supervise Jason closely enough to prevent a deadly house fire.

Foster Parents
(Note: For this exercise, rate foster family as "surrogate caregivers".)

Caregiver Resources: Material Needs

The foster parents are licensed and have adequate resources to provide for Jason.

Caregiver Resources: Family/Social Support

The foster parents are concerned for Jason's welfare and talk about him in a caring and concerned manner.

#7 - JOSÉ

Background

José, 5 years old, is an only child who lives at home with his adoptive mother and father. José was adopted internationally as an infant. His parents had tried for many years to have children and went through a lengthy adoption process. José lives in a suburban community. Both of his parents work full-time. José attends a daycare center approximately forty hours per week.

School/Daycare

José enjoys going to daycare, and he has several friends there. He enjoys playing with race cars and blocks and also likes to play outside. Although José was eligible for kindergarten, his parents decided to wait an additional year because of reports that José has some difficulty during structured activities. During these times, José has a harder time following directions than the other kids in his class. During a recent observation, José's mother noticed that, during circle time, José scooted away from the circle. He was gently coaxed back by one of the teachers with minimal disruption. Although José's behaviors are not overly disruptive, he does need help from his teacher to avoid difficulties. He has an excellent teacher at daycare who, over the years, has been able to coax José through difficult parts of the day such as "story time" and "circle time".

Home

José's parents report José is pretty well behaved at home. He mostly follows directions and household routines. His mother has noticed, however, that José sometimes seems very "needy". For example, he sometimes asks his mother to dress him, even though she knows he can dress himself. She doesn't feel José is being bad or disobedient; he just doesn't seem interested when his parents try to coax him into trying. His parents gave a few examples of things José sometimes will not try for himself, such as putting on his own coat. At these times, he can be quite insistent that he needs help. This is surprising to his mother because it contrasts with the "rough and tumble" face José often presents to the world. At home, José enjoys outdoor activities and impersonating his favorite "super heroes". He loves to tie a towel around his shoulders and "fly" around the house. He also loves playing football and soccer with his cousins. His parents state, "José is a very happy and exuberant child. It just seems like he sometimes needs a little more help than other children. We want to give him the additional year to mature before he starts kindergarten."

Community

José's parents are active members of their church. José's parents recently enrolled him on a soccer team. He seems to enjoy this quite a bit. His parents are also enjoying meeting other parents of children José's age.

Behavior Toward Others

José's father says José is "full of life" and enjoys interacting with others. Early on, José developed a sense of humor. When José was about three, he started telling "jokes" that initially made little sense. For example, he might say, "The chair is laughing", and then start giggling hysterically. Because José laughed so hard at his own "jokes", others joined in. Now that José is older, he has a repertoire of about 10 jokes he enjoys entertaining people with. In addition to his cousins, José has several friends in the neighborhood. His parents feel he gets along well with both children and adults. His daycare providers confirm this.

Moods/Emotions

José's parents describe him as an emotionally expressive child. "We are teaching José to identify and express his feelings. He lets us know when he is happy, but also when he is mad." José's daycare providers state that José seems

pretty flexible with his feelings. "José will 'use his words' when he doesn't like the way things are going, but he is not one to hold a grudge."

Self-Harmful Behavior

José does not seem to be indicating tendencies towards self-harm.

Thinking/Communication

José is a verbal child who keeps up a constant commentary on his thoughts and activities. His parents are impressed by what José can remember: events from the past, such as a family vacation two years ago. José enjoys telling stories and jokes that he has learned from his peers. His parents and daycare providers state he is an interesting and engaging child.

Caregiver Resources: Material Needs

José's parents report they waited a long time to finally have a family. They feel they are able to provide well for José's needs.

Caregiver Resources: Family/Social Support

Although José's parents are somewhat worried about what they call José's "possible social immaturity", they feel they will go the extra mile to ensure José is on track. José's parents report close familial relationships in their immediate and extended family. Despite there being many grandchildren, José is a particular favorite of his grandfather.

#8 - JIMMY

Background

Jimmy is a 6-year-old boy who lives at home with his mother, teenage aunt, and six brothers and sisters.

School/Daycare

Jimmy's mother is concerned because he has been "kicked out" of his third daycare setting. The care providers report Jimmy has very bad behavior at daycare, such as antagonizing other children. They have tried many strategies, ranging from positive reinforcement for good behavior to time-outs. Nothing seems to really help. The turning point was when one of the parents of another child at daycare threatened to sue because Jimmy has repeatedly teased and shoved his child.

Home

Jimmy's mother says, "Jimmy isn't that bad at home because we don't let him get away with stuff." His mother states, “He sometimes resists things he is supposed to do around the house. With all the children, we have certain chores they are supposed to do. Jimmy sometimes stalls getting to something, but, if I stay after him, he’ll do it eventually, but you have to take a stronger way with Jimmy because he definitely has a mind of his own."

Community

Jimmy has gotten into some trouble in the neighborhood. He threatened to hurt a neighbor boy after an argument at the playground. He vandalized a neighbor's garden by pulling up the tomato plants. The damage was not severe but there was no doubt Jimmy did it. The neighbor was very upset, although he did not report it.

Behavior Toward Others

Jimmy's mother reported that Jimmy can be a bit of a bully towards other kids. She stated, “Because Jimmy is somewhat tall and big for his age, it is pretty easy for him to push other kids around. Plus, his older brothers have taught him how to fight.” The daycare reported that, although Jimmy is not likely to harm the other children, he does antagonize them. When he walks by other children, he often teases or shoves them. His mother said she doesn't see this as much at home, but, when he plays with kids in the neighborhood, it does seem like he frequently says mean things to the other kids.

Moods/Emotions

Jimmy's mother says he is usually in a "good mood". "He gets a little upset occasionally when he gets in trouble for doing something wrong at daycare, but mostly he just seems like a 'happy-go-lucky' kid."

Self-Harmful Behavior

Jimmy's mother stated he does not appear to have a tendency toward hurting himself. She stated the family was mainly upset about Jimmy getting kicked out of daycare for hurting other students.

Thinking/Communication

Jimmy's mother reported he seems a little behind in his ability to carry on a conversation and report back any directions just given to him. She has had his hearing and speech tested. Both came back within normal limits. Jimmy's teacher pointed out Jimmy can talk pretty freely about his toy cars and about his new bicycle. However, when sentences are more complex, Jimmy often seems somewhat limited in being able to express himself clearly.

Since his teacher said that, Jimmy's mother says she has been watching him more carefully at home. She agrees Jimmy does seem to have trouble getting his point across sometimes.

Caregiver Resources: Material Needs

Jimmy's mother reports she works two jobs to make enough money to support her family. She also stated her sister, who lives with the family, pitches in by paying some of the household expenses and watching the kids while she is at work.

Caregiver Resources: Family/Social Support

Jimmy's mother stated she is doing the best she can to try to keep Jimmy out of trouble. She doesn't know why he gets into trouble at daycare. "People keep trying to give me all these ideas about what to do, but I think it is mainly up to Jimmy. If he wants to behave, he will. If he doesn't, he won't. I thought we should watch him a little more closely when he was taking stuff from around the neighborhood, but with my work schedule that is hard. His aunt is good with the children, but she is a teenager and kind of into her own thing. I like it when my kids check in, but if they don't, I figure we will find out sooner or later if they are in trouble."

#9- MICHAEL

Background

Michael is a 4-year-old boy. He lives at home with his parents and infant brother. Michael was brought to the clinic because eight months ago he was in a serious car accident with his family. Both of his parents were hospitalized for several weeks following the accident. During that time, Michael's grandmother cared for him. The children sustained minor injuries from the accident, but did not have to remain overnight in the hospital.

School/Daycare

Michael goes to daycare 5 days per week. He was able to remain in daycare while his parents were in the hospital. Daycare staff report Michael seemed a little more clingy following the accident and frequently stated his "Mommy and Daddy got some 'owies' in the car," but otherwise he seems to be doing pretty well. He enjoys playing with other children. He particularly likes playing with blocks, trucks, and cars.

Home

Michael's parents are concerned because Michael was having nightmares, almost every night for several weeks after the accident, about a big truck "coming to get him". He would wake up very scared. These nightmares have receded since the accident 8 months ago, but his mother wanted Michael evaluated by a mental health professional to make sure the accident hasn't permanently scarred Michael. At home, Michael's favorite activities are watching videotapes and playing with his Lego's. He also enjoys looking at books. His mother stated Michael continues to have a good appetite, and he sleeps for approximately 8-10 hours per day.

Community

Michael plays with other children in the neighborhood.

Behavior Toward Others

Michael enjoys playing with other children in the neighborhood and at daycare. The daycare staff feel like he mostly follows the rules except for the usual "ups and downs". His parents stated that when Michael was younger, around age 2, he was pretty willful. However, in the last year he has "become his own person with his own interests" and "seems to be pretty cooperative".

Moods/Emotions

Michael's parents state Michael has a pretty "even temperament". He is generally in a "pretty good mood" unless he is hungry or tired.

Self-Harmful Behavior

Michael’s parents, grandparents, and daycare providers have not noticed Michael trying to harm himself.

Thinking/Communication

Michael likes to talk with his family about his day. He also likes to talk about the characters in his videotapes. He has an imaginary friend, "Jacko", whom he sometimes blames for minor misdeeds around the house. Michael's parents feel Michael is a smart child with a good imagination.

Caregiver Resources: Material Needs

Both of Michael's parents work. Their car insurance helped pay the bills after the accident. Michael's grandmother lives nearby and was able to move into the family home to take care of the children, with minimal disruption, while the parents were recovering.

Caregiver Resources: Family/Social Support

Michael's mother stated that after getting out of the hospital, Michael's father initially withdrew from the family a bit because he felt the accident was his fault, even though the other driver was ticketed. She stated she was very concerned about this initially, but feels she and her mother were able to "float the boat" until Michael's father had a chance to "work through his guilt". She feels this strategy has worked because she has noticed in the last two weeks that Michael's father has been more "back to his old self". She feels they were able to pull through this event "as a family".

#10 - JUSTIN

Background

Justin is a 4-year-old boy. He lives at home with his parents and older brothers. His parents describe him as a very intelligent child, but extremely "hyper". His mother states that even before he was born, during the pregnancy, he was extremely active, moving around frequently and kicking, rarely resting or "at peace". As an infant, he was difficult to soothe and "always seemed to be moving". Currently, Justin sleeps very few hours a night. When he is awake, he is constantly "on the go".

School/Daycare

Justin's parents are concerned because his pre-school has said Justin isn't able to follow even the most basic rules or structure in the classroom. He is constantly running around, going from activity to activity, and pulling out toys. He frequently runs into or trips over other children, not in a mean way, but because "he isn't looking where he is going". Justin refuses to take naps and can't sit still for "circle time". His pre-school teacher said, "Justin seems like he is a nice boy, but often times he seems like a very active bull in a china shop. We have tried very hard to accommodate Justin's activity level but nothing seems to be working. He continues to be very disruptive to the classroom and we are, unfortunately, very close to asking him to leave because we just don't see how he can be taught in a group setting at this time."

Home

Justin is very active at home. His father states Justin is "extremely busy", going from one thing to another. His parents state that his behavior is quite demanding. His mother says he isn't really destructive, just very active. She feels she must keep a pretty good eye on him so that he doesn't get into everything.

Community

Justin has not gotten into any trouble in the community. He has not destroyed property, set fires, or stolen from people or stores.

Behavior Toward Others

Justin is interested in having friends and likes being around other children. However, both his pre-school staff and his parents notice Justin often can't settle down long enough to really play with other kids; instead he tries to get other kids to wrestle with him, sometimes jumping on their backs to play. Nobody really gets hurt, but the other children do get tired of this "rough-housing". He also initiates "chase games", but seems to get so wound up he runs into walls or trips over furniture. Despite this, the kids tend to like Justin because he seems silly and fun. At home, Justin's parents feel he tries to "be good", but because he has so many ideas and he gets so distracted, it is hard for him to mind. His older brothers get annoyed with Justin and call him "the wild child".

Moods/Emotions

His parents state Justin is generally a happy-go-lucky kid. He momentarily seems sad when he is being reprimanded, but then he is on to the next thing.

Self-Harmful Behavior

Justin occasionally gets minor bumps or bruises when he runs into things or trips. His parents don't think he is intentionally trying to hurt himself.

Thinking/Communication

Justin is a bright and verbal child. Although he speaks quickly and never stays for too long on one subject, he makes sense and seems to have a lot of intelligence and creativity.

Family Resources: Material Needs

Justin and his family live in a rural area. They live on a farm that has been in the family for many generations. His father makes a living on the farm and his mother teaches 2nd grade at the local elementary school.

Family Resources: Social Support

Justin's family spends most weekends visiting with extended family. Justin has many cousins whom he sees regularly. His parents say that family is very important to them. Although they find Justin's behavior trying at times, and feel that he needs a lot more supervision than their other boys did at a similar age, they say "Justin is not a bad boy, he just has more energy than most."

#11 - BUDDY

School/Daycare

Buddy is a 6-year-old boy who attends school and was asked to leave his after-school daycare program. He doesn't verbally communicate well with peers, but he does talk to the teacher and the daycare provider. When he is angry or frustrated, he refuses to talk to classmates. When he gets this way, he will grunt and use gestures, and sometimes doesn't talk for the rest of the school day. He is very aggressive with other children at school. He has hit, kicked, and bit several of his classmates. His mother stated he has been asked to leave his after-school daycare program because he repeatedly "beat up the other kids". The daycare provider also stated that another reason that Buddy was removed from daycare was because he frequently played with toys and dolls in a sexually provocative way – pretending that the Barbie and Ken dolls were having sex, pretending to "hump" teddy bears – and staff members were concerned about the potential safety of other children. There have been no reports of sexual behavior at school.

Home

Buddy's mother reported that many times per week she has to call her father to come over because Buddy is "freaking out". She stated, "Buddy just goes off, having one of his fits." During these times, his grandfather must hold him really tight to stop him from throwing things around the apartment or from banging his head on the floor. His mother stated, "I used to try locking him in his room, but he trashed the place. He tore his bed apart and broke out windows. I've even had to call the cops on him one time. I feel like I constantly need help from either my dad or the guy who lives downstairs to keep Buddy from hurting himself or destroying the place."

Community

His mother stated that in the neighborhood, "He has also done that 'dirty playing' like he has at daycare." She reported that "Once a mother in a park took her child away, because he placed a toy soldier on his own crotch and made kissing noises. Another mother called me and said Buddy was humping all the stuffed animals and wouldn't stop. She wanted me to come get him. Buddy has been told to not play in this way. I asked Buddy and he said he didn't do it, but I'm not sure because Buddy lies a lot. I'm not sure I can trust Buddy around other kids, but I can't keep him inside all the time."

Behavior Toward Others

Buddy does not get along with other children very well. Buddy's mother says that both the school and his former daycare have been afraid that his aggressiveness would result in a child getting hurt. Actually, Buddy rarely speaks to other kids. He typically will use gestures, head movements or pulling or pushing peers to communicate with them.

Moods/Emotions

Buddy's former daycare provider stated, "Buddy has a very short fuse. Everything seems to bother him. We often felt like we were all walking on eggshells around him. He scared us. It was hard to tell what was going on in his head, and it was even harder to predict how he might respond to situations. He was definitely an unusual child. Things that wouldn't bother other children would send him over the edge. I'm sorry to say it, but Buddy is definitely a weird and scary little guy."

Self-Harmful Behavior

Buddy's mother stated recently, on two occasions, neighbors have pulled Buddy off the train tracks when a train was coming. Buddy's mother said she told him several times the train would smash him up and kill him if he didn't stay off the tracks. His mother was outraged when Buddy stated, "That is what I want to happen."

Thinking/Communication

Buddy's former daycare provider and his teacher stated that Buddy typically won't talk to his peers, which interferes with his participation in group activities. His teacher said she put Buddy on a "sticker system" to get him to talk to his peers, but Buddy has not been responsive to this. His teacher had the school speech pathologist observe him, and it was her opinion that he has age-appropriate language skills, but is "selectively mute". The teacher now plans to refer Buddy to the school counselor.

Caregiver Resources: Material Needs

The school has filed several child protection reports for child abuse and neglect. Buddy is often not properly dressed for winter. He frequently comes to school with no socks and no coat. Last winter he was out of school several times due to pneumonia. The daycare provider was also concerned about this. She offered to give a coat to Buddy, but his mother said she doesn't take "charity". After repeatedly sending notes home about Buddy not being properly dressed for winter, the school reported Buddy's mother to children's protective services. Buddy's mother stated she doesn't have enough money to get Buddy a coat and the school shouldn't be "all in her business". The school has also tried to sign Buddy up for free breakfasts and lunches because he seems hungry. His mother has also refused this assistance.

Caregiver Resources: Family/Social Support

The daycare provider reported the family to child protective services because she had seen belt marks on Buddy's legs on several occasions. Sometimes these bruises would last for several days. She has also seen Buddy with a swollen lip. The mother admitted that when Buddy "gets out of hand", she and her father sometimes whip Buddy with a belt. She also stated she has "cracked Buddy in the mouth".

#12 - STEVEN

Background

Steven is a 7-year-old boy. Steven was diagnosed with cancer a year ago, at the beginning of first grade. The cancer was found after he broke his hand while playing baseball. When X-rays where performed, a malignant mass was found. After initial intervention, it was determined that he needed to have his hand amputated. After the surgery, he received follow-up treatment that left him weak, sick, and unable to attend school. Thankfully, the cancer responded well to the treatment and does not appear to have spread. Steven obtained rehabilitation services and a prosthesis for his hand. He seemed to recover physically.

School/Daycare

He is in the first grade for the second time. He had to repeat the grade because he missed many months of school last year due to having serious medical problems. He is doing well academically and participates with his peers. However, since the beginning of the year, about two times per month, Steven will not go to school. Initially he said that he felt sick, which panicked his family, but they have now come to believe that Steven is avoiding school on these days, although they are not certain why. When he says he doesn't want to go to school, his parents are afraid to insist, so they let him stay home for the day.

Home

Steven parents report that at home Steven is mostly respectful and cooperative. They stated, "of course the year that Steven was sick took a big toll on him but he basically remained a trooper through all of it." Steven is an only child. His parents state that he minds them and that they do not have any significant behavior problems with him. His mother stated, "Last year everything was on hold as we were on the 'cancer rollercoaster'. His father and I have moments of still being scared to death but Steven is an amazing kid and really seems to be doing well for the most part."

Community

Steven's community, especially his baseball team, was a big source of support to Steven during his illness. They had fundraisers to help with medical expenses and Steven was able to return to the team despite losing his hand.

Behavior Toward Others

Steven's parents state that he has many friends and that his team has really rallied around him. His teachers report that he does spend time with other children while he is in school. One thing that both his parents and his teacher commented on is that Steven can be very controlling with his friends. His father stated, "Steven really needs to call the shots. The other kids often give in to him, which I don't really like." His teacher stated, "Steven is a kind of a local hero at school because of what he went through. I must admit that I am still lenient with him because of all that he went through last year. I have noticed that Steven frequently orders the other kids around in a way I don't really like. I spoke to the school counselor about this behavior initially. She said it might be Steven's way of trying to regain some control over his own life, which makes sense, but I feel that this has gone on too long and is really beginning to be a fixed behavior pattern. I am concerned about this and so are his parents."

Moods/Emotions

Steven's parents state that they feel Steven has been doing pretty well but they have noticed since his illness that Steven has become quite "rigid" about certain things. He is quite concerned about germs and orderliness. His mother stated that for almost a year, Steven has become quite concerned about whether his food has germs in it or whether he could get sick from germs around the house. Initially this made sense to his parents because of the

diagnosis of cancer and Steven feeling sick. Also during treatment, Steven's immune system was compromised so the family became very concerned about keeping Steven from being exposed to germs. However, these concerns appear to have lasted long after they were functional. Steven's parents have reassured Steven, but he still seems concerned. The family does not feel that these concerns interfere with Steven "living his life", but they feel that he worries too much about germs.

Self-Harmful Behavior

When Steven was initially told that he would lose his hand, his mother reported that there was a period of several weeks when Steven talked about wanting to die. This amazed them, given Steven's young age. The family sought assistance from the pediatric oncology social worker, who was able to work with Steven and help the family as well. Steven's parents state that they continue to monitor this closely and have not heard any comments about suicide for almost one year.

Thinking/Communication

Steven's parents feel that Steven is an expressive child. They are a little concerned with some of Steven's ideas. His mother stated, "Steven thinks that peanut butter is made of apples, no matter how many times we explain that it's called peanut butter because that's what in it". He also thinks that Chicken of the Sea tuna is really chicken. He used to say things when he was younger, and we thought it was funny, but he hasn't outgrown them. It didn't seem too odd when he was 4, but at 7, I'm beginning to be concerned."

Caregiver Resources: Material Needs

The family reported financial difficulty when Steven became ill. His mother stated, "Our insurance was not that great and it was really tough until government aid kicked in. The community was really helpful, but we are still very strapped. I had to quit my job to take care of Steven and to get him to all of his appointments. I haven't been able to get back into the job market. I suppose there is a part of me that is still holding my breath to make sure Steven is okay. We have a lot to be grateful for with Steven's recovery. We always had a roof over our heads and food, even if it wasn't the best food, so I can't really complain."

Material Resources: Family/Social Support

The family has very close relationships with their extended family. Steven and his family spend most weekends and holidays with family. While Steven was receiving treatment, it became evident to the hospital staff that Steven's father was physically abusive to his mother. This matter was broached with Steven's mother, who did acknowledge that her husband has a bad temper and sometimes "got rough with her". This had been happening since early in the marriage but had intensified with the stress of Steven's illness. His mother reported recently that the hitting had died down a little but that Steven's father continued to push her around when he became angry.

Vignette #1 Polly Age 6 Rater Name (print)_____ **PECFAS® SELF-TRAINING**

Scale Score	Subscale	Item #	Rationale for Scoring
_____	School/Daycare	_____	_____
		_____	_____
			_____
_____	Home	_____	_____
		_____	_____
			_____
_____	Community	_____	_____
		_____	_____
			_____
_____	Behavior Toward	_____	_____
	Others	_____	_____
			_____
_____	Moods/Emotions	_____	_____
		_____	_____
			_____
_____	Self-Harmful Behavior	_____	_____
		_____	_____
			_____
_____	Thinking/Communication	_____	_____
		_____	_____
			_____
Primary Caregiver Resources			
_____	Material Needs	_____	_____
_____	Family/Social Support	_____	_____
		_____	_____

Vignette #2 Tim Age 5 Rater Name (print)_____ **PECFAS® SELF-TRAINING**

Scale Score	Subscale	Item #	Rationale for Scoring
_____	School/Daycare	_____	_____
		_____	_____
			_____
_____	Home	_____	_____
		_____	_____
			_____
_____	Community	_____	_____
		_____	_____
			_____
_____	Behavior Toward	_____	_____
	Others	_____	_____
			_____
_____	Moods/Emotions	_____	_____
		_____	_____
			_____
_____	Self-Harmful Behavior	_____	_____
		_____	_____
			_____
_____	Thinking/Communication	_____	_____
		_____	_____
			_____
Primary Caregiver Resources			
_____	Material Needs	_____	_____
_____	Family/Social Support	_____	_____
		_____	_____

Vignette #3 Samantha Age 4 Rater Name (print)_____ **PECFAS® SELF-TRAINING**

Scale Score	Subscale	Item #	Rationale for Scoring
_____	School/Daycare	_____	_____
		_____	_____
			_____
_____	Home	_____	_____
		_____	_____
			_____
_____	Community	_____	_____
		_____	_____
			_____
_____	Behavior Toward	_____	_____
	Others	_____	_____
			_____
_____	Moods/Emotions	_____	_____
		_____	_____
			_____
_____	Self-Harmful Behavior	_____	_____
		_____	_____
			_____
_____	Thinking/Communication	_____	_____
		_____	_____
			_____

Primary Caregiver Resources (Foster Parents):

_____	Material Needs	_____	_____
_____	Family/Social Support	_____	_____
		_____	_____

Non-Custodial or Surrogate Caregiver Resources (Biological Parents):

_____	Material Needs	_____	_____
_____	Family/Social Support	_____	_____
		_____	_____

Vignette #4 LaToya Age 7 Rater Name (print)_____ **PECFAS® SELF-TRAINING**

Scale Score	Subscale	Item #	Rationale for Scoring
_____	School/Daycare	_____	_____
		_____	_____
			_____
_____	Home	_____	_____
		_____	_____
			_____
_____	Community	_____	_____
		_____	_____
			_____
_____	Behavior Toward	_____	_____
	Others	_____	_____
			_____
_____	Moods/Emotions	_____	_____
		_____	_____
			_____
_____	Self-Harmful Behavior	_____	_____
		_____	_____
			_____
_____	Thinking/Communication	_____	_____
		_____	_____
			_____
Primary Caregiver Resources			
_____	Material Needs	_____	_____
_____	Family/Social Support	_____	_____
		_____	_____

Vignette #5 Marcus Age 6 Rater Name (print)_____ **PECFAS® SELF-TRAINING**

Scale Score	Subscale	Item #	Rationale for Scoring
_____	School/Daycare	_____	_____
		_____	_____
			_____
_____	Home	_____	_____
		_____	_____
			_____
_____	Community	_____	_____
		_____	_____
			_____
_____	Behavior Toward	_____	_____
	Others	_____	_____
			_____
_____	Moods/Emotions	_____	_____
		_____	_____
			_____
_____	Self-Harmful Behavior	_____	_____
		_____	_____
			_____
_____	Thinking/Communication	_____	_____
		_____	_____
			_____
Primary Caregiver Resources			
_____	Material Needs	_____	_____
_____	Family/Social Support	_____	_____
		_____	_____

Vignette #6 Jason Age 5 Rater Name (print)_____ **PECFAS® SELF-TRAINING**

Scale Score	Subscale	Item #	Rationale for Scoring
_____	School/Daycare	_____	_____
		_____	_____
			_____
_____	Home	_____	_____
		_____	_____
			_____
_____	Community	_____	_____
		_____	_____
			_____
_____	Behavior Toward	_____	_____
	Others	_____	_____
			_____
_____	Moods/Emotions	_____	_____
		_____	_____
			_____
_____	Self-Harmful Behavior	_____	_____
		_____	_____
			_____
_____	Thinking/Communication	_____	_____
		_____	_____
			_____

Primary Caregiver Resources (Biological Mother):

_____	Material Needs	_____	_____
		_____	_____
_____	Family/Social Support	_____	_____

Non-Custodial or Surrogate Caregiver Resources (Foster Parents):

_____	Material Needs	_____	_____
_____	Family/Social Support	_____	_____
		_____	_____

Vignette #7 José Age 5 Rater Name (print)_____ **PECFAS® SELF-TRAINING**

Scale Score	Subscale	Item #	Rationale for Scoring
_____	School/Daycare	_____	_____
		_____	_____
			_____
_____	Home	_____	_____
		_____	_____
			_____
_____	Community	_____	_____
		_____	_____
			_____
_____	Behavior Toward	_____	_____
	Others	_____	_____
			_____
_____	Moods/Emotions	_____	_____
		_____	_____
			_____
_____	Self-Harmful Behavior	_____	_____
		_____	_____
			_____
_____	Thinking/Communication	_____	_____
		_____	_____
			_____
Primary Caregiver Resources			
_____	Material Needs	_____	_____
_____	Family/Social Support	_____	_____
		_____	_____

Vignette #8 Jimmy Age 6 Rater Name (print)_____ **PECFAS® SELF-TRAINING**

Scale Score	Subscale	Item #	Rationale for Scoring
_____	School/Daycare	_____	_____
		_____	_____
			_____
_____	Home	_____	_____
		_____	_____
			_____
_____	Community	_____	_____
		_____	_____
			_____
_____	Behavior Toward	_____	_____
	Others	_____	_____
			_____
_____	Moods/Emotions	_____	_____
		_____	_____
			_____
_____	Self-Harmful Behavior	_____	_____
		_____	_____
			_____
_____	Thinking/Communication	_____	_____
		_____	_____
			_____
Primary Caregiver Resources			
_____	Material Needs	_____	_____
_____	Family/Social Support	_____	_____
		_____	_____

Vignette #9 Michael Age 4 Rater Name (print)_____ **PECFAS® SELF-TRAINING**

Scale Score	Subscale	Item #	Rationale for Scoring
_____	School/Daycare	_____	_____
		_____	_____
			_____
_____	Home	_____	_____
		_____	_____
			_____
_____	Community	_____	_____
		_____	_____
			_____
_____	Behavior Toward	_____	_____
	Others	_____	_____
			_____
_____	Moods/Emotions	_____	_____
		_____	_____
			_____
_____	Self-Harmful Behavior	_____	_____
		_____	_____
			_____
_____	Thinking/Communication	_____	_____
		_____	_____
			_____
Primary Caregiver Resources			
_____	Material Needs	_____	_____
_____	Family/Social Support	_____	_____
		_____	_____

Vignette ___#10 Justin___ Age _4_ Rater Name (print)_____ **PECFAS® SELF-TRAINING**

Scale Score	Subscale	Item #	Rationale for Scoring
_____	School/Daycare	_____	_____
		_____	_____
			_____
_____	Home	_____	_____
		_____	_____
			_____
_____	Community	_____	_____
		_____	_____
			_____
_____	Behavior Toward	_____	_____
	Others	_____	_____
			_____
_____	Moods/Emotions	_____	_____
		_____	_____
			_____
_____	Self-Harmful Behavior	_____	_____
		_____	_____
			_____
_____	Thinking/Communication	_____	_____
		_____	_____
			_____
Primary Caregiver Resources			
_____	Material Needs	_____	_____
_____	Family/Social Support	_____	_____
		_____	_____

Vignette #11 Buddy Age 6 Rater Name (print)_____ **PECFAS® SELF-TRAINING**

Scale Score	Subscale	Item #	Rationale for Scoring
_____	School/Daycare	_____	_____
		_____	_____
			_____
_____	Home	_____	_____
		_____	_____
			_____
_____	Community	_____	_____
		_____	_____
			_____
_____	Behavior Toward	_____	_____
	Others	_____	_____
			_____
_____	Moods/Emotions	_____	_____
		_____	_____
			_____
_____	Self-Harmful Behavior	_____	_____
		_____	_____
			_____
_____	Thinking/Communication	_____	_____
		_____	_____
			_____
Primary Caregiver Resources			
_____	Material Needs	_____	_____
		_____	_____
_____	Family/Social Support	_____	_____
		_____	_____

Vignette #12 Steven Age 7 Rater Name (print)_____ **PECFAS® SELF-TRAINING**

Scale Score	Subscale	Item #	Rationale for Scoring
_____	School/Daycare	_____	_____
		_____	_____
			_____
_____	Home	_____	_____
		_____	_____
			_____
_____	Community	_____	_____
		_____	_____
			_____
_____	Behavior Toward	_____	_____
	Others	_____	_____
			_____
_____	Moods/Emotions	_____	_____
		_____	_____
			_____
_____	Self-Harmful Behavior	_____	_____
		_____	_____
			_____
_____	Thinking/Communication	_____	_____
		_____	_____
			_____
Primary Caregiver Resources			
_____	Material Needs	_____	_____
		_____	_____
_____	Family/Social Support	_____	_____
		_____	_____

Reliability Grid for PECFAS®

For trainer use only
- ❑ Pass # of Errors _____
- ❑ Pass with Remediation
- ❑ Fail

Rater Name _____ **Degree** _____ **Field** _____
(e.g., BA, MSW, PhD, etc.) **(e.g., social work, counseling, psychology, education, etc.)**

Agency Name _____ **Date** ____/____/____

Agency Address _____ _____ _____
(Street) **(City)** **(State)** **(Zip)**

Phone _____ **Fax** _____ **Email** _____

Did you Self Train with this manual (FAS115)? ☐ Yes ☐ No
If No, give trainer and training location _____

Note: This chart shows discrepancies ONLY between the rater's score and the correct answer. For example, use +10 to signify that the rater scored the scale 10 points too high, whereas -20 would mean that the rater scored the scale 20 points lower than he/she should have.

PECFAS® Scale	Polly #1	Tim #2	Samantha #3	LaToya #4	Marcus #5	Jason #6	José #7	Jimmy #8	Michael #9	Justin #10	Buddy #11	Steven #12
School/Daycare												
Home												
Community												
Behavior Towards Others												
Moods/Emotions												
Self-Harmful Behavior												
Thinking/Communication												
Caregiver Material Needs												
Caregiver Family/Social Support												