ECSII

Early Childhood Service Intensity Instrument©

for Infants, Toddlers, and Preschool-aged Children Ages 0-5

AMERICAN ACADEMY OF CHILD & ADOLESCENT PSYCHIATRY

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USER'S MANUAL

VERSION 1.1

Early Childhood Service Intensity Instrument
ECSII Manual

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INTRODUCTION

PURPOSE OF THE Early Childhood Service Intensity Instrument (ECSII)

The Early Childhood Service Intensity Instrument (ECSII) was developed to assist providers and others caring for young children in determining intensity of services need for infants, toddlers, and children from ages 0-5 years. The ECSII is targeted to children and their families with emotional, behavioral, and/or developmental needs, including those who are experiencing environmental stressors that may put them at risk for such problems. Such children and their families may need services from a host of agencies and providers including child welfare, mental health, primary and specialty health care, child care, early education, adult mental health and substance abuse services, and a variety of community supports. The ECSII provides a common language for these diverse providers and guides them in selecting appropriate services at the appropriate intensity for their youngest and most vulnerable children. The ECSII is designed to support initial service planning as well as to monitor progress over time, through repeated administrations.

CONCEPTUALIZATION OF SERVICE INTENSITY

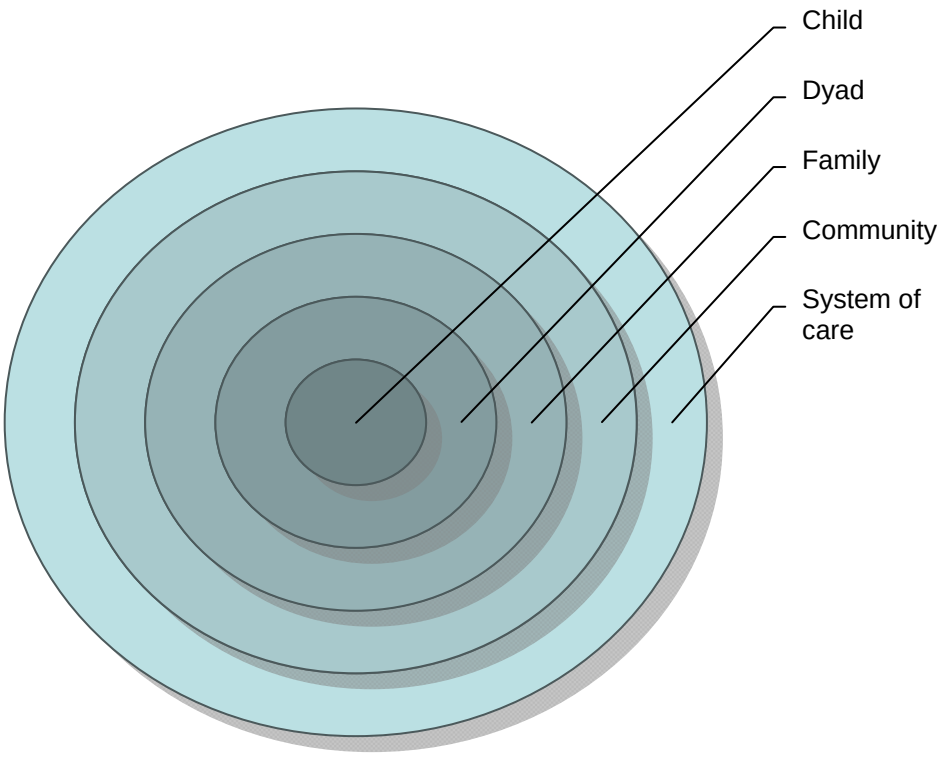
The ECSII uses the concept of Service Intensity (SI) instead of traditionally defined level of care. A traditionally defined "level of care" implies a program or facility, whereas infants and young children as a population tend to receive care or services in multiple contexts. Hence, a "level of care" in this age group may be defined by factors such as the frequency and quantity of services, the extent to which multiple providers or agencies are involved, as well as the level of care coordination required. These are more accurately captured by the concept of "service intensity". The philosophy of the ECSII is that level of Service Intensity can be achieved with multiple approaches, each individualized to the unique needs, beliefs, and strengths of each child and family. The ECSII is non-prescriptive regarding which specific services are needed to achieve each level of Service Intensity, but it does provide information that can inform service planning.

VALUES AND PHILOSOPHY

The ECSII is based on a developmental perspective, which recognizes the changing capacities and needs of the child over this rapid period of development, as well as the considerable

individual variations in normal development. It emphasizes the central importance of significant relationships in the development of young children. It thus follows that early identification of compromise or insecurity in the child's significant relationships, and provision of services or supports addressing those concerns, is needed to mitigate current and future developmental problems. The ECSII provides a framework for assessing these developmental risks and identifying need for services. In addition to significant relationships, the ECSII addresses other biological, social, and environmental risks and protective factors across important domains that impact child development. Throughout the ECSII there is an emphasis on a transactional model, i.e. the dynamic interplay of risk or protective factors with the child's temperament and developmental capacities, rather than on any factors in a static way.

The ECSII also incorporates the role of extended family and other informal and formal supports available to family. This is conceptualized ecologically as a Caregiving System in which the parts are interdependent.



ECOLOGICAL VIEW OF THE CHILD'S CAREGIVING SYSTEM

This Caregiving System includes relationships not only between the child and significant caregivers (i.e. dyadic relationships), other adults and peers, but also between the caregivers and other family members, and individuals in their community and social network. Additionally, each family has a unique cultural identity consisting of beliefs and values, strengths, practices, and ways of relating to their community.

EARLY CHILDHOOD SYSTEM OF CARE VALUES AND PRINCIPLES

The Early Childhood Service Intensity Instrument (ECSII) is also rooted in the core values and principles of the Child and Adolescent Service System Program (CASSP), the federal program (now called the Center for Mental Health Services) responsible for supporting the development of local community-based systems of care for children with serious emotional disturbances through a competitive granting process since the late 1980s. These principles are included in this manual as Appendix A. They offer a family-driven, child-centered model of care that integrates and coordinates the efforts of different agencies and providers to individualize care in the least restrictive setting possible. The authors believe that this model is uniquely well suited for young children who receive services from multiple agencies that may not be organizationally structured to partner with each other.

The principles of the Wraparound Process are essential to the success of local systems of care in providing the individualized services that a young child and their family may need to overcome the challenges they face. The Child and Family Team, which works together to develop the Wraparound (Individualized Service) Plan, is composed of both professionals and those members of the community who wish to play a role in supporting the child (in the case of the child under five, their caregiving system). The ECSII is designed to assist Child and Family Teams in identifying the needed intensity of service and to provide for the development of a Wraparound Plan.

True partnership with parents (and other caregivers) and building on the strengths of the child and family as well as remediating areas of weakness are hallmarks of the Wraparound Process (Vandenberg and Grealish, 1996). The use of both formal (agency-provided, paid-for) and informal (community-based and volunteer or donated) supports are also essential to the work of

the Child and Family Team. Both formal and informal supports are elements used in the development of a specific level of service intensity—the higher the service intensity, the more of both types of supports is needed.

Because it truly is a community effort to raise healthy children, the ECSII focuses on ways in which community supports can be mobilized to help stabilize families and collaborate with them in building on child and family strengths. The American Academy of Child and Adolescent Psychiatry (AACAP) Work Group on Community-Based Systems of Care identified "Best Principles for Early Childhood Systems of Care" that guided development of this tool:

- **The system of care prioritizes the biological, cognitive, and socio-emotional development of the young child.**
- **The system of care strives to strengthen and preserve the young child's primary attachment and family relationships.**
- **The system of care emphasizes prevention and early intervention through timely delivery of services, to maximize the young child's opportunities for normative development.**
- **The system of care supports the stability of the young child's family, whether biological, adoptive, or foster.**
- **The system of care empowers families by making them full partners in the planning and delivery of services.**
- **The system of care provides culturally competent services that respect the family's unique social and cultural values and beliefs.**
- **The system of care provides individualized service plans based on comprehensive bio-psycho-social assessment.**
- **The system of care provides individualized services that are of appropriate intensity, flexibility, and comprehensiveness to meet the child and family's needs. These services are integrated and coordinated between different child-serving agencies.**
- **The system of care strives to have an ethical balance between protecting the rights of children and supporting the rights of parents.**

OVERVIEW OF THE ECSII

DOMAINS

The ECSII is a service planning tool. Although it emphasizes determination of the *intensity of services* that the child and family will benefit from, it also provides specific information as to their present concerns and challenges. This information is derived from the ECSII assessment of important life domains of a young child and family. Each of the following life domains were chosen because they have important implications for the child's development and the functioning of key relationships and environmental factors, all of which will have crucial implications for the intensity and nature of services the child and family need.

These Domains* of functioning include:

I. **Degree of safety**
II. **Child-Caregiver Relationships**
III. **Caregiving Environment**
IV. **Functional/Developmental Status**
V. **Impact of Medical, Developmental, or Emotional/Behavioral Problems**
VI. **Services Profile***

* Note that only the Domains I-V are computed in the score of the ECSII. Domain VI is used for additional considerations in service planning.

For each Domain, the child is rated at one of five levels of functioning or impairment, generally characterized as: Optimal, Adequate, Mild, Moderate, and Severe. Ratings presume that all young children require certain conditions for optimal development and functioning. These include emotional engagement from caregivers, support of their daily functions, supervision, safety and stimulation in their environment, and provision of material needs such as food, housing, clothing, and medical care. It is also true that the child's caregivers need support from other adults, and other community supports are often needed to comprise an adequate "caregiving system" for a child.

The Services Profile is an innovative aspect of the ECSII. This Domain is intended to provide insight as to whether current services match up to the child and family needs and inform providers how they can better shape services to improve outcomes. The Services Profile includes three subscales: A) Involvement in Services (rated for Caregiver(s) and the Child); B) Services Fit; and C) Service Effectiveness. The Services Profile Domain is rated if the child and family are presently receiving or have in the past received services beyond basic health care; this includes evaluations. The Services Profile provides information that can inform service planning. For example, if there is a poor service fit or low involvement in services, the solution may be a different service array or approach rather than a higher intensity of services.

SERVICE INTENSITY LEVELS

Scoring on the ECSII Domains I-V yields a Service Intensity Level from 0-5, as indicated in the Table below. A Service Intensity level is different from a level of care, which is often used to define specific programs in ascending levels of restrictiveness, e.g. day treatment, residential and hospital levels of care. A Service Intensity Level is a *composite* of all services and supports needed, and encompasses services across *all* needed service types, specified in an individualized service plan. A specific Service Intensity level may be formulated in different ways. For example a Moderate (Level 3) Service Intensity Level may consist of intensive developmental/rehabilitative services and few formal mental health services, whereas another Moderate (Level 3) Service Intensity Level may consist of primarily intensive mental health services. See pages 45-49 for more detailed descriptions of each Service Intensity Level indicated below.

ECSII SERVICE INTENSITY LEVELS		
LEVEL	**0**	Basic health services
LEVEL	**1**	Minimal service intensity (beginning care)
LEVEL	**2**	Low service intensity
LEVEL	**3**	Moderate service intensity
LEVEL	**4**	High service intensity
LEVEL	**5**	Maximal service intensity

TERMINOLOGY

The ECSII has selected certain terms and used them throughout for consistency. “Caregiver” is used to describe parent(s) or other primary caregiving adults. We use the term “child” throughout to include infants, toddlers, and preschool-aged children. The “caregiving system” includes the family as well as other resources that could be available to strengthen the family’s ability to care for the child. These include extended family, friends, faith communities, paraprofessionals, formal services, and other natural supports. The ECSII contains a glossary on pages 58-62 to further define terms used in the tool or that may be applicable to service planning.

GENERAL INSTRUCTIONS FOR RATING THE DOMAINS

The ECSII is rated by a clinician or provider with knowledge of the child and family, usually based on a comprehensive clinical assessment. A suggested strategy is to do the rating with a child and family team (including family members and individuals they choose to include on their team). This affords the opportunity to rate the ECSII using information collected by all participants. The rater should review the introduction to each Domain to understand the intent and definitions. Each Domain lists five levels of functioning. Each level of functioning is described by a list of anchor points. In assigning a score to each Domain, all anchor points under each level should be reviewed. The anchor point may include multiple descriptors. *Not all descriptors in each anchor point must be met to choose that level.* Additionally, the exact wording of the anchor points may not fit the particular child. Hence, these anchor point descriptors are intended to serve as examples that convey the intent and the severity level of that anchor point. In choosing the level to rate each domain, the most impaired anchor point that currently applies (i.e. the highest score) should be chosen. *If you do not have the information needed to rate the domain the clinician should go back and get the information.* The time period for rating should be determined by the rater based on how the ECSII is being used and what makes sense practically. For example, if there are acute and very urgent problems, only the past two weeks may be rated and the ECSII could be scored again soon afterwards when the situation may have changed. In a similar vein, if the ECSII is scored when the child is placed in an intensive level of services the ECSII it may be repeated again fairly soon to assess for readiness to proceed to another level of services.

SERVICE PLANNING

The ECSII provides a great deal of additional information and guidance that is useful to service planning, beyond the summary Service Intensity Level score based on rating Domains I-V. The specific information derived from scoring Domains I-V should be used to document *specific* challenges, vulnerabilities and needs of the child and family that are critical to address in service planning. These specific areas of concern identified in each Domain should be used to set priorities for the service plan. Additionally, the Services Profile (Domain VI) provides useful information as to what aspects of the current service plan might need to be modified in order to help the child and family benefit maximally from services and supports. Please see pages 42-45 for more information about service planning. The ECSII also provides a Services Planning Worksheet on page 57 and a set of tables for seven service categories indicating specific services in ascending levels of service intensity (pages 50-56).

ECSII DOMAINS

I. DEGREE OF SAFETY

This domain considers a child's potential to be harmed by others or to cause significant harm to self or others. Each category contains items that assess a child's degree of safety, including the risk of being harmed by the actions or inaction of others, as well as, the risk of harming him/herself and of harming others. The degree of safety for a child is most frequently impacted by neglect, abuse and accidents (including "accidental" poisonings) outside of the child's control as a result of environmental or parent/caregiver factors. However, it may also be impacted by the child's inability to care for self, to self-regulate within expected developmental parameters, by his/her innate impulsivity, by his/her immature appreciation of reality, and, for the older young child, by suicidal or homicidal impulses and behaviors. The assessment of the degree of safety and risk of harm thus needs to include an integrated assessment of general environmental factors (e.g., community safety), caregiver attributes (e.g., capabilities and challenges) and the child's developmental abilities to maintain safety.

The degree of safety will be ameliorated or lessened by environmental conditions, caregiver abilities in providing protection and supervision, and the child's ability to perceive and avoid threats to safety. In this regard, infants, younger children, and children with developmental or other disabilities, unless appropriately protected, are more vulnerable. Children of any age who have experienced unstable placements, losses, traumas, and/or abuse may be unable to perceive threat or take adequate measures to enhance their safety.

In addition to evidence of current environmental and/or interpersonal vulnerability from interview and observation of the child, the caregiver and the environment; historical factors should be considered in assessing the likelihood of future disruption to child, to the caregiver's protective function and/or to the environment's stability that might decrease the degree of safety. Thus, for the child, factors such as past exposure to abuse, multiple placements, medical and neurodevelopmental conditions, inabilities to utilize available external supports, and/or past history of self-endangering or harmful behaviors should be considered. For the caregiver, past incidents of domestic violence and/or abuse, other life challenges, and difficulties in engaging available caregiver supports need to be considered. It is also important to be alert to potential biases that may lead to over- or under-estimation of caregivers' strengths because of racial, ethnic, gender, socio-economic, religion, and/or sexual orientation factors.

1. OPTIMAL DEGREE OF SAFETY

a. The child's environment is safe and protective, and there are no significant environmental dangers, instabilities or risks placing the child at risk for abuse, neglect or harm (e.g., stable, safe and protective community setting).
b. The child is experiencing constancy in caretaking, living and support systems with no recent experience of loss, trauma, abuse and/or disruptive family changes (e.g., stable nuclear and/or extended family network).

c. The caregiver demonstrates a capacity to respond with attention to safety across normative environmental conditions (e.g., mother intervenes sensitively to the child's challenging behaviors).
d. The caregiver exhibits no conditions or risk behaviors that present risk of endangerment of self or child.
e. The caregiver's knowledge base, beliefs or behaviors involving infant or young child are developmentally appropriate to the needs of the child (e.g., caregivers' expectations of youth match child's capacity in all major functional realms such as feeding, toileting, and walking).
f. The child exhibits developmentally appropriate ability to maintain physical safety and/or use environment for safety (e.g., preschool-aged child does not run into impulsively into the street).
g. No current indication of self-harming or other-directed aggressive behaviors by the child (e.g., child has never harmed self or others).
h. Other _____

2. ADEQUATE DEGREE OF SAFETY

a. The child's environment is generally safe and protective, but there are some environmental dangers, instabilities or risks that could place the child at risk for harm, abuse or neglect (e.g., stable, safe and protective community setting but housing is old with need to repair old window guards).
b. The child is experiencing overall stability in caretaking, living and support systems with minimal recent experience of loss, trauma, abuse and/or disruptive family and environmental changes (e.g., generally stable nuclear and/or extended family network but caregiver experiences episodic conflicts in their relationship).
c. The caregiver exhibits brief and/or only limited lapses in ability to respond with attention to safety across normative environmental conditions (e.g., caregiver is distracted by television while supervising the child).
d. The caregiver exhibits conditions or risk behaviors with minimal risk of endangerment to self or other.
e. The caregiver's knowledge base, beliefs or behaviors involving child are mildly developmentally inappropriate and place child at low risk of harm, i.e., caregivers' expectations of youth match child's capacity in most major functional realms such as feeding, toileting, and walking (e.g., caregiver expects child to be toilet trained before developmentally appropriate).
f. The child exhibits some developmental challenges in maintaining physical safety and/or making use of the environment for safety (e.g., child usually seeks adult assistance when appropriate).
g. Indication in child's present situation of occasional self-harming or of other-directed aggressive behaviors with minimal physical or emotional consequences for self or others (e.g., during tantrums the child has a history of throwing objects not directed at others).
h. Other _____

3. MODERATE DEGREE OF SAFETY

a. The child's environment is not optimally safe and protective, i.e. there are several significant environmental dangers, instabilities, or risks that caregivers cannot fully address that could place the child at risk for harm, abuse or neglect (e.g., child lives in high crime neighborhood).
b. The child is experiencing moderate disruptions in caretaking, living and support systems, with recent experience of loss, trauma, abuse and/or disruptive family and environmental changes (e.g., existence of persistent tension and conflict in between family members; recent death or departure of grandparent).
c. The caregiver exhibits moderate and/or periodic lapses in ability to respond with attention to safety across normative environmental conditions (e.g., caregiver locks overactive child in room at night).
d. The caregiver exhibits conditions or risk behaviors with moderate risk of endangerment of self or others (e.g., caregiver drive with youngster in car after drinking at a party).
e. The caregiver's knowledge base, beliefs or behaviors involving infant or young child are often developmentally inappropriate and place child at moderate risk of harm (e.g., caregiver allows child to play with older children without supervision).
f. The child exhibits moderate developmental difficulties in maintaining physical safety and/or making use of the environment for safety (e.g., child who does not respond to limits and persists in potentially dangerous behavior when told not to, such as touching a hot stove or climbing in an unsafe way).
g. Indication in child's present situation of periodic self-harming or other-directed aggressive behaviors with moderate physical or emotional consequences for self or others (e.g., child bangs head against floor when limits are set by caregiver).
h. Other _____

4. IMPAIRED DEGREE OF SAFETY

a. The child's environment is often not safe and protective, and there are multiple significant environmental dangers, instabilities and risks that place the child at risk of harm, abuse or neglect (e.g., the child is exposed to potentially unsafe adults in the home and the neighborhood).
b. The young child is experiencing considerable instability in caretaking, living and support systems with significant recent experiences of loss, trauma, abuse and/or disruptive family and environmental changes (e.g., child witnesses domestic violence incidents; has been in multiple foster placements).
c. The caregiver exhibits substantial and/or frequent lapses in ability to respond with attention to safety across one or more normative environmental conditions (e.g., caregiver takes drugs while caring for the child).
d. The caregiver exhibits conditions or risk behaviors with substantial risk of endangerment of self or others (e.g., depressed parent is experiencing suicidal ideation and is not seeking help).
e. The caregiver's knowledge base, beliefs or behaviors involving child are frequently developmentally inappropriate and place child at substantial risk of harm (e.g.,

caregiver leaves the child in the care of another young child for long periods of time; caregiver feels child's unwanted behavior is done purposefully to hurt the caregiver).

f. The child exhibits significant developmental difficulties in maintaining physical safety and/or making use of the environment for safety (e.g., child is highly impulsive and does not understand dangers of running out of home and into street).
g. Indication in child's present situation of self-harming or other-directed aggressive behaviors with significant physical or emotional consequences for self or others (e.g., child with history of having been sexually abused and reenacts inappropriate touching behaviors with peers).
h. Other _____

5. LOW DEGREE OF SAFETY

a. The child's environment is rarely safe and protective, and there are multiple serious environmental dangers, instabilities and risks that place the child at risk of harm, abuse or neglect (e.g., child's safety is threatened by living in a home with domestic violence or which is used for illicit purposes such as drugs and/or prostitution).
b. The child is experiencing serious instability in caregiving, living and support systems with severe recent experiences of loss, trauma, abuse and/or disruptive family and environmental changes (e.g., child has been abandoned by the primary caregiver, death of primary caregiver, has been physically beaten).
c. The caregiver is disorganized and /or shows minimal capacity to respond with attention to safety across normative environmental conditions (e.g., caregiver neglects the child).
d. The caregiver exhibits persistent and/or serious conditions or risk behaviors that present significant risk of endangerment of self or infant/young child (e.g., caregiver has severe and persistent mental illness with frequent periods of psychotic preoccupation and delusions; caregiver has serious substance abuse with periods of intoxication).
e. The caregiver's knowledge base, beliefs or behaviors involving child are typically developmentally inappropriate and place child at significant risk of harm (e.g., caregiver leaves child unattended at home or in locked car while shopping; caregiver unwilling to get child clearly needed medical services).
f. The child exhibits substantial developmental inability to maintain physical safety and/or use environment for safety (e.g., a child with developmental delay is extremely self-abusive).
g. Indication in child's present situation of persistent and extremely dangerous self-harming or other-directed aggressive behaviors (e.g., child repeatedly injures new-born sibling).
h. Other _____

Note: A rating of Low Degree of Safety (score=5) requires care at a level 5 Service Intensity, independent of other Domains.

II. CHILD-CAREGIVER RELATIONSHIPS

This domain rates the nature of the relationships between the child and the important caregiver(s) in his or her life. This domain refers specifically to intimate emotional relationships. Relationships are seen from the perspective of the child in terms of the quality of relationships, and the degree to which the child's overall relationship experience supports his or her emotional development. We also include the extent to which the relationship enhances the caregiver's functioning since that in turn affects their emotional availability.

Quality of relationship includes factors such as: 1) enjoyment for both child and caregiver; 2) degree of reciprocity and warmth of interactions; 3) flexibility of the relationship in being able to withstand stresses; 4) the degree to which the caregiver is attuned to the child's developmental level and emotional needs and has a positive view of the child; and 5) the overall impact of the child-caregiver relationship on the functioning of both the child and caregiver.

RATING THIS DOMAIN: The rater should determine who the most important caregivers of the child are and rate each of these relationships separately. It is recommended to rate no more than three important relationships. The final score for this domain will be based on a *composite* of the quality of the child's relationships based on how the child's emotional and developmental needs are being met.

SELECTING WHICH RELATIONSHIPS TO RATE: The rater should begin rating this domain by selecting the caregiver with whom the child has his or her primary relationship. This will be based on factors such as amount of time spent, impact of the relationship on the child, who the child is most comfortable with, how long the caregiver has been involved with the child, etc. This may, in other contexts, be referred to as a primary attachment relationship. For this scale, however, we have defined child-caregiver relationship to take into account the role of more than one relationship in the child's development.

After scoring the primary child-caregiver relationship, the rater should then identify and score other important relationships. In some cases, the primary relationship may be the child's mother and the father the second important relationship. However, there are many other possibilities. For example, consider situations where the mother is not the primary relationship and another caregiver, e.g. the grandmother, is the primary or comparably important relationship.

ASSIGNING A COMPOSITE SCORE: After the important child-caregiver relationships (up to 3 maximum) are scored, a composite score will be determined using the following process: Scoring will start with the most significant relationship. If another significant relationship that is more positive or negative has a significant impact on the child, the score may be raised or lowered depending on the overall impact of these relationships on the child. For example, if the child spends the majority of his time with his mother, with whom he has a mostly positive relationship (e.g., rated 2 on this scale), but the child visits once a week with his father and experiences this as very emotionally disruptive (such that it takes 1-2 days to recover, and that relationship is rated a 5 on this scale), the overall score would be brought down to a level of impairment (i.e., higher score) depending on the overall effect on the child as described by the bullets in each impaired level. Note that if two primary caregivers are present and there is

significant stress in their relationship this may diminish the quality of the child's relationship experience and may raise the score.

The extended relationships (e.g., with a day care provider with whom the child has a connection but does not function as a primary intimate relationship) will be rated in Domain III (Caregiving Environment). This Child-Caregiver Relationships Domain emphasizes the *quality of the relationships* with significant caregiving figures, whereas Caregiving Environment will emphasize the *characteristics of the environment* in which the child receives care.

RECOGNIZING DISTURBED INTERACTIONS: Disturbances seen in child-caregiver relationship interactions may include: high levels of conflict or distress, noticeable disengagement or avoidance, disorganized or chaotic behavior, high levels of anxiety, and in the most severe disturbances, caregiver neglect and/or abuse.

1. OPTIMAL CHILD-CAREGIVER RELATIONSHIPS

a. The relationship is functioning well and is consistently satisfying to both caregiver and child
b. Interactions are consistently reciprocal, warm, and flexible.
c. The relationship supports the child's development and enhances the caregiver's functioning.
d. The caregiver consistently shows empathy for the child and understanding of his or her emotional needs.
e. Other _____

2. ADEQUATE CHILD-CAREGIVER RELATIONSHIPS

a. The relationship is largely adequate and satisfying to both caregiver and child, but extra support may be required to maintain the quality of the relationship (e.g., a temperamentally fussy child who requires extra soothing).
b. Interactions are usually, but not always, reciprocal and warm for both partners (e.g., caregiver occasionally doesn't have the energy to engage with an active, high-spirited child).
c. Disturbances if present are transient and have minimal impact on developmental progress (e.g., child wants to use a bottle again or engages in attention-seeking behavior after the birth of the sibling).
d. The caregiver has a general understanding of the child's emotional needs but may not have an in-depth understanding of his or her emotional experience (e.g., the caregiver does not understand why his/her anxious child is so upset over not choosing the right clothing).
e. Other _____

3. MILD IMPAIRMENT IN CHILD-CAREGIVER RELATIONSHIPS

a. Strains in the relationship are apparent and are beginning to adversely affect the subjective experience of the caregiver and/or the child.

b. Some interactions are conflictual (e.g., caregiver and child engage in power struggles on a regular basis).
c. The relationship disturbance presents some risk to the developmental progress of the child or to the caregiver's functioning (e.g., the child's frequent night awakening is impacting the caregiver's daytime functioning).
d. The caregiver's empathy for the child and understanding of his or her emotional needs is disturbed when the caregiver is under stress, or is impaired in one area (e.g., the caregiver may have his/her own conflict in an area such as eating, and finds it difficult to empathize with the child's experience).
e. Other _____

4. MODERATE IMPAIRMENT IN CHILD-CAREGIVER RELATIONSHIPS

a. The relationship is characterized by significant distress in the child and/or caregiver (e.g., the child becomes significantly withdrawn and unresponsive in response to repeated angry out bursts by the caregiver; a caregiver becomes overwhelmed by the child's temper outbursts or unresponsiveness).
b. A significant portion of interactions are conflicted, and show limited response to interventions.
c. The disturbance in the relationship is moderately impacting the child's physical, emotional, or cognitive/language development and/or the caregiver's ability to function (e.g., the child's language development is lagging because of lack of verbal interaction with the caregiver).
d. The caregiver displays limited empathy for the child and impaired understanding of the child's emotional needs in most situations (e.g., he/she may take personally the child's emotions and become angry with the child).
e. Other _____

5. SEVERE IMPAIRMENT

a. The relationship is severely disturbed and distressing to the caregiver and child such that the child is in imminent danger of physical harm (e.g., from physical abuse, sexual abuse, neglect, or malnutrition).
b. Interactions are consistently disturbed in all areas and are resistant to change.
c. The disturbance in the relationship is severely impacting the child's development (physical, emotional, or language) and/or the caregiver's ability to function (e.g., a caregiver who becomes clinically depressed and is unresponsive to the child).
d. The caregiver's empathy for the child is negligible and he/she shows little understanding of the child's emotional needs (e.g., uses cruelty, humiliation, or excessive punishment).
e. Other _____

Note: A rating of Severe Impairment of Child-Caregiver Relationships (score=5) requires that the Service Intensity level increases by 1 level. Only 1 level is raised if Domains II and IV are both rated 5.

III. CAREGIVING ENVIRONMENT

This domain rates the factors in the child's current caregiving environment that may contribute directly to optimizing or impairing the child's development and functioning. This domain emphasizes the characteristics of the environment in which the child receives care. Note that the quality of the child's relationships with significant caregiving figures is rated in Domain II rather in this domain.

The **"caregiving environment"** encompasses the family milieu with which the child comes into contact most regularly and the more broadly based "caregiving system." Important members of the family, including extended family and other supports, will be identified by the primary caregiver(s). The caregiving system also includes informal supports in the community as well as more formal supports including medical, social services, public health, early intervention, Head Start, child-care, or preschool. Access to adequate services, delivered in a culturally competent and coordinated fashion is an aspect of the supports available to the caregiver system.

This domain also assesses the factors that enhance or impair the caregiver's ability to support the development of the child, i.e. protective and risk factors. Protective factors for the child in the caregiving environment include: presence of a stable supportive family with friends and community resources; availability of professional supports; availability of adequate housing and material resources (i.e. food, shelter clothing, heath care, recreational support, and enrichment in environment to support child development); and safe environment which protects the child from exposure to violence. There is evidence that the protective factors noted above which have direct effect on the in the child's developmental and functioning also have indirect effect on the caregivers' functioning.

Some examples of risk factors include family/community violence, instability of caregivers, poverty, inadequate community supports, unstable family relationship, and illness in family members. The more risk factors that impact the family, the more likely it will impair the child's development. Typically it is the balance between protective and risk factors that influences the child and family's functioning.

Two subscales are used to measure the caregiving environment: Strengths/Protective Factors and Stressors/Vulnerabilities. Each is scored and enters into the total score. The two subscales are designed to balance the relative contributions of these factors. Items are rated from the perspective of the child and also based on environmental factors of relevance to caregivers.

STRENGTHS/PROTECTIVE FACTORS IN THE CAREGIVING ENVIRONMENT

1. OPTIMAL STRENGTHS/PROTECTIVE FACTORS

a. The family and/or community resources are optimal to address the child's developmental and/or material needs.
b. There is continuity of active, engaged family and community caregivers.
c. Caregivers readily use potentially helpful or enriching resources.
d. The caregiving system supports a stable home environment for the child.

e. The caregiving system provides optimal resources and services to support the family (e.g., sufficient respite care for the child and sufficient supports for the needs of the primary caregivers).
f. Other _____

2. ADEQUATE STRENGTHS/PROTECTIVE FACTORS

a. The family and/or community resources are sufficient to address the child's developmental and/or material needs.
b. The continuity of family, extended family (or other family supports), and community caregivers is only occasionally disrupted (e.g., the father is absent a few days a week due to business).
c. Caregivers are willing and able to make use of recommended resources and services (e.g., clinician recommends child care or therapeutic play group which parents access).
d. The caregiving system is able to respond to a challenge or crisis to maintain a stable home environment (e.g., placement of child with family member is arranged when a parent goes into treatment; housing with extended family is available when family loses home).
e. The caregiving system provides basic resources and services to support the family (e.g., a single parent is enrolled in medical assistance).
f. Other _____

3. LIMITED STRENGTHS/PROTECTIVE FACTORS

a. The family and/or community resources have limited ability to respond appropriately to the child's developmental and/or material needs (e.g., the family periodically has a shortage of food).
b. The continuity of family and community caregivers is often disrupted (e.g., a sibling who is periodically hospitalized).
c. Caregivers make use of resources and services episodically (e.g., parents do not attend well baby visits regularly).
d. The caregiving system has limited ability to respond quickly and competently in a crisis that puts the home environment at risk (e.g., family loses housing and moves in with friends living in chaotic circumstances).
e. The caregiving system provides limited resources and services to support the family (e.g., there is limited or no access to specialized care).
f. Other _____

4. MINIMAL STRENGTHS/PROTECTIVE FACTORS

a. The family and/or community resources are minimally responsive to the child's developmental and/or material needs.
b. The continuity of family and community caregivers is usually disrupted.

c. Caregivers have serious disagreements with resources and services (e.g., parents disagree with pediatrician's recommendation for specialized mental health assessment of the child).
d. The caregiving system's lack of ability to respond to family needs results in a change of home placement (e.g., family becomes homeless when evicted from housing).
e. The caregiving system provides few resources and services to support the family (e.g., there is a long waiting time for basic services).
f. Other _____

5. NO STRENGTHS/PROTECTIVE FACTORS

a. The family and/or community are unable to meet the child's developmental and/or material needs.
b. There is no continuity of family and community caregivers.
c. Caregivers actively refuse needed resources and services.
d. The caregiving system is unable to respond to dangerous conditions affecting the child (e.g., no one is available to remove the child from an unsafe home).
e. The caregiving environment is unstable is a way that is dangerous to the child (e.g., child maltreatment in a foster care setting).
f. Other _____

STRESSORS/VULNERABILITIES IN THE CAREGIVING ENVIRONMENT

In rating this domain, consider the following potential stressors in the caregiving environment:

Family:
- Caregiver mental health/developmental/substance abuse issues;
- Family member criminal behavior/incarceration
- Domestic violence
- Lack of employment/underemployment, poverty or inadequate income, lack of health insurance
- Significant transitions or losses: loss of family member, new member of the family, move of household, parental separation or divorce

Community
- Violence, safety concerns in the neighborhood
- Cultural intolerance
- Lack of appropriate child care or other community supports
- Social isolation

1. ABSENT STRESSORS/VULNERABILITIES

a. Absence of family or community stressors (e.g., family members are in good health and there are no threats of violence in the home or neighborhood).

b. Absence of recent transitions or losses of consequence (e.g., no change in composition of family, residence, marital status of caretakers, or no birth/death of family member).
c. Material needs are being met without concern that they may diminish in the near future (e.g., family income is stable).
d. Family receives sufficient supports and services from the community (e.g., adequate respite care, availability of other formal and informal supports such as medical care for the child and family, availability of childcare and/or preschool).
e. Community recognizes and supports family's cultural needs (e.g., services available in the family's language).
f. Family is optimally able to meet the developmental needs of the child (e.g., parent talks to infant; or parents recognize speech delay of child and arrange for appropriate assessment).
g. Other _____

2. MILD STRESSORS/VULNERABILITIES

a. Intermittent or short-term exposure to non-violent stressors in the home or community (e.g., exposure to occasional parental arguments, problems with other children in the neighborhood).
b. Minor transition or loss that has an effect on the child and family such as change in residence, caregiver at day care, or composition of the family such as the death of a distant family member (e.g., birth of a second child).
c. Material resources are adequate but not optimal (e.g. family is making ends meet but has little left over at the end of the month).
d. Community supports and services are available with some limitations (e.g., intermittent availability of family members to provide back-up child care).
e. Community partially recognizes and supports family's cultural needs (e.g., community center is available but does not acknowledge ethnic diversity).
f. Family is adequately able to meet child's developmental needs (e.g., caregiver takes child to well baby visits and/or often understands child's developmental limitations).
g. Other _____

3. MODERATE STRESSORS/VULNERABILITIES

a. Frequent exposure to non-violent stressors (e.g., caregiver mental health or other condition that interferes with active, engaged parenting); or some exposure to verbal aggression or threats.
b. Moderate disruption of family/social milieu (e.g., family moves to a significantly different living situation, change of day care, absence of a caregiver).
c. Family is experiencing finances as a stressor due to significant financial challenges or concerns about loss of resources in the future (e.g., paying off a large hospital bill, parent underemployment).
d. Community supports and services are minimal but do not threaten the stability of the family (e.g., no childcare program available in area).

e. Community inconsistently recognizes family's cultural needs (e.g., some service staff understand child culture while others don't).
f. Family poorly meets the child's developmental needs and is often neglectful (e.g., caregiver works night shift and sleeps during the day with inconsistent substitute care; depressed parent is inconsistently able to respond to the cues of the child).
g. Other _____

4. SERIOUS STRESSORS/VULNERABILITIES

a. Frequent exposure to threats of violence or intermittent aggression in the family, or serious conditions in the caregiver (e.g., mental health, developmental, physical, or substance abuse disorders) that significantly compromise his/ her ability to care for the child.
b. Serious disruption of family/ social milieu (e.g., due to death, divorce, or separation of caregiver and child).
c. Loss or absence of material resources has a significant impact on child and family (e.g., parent is laid off or fired, and/ or loss of family health insurance).
d. Community supports and services are rarely available and this threatens stability of the family (e.g., family in rural setting with infrequent mental health consultation available).
e. Community is insensitive to family's cultural needs (e.g., clinicians or other providers ignore cultural norms).
f. Family is frequently neglectful of child (e.g., caregiver works night shift and sleeps during the day with inconsistent substitute care; depressed parent is unable to respond to the cues of the child).
g. Other _____

5. SEVERE STRESSORS/VULNERABILITIES

a. Constant exposure to serious family violence; conditions in the caregiver (e.g., mental, developmental, physical, or substance use disorders) that make him/ her unable to safely care for the child; or safety-compromising criminal activity (e.g., child living in a house drug-involved house).
b. Fragmentation of the family (e.g., death of both caregiver in an accident; single caregiver who is incarcerated).
c. Loss or absence of material resources has a significant impact on the child and family; and community supports and services are absent, resulting in the inability of family to care for the child.
d. Community supports and services needed to maintain stability family are unavailable (e.g., community or insurance plan does not offer specific service essential for family stability such as adult substance abuse treatment).
e. Severe cultural stigmatization in the community (e.g., severe discrimination and hostility in the neighborhood).
f. Family constantly neglects child (e.g., caregiver leaves child in car or home alone on a regular basis or exposes child to dangerous situations).
g. Other _____

IV. FUNCTIONAL/DEVELOPMENTAL STATUS

This domain considers the child's functioning and developmental status as compared with normal expectations for a child of this chronological age. Aspects of functioning and development included in this domain are:

- Affective state and state regulation
  - Capacity to maintain a comfortable and consistent internal state
  - Range of affect (affect is the nature and intensity of expression of the child's emotional responses to internal and external events or stimuli.)
  - Capacity to regulate emotions
- Adaptation to change
  - Response to transitions
  - Ability to adapt to change (flexibility)
  - Response to external stimuli; curiosity and exploration of the environment; child's ability to balance interest in novel stimuli with potential danger in exploring these new stimuli
- Biological patterns
  - Sleep
  - Eating
  - Toileting
- Social interaction with adults and other children
  - Relatedness, including interest in sharing experience
  - Selective attachment (e.g., discriminating between attachment figures and others)
  - Impulse control and aggression
- Cognitive, language, and motor development
  - Cognitive, including problem solving ability, attention, etc.
  - Speech and language development, including non-verbal communication
  - Gross and fine motor development

Although each aspect of a child's development may be progressing at a different rate, this domain seeks to identify, for the purposes of scoring, the aspect of development and functioning with the most significant impairment or delay. The score for this domain should be chosen by identifying the bullet that matches the functional/developmental aspect with the greatest impairment or delay, i.e. although anchor points may apply from multiple levels, the highest score should be chosen. Note that in scoring, not all elements of an anchor point need to be met. Note that most children who have an adequate level of functioning require some support and modification of routines to function under stress.

1. OPTIMAL FUNCTIONAL/DEVELOPMENTAL STATUS

a. Ability to maintain a calm, alert, and affectively available state. Displays the full range of affect. Able to regulate affect.
b. Adapts easily to change. Flexible during transitions. Developmentally appropriate level of curiosity about the environment. Tolerance for age appropriate separations.

c. Settles easily for sleep with developmentally appropriate support. No appetite disturbance. Toileting ability is age appropriate.
d. Developmentally appropriate relationships with others. Intact ability to control impulses. Does not initiate aggressive behavior.
e. Communication, motor, and cognitive capacities (e.g., problem-solving) are age appropriate.
f. Other _____

2. ADEQUATE FUNCTIONAL/DEVELOPMENT STATUS

a. Able to maintain calm, affectively available state with limited environmental modification by caregivers. Affect may be constricted or reactive under stress, but improves with support from caregivers.
b. Requires some support for transitions. Flexibility occasionally compromised under stress. Able to explore environment with encouragement by caregivers.
c. Requires some efforts by caregivers to soothe child for sleep. Appetite varies under stress. Occasional regression in toileting.
d. Engages with peers successfully with caregiver support. Occasional impulsive behavior or aggression typical of developmental age, requiring slight increase in monitoring of interactions by caregivers.
e. Although some areas of development may be uneven, developmental progress is generally appropriate and does not require formal intervention (e.g., speech delays occasionally interfere with the child's ability to communicate needs, but the child succeeds with persistence; the child successfully masters fine and gross motor tasks with persistence).
f. Other _____

3. MILD FUNCTIONAL/DEVELOPMENTAL IMPAIRMENT

a. Significant, but not overwhelming disturbance in the child's ability to maintain calm, affectively available state requiring additional support and environmental modification by caregivers. Some restriction of affect noted outside of most familiar situations or difficulties modulating affect.
b. Flexibility compromised under stress (e.g., able to transition, but requires frequent cueing and more intensive caregiver support). Requires added caregiver support for exploration of environment.
c. Routinely needs environmental modification for sleep, eating, or toileting. E.g., awakens easily and frequently during the night; requires additional feeding time or other basic interventions (such as adding high calorie formula) due to picky eating or inadequate weight gain; is somewhat behind in developing age appropriate toileting behavior.
d. Mild impairment in age-appropriate social skills (e.g., engages with peers successfully only in structured, well-supervised situations with caregiver intervention and support.) Impulse control impaired, but increased environmental supports help caregivers to maintain safety in most circumstances. Intermittent aggressive behavior,

managed by heightened caregiver supervision. Warm interactions possible primarily with trusted caregivers, others with significant support.

e. Developmental delay is associated with some impairment in functioning (e.g., speech delay intermittently impairs the child's ability to communicate and may result in periodic frustration, but without significant behavioral problems; motor or cognitive delays impact age appropriate tasks or activities but do not prevent the child from participating).
f. Other _____

4. MODERATE FUNCTIONAL/DEVELOPMENTAL IMPAIRMENT

a. Affect constricted or poorly modulated in most circumstances. Intensive caregiver support required for normative interaction, (e.g., daily tantrums or withdrawal except when all the child's needs and demands are immediately gratified).
b. Requires intensive support to transition (e.g., multiple cues for an extended period). Transitions often result in tantrums or tearfulness. Hesitant, easily derailed exploration of environment, also requiring intensive caregiver support for success.
c. Serious disturbance in age-appropriate patterns of sleep, feeding or toileting. E.g., requires more than one hour to fall asleep, awakens frequently during the night, and requires caregiver intervention to return to sleep; feeding is significantly disrupted, and difficulty maintaining age-appropriate weight continues despite preliminary interventions; lacks age-appropriate toileting behavior.
d. Moderate impairment in age-appropriate social skills. Child requires intensive input from caregivers for most social interactions, and successful peer interactions are infrequent. Aggressive behavior has caused injury to others or threatens placement (e.g., child may have been expelled or is at risk of expulsion from one-day care setting for aggressive behavior). Frequent compromise of safety due to impulsivity despite close caregiver supervision and support.
e. Developmental delay is associated with significant impairment in functioning (e.g., extra time and support is needed to help child with speech delay make his or her needs known, and without these supports the child becomes angry or aggressive; child with gross or fine motor delay frequently gives up on age appropriate motor tasks, even with significant support, and has difficulty completing age appropriate tasks).
f. Other _____

5. SEVERE FUNCTIONAL/DEVELOPMENTAL IMPAIRMENT

a. Profound inability to regulate internal affective state present in all settings (e.g., overwhelmed by normative sensory experience even with maximal support; severe constriction of affect and interest in the environment that is minimally responsive to intensive attempts to engage the child). Tantrums are frequent and severe and unresponsive to caregiver's interventions.
b. Transitions poorly regardless of caregiver's interventions. Small changes in routine result in severe behavioral disruption.

c. Profound disturbance in age-appropriate patterns of sleep, feeding or toileting. E.g., unable to sleep more than a few hours per night, even with caregiver presence; wakes with minimal environmental stimulation and requires maximal effort by caregivers to return to sleep; profound feeding disturbance resulting in severe failure to thrive; severe problems with toileting such as smearing or ingesting feces.
d. Severe impairment of age-appropriate social skills. Unable to exercise developmentally appropriate impulse control, even with maximal support (e.g., endangers self by running away from caregivers without age-appropriate regard for safety). Aggressive behavior has resulted in removal from multiple childcare settings. Near complete withdrawal from interaction with environment, even with maximal supports.
e. Marked developmental delays result in severe impairment of developmental progress. E.g., marked speech delays present in multiple settings, resulting in extreme frustration and tantrums secondary to inability to communicate needs, even with supports; severe impairment in gross and/ or fine motor skills, resulting in the child being unable to participate in age-appropriate tasks or activities.
f. Other _____

Note: A rating of Severe Functional/Developmental Impairment (score=5) requires that the Service Intensity level increases by 1 level. Only 1 level is raised if Domains II and IV are both rated 5.

V. IMPACT OF THE CHILD'S MEDICAL, DEVELOPMENTAL, OR EMOTIONAL/BEHAVIORAL PROBLEMS

This domain assesses the impact of medical, developmental, and/or emotional/behavioral problems or conditions in the child on the coping and adaptation of the caregiver(s) and child. The key element is the impact of the problem(s) on the caregiver(s) or child rather than the severity of the condition per se. Particular attention is paid to the impact of needs related to the problem on daily family life. The impact of a medical, developmental, or emotional/behavioral problem encompasses many variables, including:

- Psychological adjustment of the child and caregiver(s)
- Effect on usual family routines
- Perceptions of child as impaired by self, family, and others (i.e. stigmatization)
- Caregiver strain related to multiple service needs
- Financial consequences, both direct and indirect (i.e. cost of care and potential loss of employment to care for child)
- Intensity of interventions needed in the daily caregiving environment (e.g. respiratory, feeding support)
- Risk for developmental compromise

In rating this domain, keep in mind that greater emphasis is given to the impact on the child and family than the actual condition. For example, the family of a child with Down's syndrome (and significant associated impairments) may adjust well, whereas a caregiver whose child has facial abnormalities that have minimal physical impact may become depressed due to the child's

appearance and the response of others. **In rating this domain, choose the level of functioning that characterizes the greatest impairment in coping and adaptation of either the caregiver(s) or the child.**

1. **OPTIMAL FUNCTIONING**

    a. No medical problems in the child.
    b. No developmental problems in the child.
    c. No emotional or behavioral problems in the child.
    d. No emotional stress on family related to the child's medical, developmental, or emotional/behavioral problem.
    e. No financial stress on family related to the child's medical, developmental, or emotional/behavioral problem.
    f. Other _____

2. **ADEQUATE FUNCTIONING**

    a. Minor medical problems typically seen in primary care (e.g., mild asthma, occasional ear infections).
    b. Developmental disturbance is mild and improving with natural supports (e.g., a "late talker" whose language delay improves with increased stimulation form family and preschool).
    c. Emotional or behavioral disturbances are minor and/or transient (e.g., occasional temper tantrums).
    d. Caregivers are able to cope with the child's medical, developmental, or emotional/behavioral problem with their natural support system.
    e. Costs related to the child's medical, developmental, or emotional/behavioral problem can be met by family resources and/or health insurance.
    f. Other _____

3. **MILD IMPAIRMENT**

    a. Chronic medical problems that may require specialist consultation and have some impact on functioning, but are responsive to interventions (e.g., well controlled diabetes).
    b. Developmental disturbance is mild and is not improving with natural supports alone (e.g., cerebral palsy with low muscle tone requiring physical therapy).
    c. Emotional or behavioral problems of mild severity needing interventions (e.g., temper tantrums that are frequent and may disrupt family activities).
    d. Caregivers display mild symptoms of anxiety, distress or fatigue due to the child's medical, developmental, or emotional/behavioral problem.
    e. Costs related to the child's medical, developmental, or emotional/behavioral problem cause budgetary challenge (e.g., due to cost of needed services not adequately covered by insurance).
    f. Other _____

4. MODERATE IMPAIRMENT

a. Serious medical problem requiring multiple interventions and causing ongoing functional impairment in child (e.g., poorly controlled asthma that limits child's activities and may result in occasional acute hospitalization).
b. Moderate developmental delays requiring more frequent and intensive interventions (e.g., severe cerebral palsy requiring braces and frequent physical therapy).
c. Emotional or behavioral problems of moderate severity, which interfere with the child's daily functioning (e.g., daily temper tantrums that are prolonged and intense) and may threaten a school or child care placement.
d. Caregivers periodically feel hopeless or helpless about the child's medical, developmental, or emotional/behavioral problem and/or experience adverse impact on caregiver's relationship with other adults, community activities or work.
e. The cost of interventions for the child's medical, developmental, or emotional/behavioral problem requires caregivers to actively increase income or intensity of care giving requirements requires caregivers to decrease work.
f. Other _____

5. SEVERE IMPAIRMENT

a. Severe medical disorder causing severe functional impairment in the child and multiple hospitalizations, or specialized care facility (e.g., congenital heart disease requiring multiple hospitalizations and severely limiting activity).
b. Severe developmental delays which threaten the child's developmental progress and requires constant interventions (e.g., severe cerebral palsy requiring assistance in activities of daily living such as feeding and moving).
c. Emotional or behavioral problems severe enough to threaten child's current home placement.
d. Caregiver is overwhelmed and experiences persistent hopelessness and helplessness due to the child's medical, developmental, or emotional/behavioral problem which threatens or severely compromises necessary care for the child.
e. The cost of interventions related to the child's medical, developmental, or emotional/behavioral problem is catastrophic and leads to loss of home or relinquishment of custody of the child.
f. Other _____

VI. SERVICES PROFILE

This Domain considers the child and family's involvement in previous and current services, the fit of services to the problem(s), and the effectiveness of services. It should be kept in mind that in a caregiver or child's relationship with a provider, both parties contribute to a successful level of involvement; either may experience difficulties interfering with establishing a successful relationship.

Services are not limited to formal mental health interventions, but may include assessments and evaluations and any services addressing the child's social/emotional functioning, developmental

status, and social environment. Note that an appropriate evaluation, even when treatment has not been started, may improve the fit as it implies that the child and family may be starting on the right path. Such services may include primary health care, community health nursing, in-home services, Early Intervention (or other educational/rehabilitative) services, respite or other family support services, parent counseling or chemical dependency treatment; as well as mental health services such as child or family therapy, therapeutic nursery, or day treatment. It should be emphasized that a high score in this domain (i.e. poor response to services) will not necessarily indicate a need for higher service intensity or more restrictive care. In some cases, especially in which the service fit is not optimal, the service array should be reconfigured in order to achieve a more appropriate individualized fit to the child and family's needs. Service intensity may be increased in the form of care coordination or case management to resolve problems in collaboration or service fit.

The Services Profile is scored only if the child and/or family have already received services or evaluations. This domain should not be rated if the child has had no services or evaluation beyond primary health care. Similarly, if there are no current services or have been no previous services for the family, this domain is not rated.

The Services Profile consists of three subscales. Information derived from the Services Profile may indicate changing the type of service in order to improve service fit (without changing the service intensity), or improving the degree of collaboration between the family and providers through a strengths-based child and family team process. **This domain can also serve as an outcome measure to be tracked over time.**

There are three subscales in the Services Profile domain:

A. Caregiver/child involvement in services. Although this subscale describes the degree of involvement of child/caregiver in services, we wish to emphasize that reasons for the end result may include provider factors, and lack of coordination among providers, as well as caregiver/child factors. Involvement in services includes the extent of agreement of the family and providers as to the problems needing to be addressed.

   This subscale includes separate ratings for the child and caregiver. The child's involvement is rated regardless of age. The child rating should be considered in an age-appropriate context, (e.g. the younger child will not be cognitively ready for verbally-oriented therapy). Involvement includes: interaction, ability to meet and communicate, engagement, and for the caregiver, ability to reach a consensus about service planning.

   After rating the caregiver's involvement and child's involvement, only one of the two scores will be selected for the total scale score. Generally, the adults' level of involvement in services will be used for the total score unless the primary service is a child-focused service in which the child is unable to participate (e.g. a child with a regulatory disorder in a day treatment program has continual tantrums due to experiencing overstimulation).

B. Service fit. This is an extremely important component of assessing service response. Historically, higher levels of care were thought to be necessary when lower intensity services were ineffective. The system of care approach has looked more closely at service fit, finding that less restrictive services can at times work as well if they are tailored to the child and family's individual needs and match the family's perception of what would be most helpful.

   Service appropriateness incorporates a number of variables including comprehensiveness, match to the specific problem, degree to which needs and strengths are addressed, timeliness of intervention, and ability of child and family to use the services. This domain also includes the climate in which services are provided, defined as the degree of respect and supportiveness that promote participation in care. Note that access to services includes access to flexible, non-traditional services, not just traditional (categorical) services.

C. Effectiveness of services. Considers the extent to which services are associated with improvement in family-defined concerns. The family's perception of effectiveness should be most prominent here, but other perspectives can be considered if there is disagreement (e.g. a family experiencing domestic violence or substance abuse may report the absence despite evidence of an impact on the child.)

A. INVOLVEMENT IN SERVICES

CAREGIVER(S) INVOLVEMENT IN SERVICES

1. OPTIMAL

a. All caregivers and providers agree that there is optimal engagement, i.e. both respect each other and view the other as having knowledge and expertise necessary for the treatment of the child.
b. Caregiver(s) routinely meets and or communicates with providers regarding the child and family's needs.
c. Caregiver(s) and providers have complete agreement about the child and family's strengths and needs regarding the child's service plan.
d. Other _____

2. ADEQUATE

a. One caregiver is fully engaged with all needed services and providers and communicates effectively with all other caregivers.
b. Caregiver(s) communicates often enough with providers to maintain the service plan.
c. Caregiver(s) and providers generally agree about the child and family's strengths and needs regarding the child's service plan.
d. Other _____

3. LIMITED

a. One caregiver is engaged with all services and providers but another significant caregiver isn't engaged, (e.g., this could occur between divorced parents, parent and foster parent, or between primary caregiver and other extended family members).
b. Caregiver(s) communicates with selected providers only.
c. Caregiver(s) and providers are in disagreement about some aspect of the service plan.
d. Other _____

4. MINIMAL

a. Caregiver(s) engages with essential services and interacts with providers only during crises.
b. Caregiver(s) communicates with selected providers only when contacted by providers.
c. Caregiver(s) and providers are in disagreement about many aspects of the service plan.
d. Other _____

5. NONE

a. There is no engagement between caregiver(s) and providers. There is a pervasive lack of respect between caregiver(s) and providers and neither views the other as having knowledge and expertise necessary for the treatment of the child.
b. Caregiver(s) and providers fail to meet and or communicate.
c. Caregiver(s) and providers have complete disagreement about the child and family's strengths and needs regarding the child's service plan.
d. Other _____

CHILD'S INVOLVEMENT IN SERVICES (rate for all children if any services include the child)

1. OPTIMAL

a. Child is fully engaged during all interactions with provider(s) in an age appropriate manner.
b. Child and provider(s) are able to meet regularly. Child is able to express his or her needs and have them understood by provider(s).
c. Child is fully cooperative with provider(s)' interventions.
d. Other _____

2. ADEQUATE

a. Child is engaged with provider(s) during most interactions.
b. Child and provider(s) are able to able to meet when needed. Child is able to express his or her needs and have them understood by some, but not all, providers.

c. Child is cooperative with provider(s)' interventions most of the time.
d. Other _____

3. LIMITED

a. Child is intermittently engaged with provider(s) during interactions.
b. Child and provider(s) are able to meet infrequently. Child is intermittently unable to express his or her needs and have them understood by provider(s). The child's social, emotional or behavioral disturbance intermittently interferes with the development of a working relationship with provider(s).
c. Child is intermittently cooperative with provider(s)' interventions.
d. Other _____

4. MINIMAL

a. Child is rarely engaged with provider(s) during interactions.
b. Child and provider(s) are unable to meet regularly or meet during crises only. Child is rarely able to express his or her needs and have them understood by provider(s). The child's persistent social, emotional or behavioral disturbance interferes with the development of a working relationship with provider(s).
c. Child is rarely cooperative with provider(s)' interventions.
d. Other _____

5. NONE

a. Child is not engaged during any interactions with provider(s).
b. Child and provider(s) are unable to meet even during crises. Child is unable to express his or her needs and/or have them understood by provider(s).
c. Child is routinely not cooperative with provider(s)' interventions.
d. Other _____

B. SERVICE FIT

1. OPTIMAL

a. Caregiver(s) and provider(s) agree that all services and supports offered are appropriate for the needs of the child and family.
b. Services optimally address the child's developmental, social/emotional, or medical needs.
c. Services are provided in a respectful and supportive manner, promoting active participation.
d. There is full access to needed services, including appropriate flexible services (e.g., respite, in-home services, parent-to-parent support, mentoring).
e. All services are culturally competent (e.g., having a clinician who speaks the same language or has personal experience or knowledge of the family's culture).

f. There is active collaboration among providers, involved agencies, and the family; services are well coordinated.
g. Other _____

2. ADEQUATE

a. Caregiver(s) and provide(s) agree that most of the services and supports offered are appropriate for the child and family's needs (e.g., clinic is not able to honor caregiver's request for a specific therapist but assigns a competent therapist for the problem).
b. Services address the majority, but not all of the child's developmental, social/emotional, or medical needs.
c. Services are provided competently, but without creating a climate for optimal participation by the child and/or family (e.g., the provider is generally supportive but does not provide enough time to answer questions).
d. There is access to most, but not all, needed services (including flexible services).
e. Most services are culturally competent. (e.g., a language interpreter is available most times but not for all services on a consistent basis).
f. Collaboration and coordination of services occurs most of the time.
g. Other _____

3. LIMITED

a. Caregiver(s) and provider(s) disagree about the services and supports offered (e.g., caregiver(s) requests sensory integration therapy but only traditional occupational is offered).
b. Services address one aspect of the child's developmental, emotional, or medical needs, but do not fit in one significant area (e.g., a 3-year-old child is receiving individual therapy for oppositional behavior, but no services for a significant speech/language delay).
c. The climate in which services are provided promotes only limited participation (e.g., the clinician is supportive but does not have toys or chairs appropriate for the child).
d. There is lack of access to or delay in availability of some needed services (e.g., overly long waiting time for needed services).
e. Services do not address diverse cultural needs (e.g., services do not incorporate culturally recognized traditional systems of care such as native elders, traditional healers, religious sponsored programs, kinship support).
f. Collaboration and coordination of services occurs less often than needed (e.g., meetings held only when crises occur).
g. Other _____

4. MINIMAL

a. Caregiver(s) and providers have minimal agreement about the services and supports offered.

b. Services address the child's developmental, emotional, or medical needs poorly (e.g., play therapy as a single modality for a child with autism).
c. The climate in which services are provided promotes minimal participation (e.g., child and/or family feel blamed for lack of progress).
d. Access to needed supports and services is minimal (e.g., child does not have access to a needed specialty evaluation such as child and adolescent psychiatry or psychological testing).
e. Services do not recognize significant aspects of the family's culture (e.g., the family's cultural beliefs do not include the service as it is being offered; the therapist is unfamiliar with non-traditional families such as gay couples, single by choice, or extended family; language translation is available only infrequently and not in all services).
f. Services are in place (some of which may be appropriate), but they are not coordinated with each other and may be duplicative.
g. Providers/agencies do not communicate.
h. Other _____

5. NONE

a. Total mismatch of services with caregiver(s) perception of child and family's problems and needs.
b. Services are mismatched to the child's developmental, emotional, or medical needs and may therefore be harmful (e.g., antidepressant medication for a 2-year old child who is described as depressed by a caregiver with Munchausen's By Proxy).
c. The climate in which services are offered is experienced as totally disrespectful and unsupportive, preventing any meaningful participation.
d. Lack of access to services prevents the child and family from getting needed care (e.g., family is unable to attend office-based sessions due to caregiver disability and in-home services are unavailable).
e. Services are incompatible with critical cultural issues of the family resulting in services not being viable (e.g., condemnation of a normative family structure that is different from the clinician's own culture; language translators are never available leading to linguistic incompatibility of caregiver and/or child with service provider).
f. Services are totally uncoordinated or duplicative.
g. Other _____

C. EFFECTIVENESS OF SERVICES

1. OPTIMAL EFFECTIVENESS

a. Caregiver(s), child (if relevant), and provider(s) believe that services are completely effective (e.g., caregiver reports that child sleeps through the night following interventions).
b. Caregiver(s) and provider(s) see child's growth and development as age appropriate or fully back on track; if applicable, rehabilitation goals have been fully met.

c. Caregiver(s) and provider(s) believe that family difficulties or concerns have resolved or reached the desired outcome(s).
d. Caregiver(s) and provider(s) feel the child and family's future needs have been well prepared for.
e. Other _____

2. ADEQUATE EFFECTIVENESS

a. Caregiver(s), child (if relevant) and providers believe that services are mostly effective as evidenced by significant improvement in child's symptoms (e.g., a child with feeding problems is still a fussy eater but is now gaining weight).
b. Caregiver(s) and provider(s) see child's growth and development as largely back on track; if applicable, substantial progress has been made toward rehabilitation goals.
c. Caregiver(s) and provider(s) believe that family difficulties or concerns have largely resolved or largely reached the desired outcome(s).
d. Caregiver(s) and provider(s) feel the child and family's future needs have been mostly prepared for.
e. Other _____

3. LIMITED EFFECTIVENESS

a. Caregiver(s), child (if relevant) or provider(s) believe that services are helping improve some of the child's symptoms (e.g., caregiver reports that child sleeps through night following interventions, but that falling asleep is still a problem).
b. Caregiver(s) or provider(s) see child's growth and development as partially on track; if applicable, rehabilitation goals have been partially met.
c. Caregiver(s) or provider(s) believe that family difficulties or concerns have only partially resolved or partially reached the desired outcome(s).
d. Caregiver(s) or provider(s) feel the child and family's future needs have been partially prepared for.
e. Other _____

4. MINIMAL EFFECTIVENESS

a. Caregiver(s), child (if relevant) or provider(s) believe that services are having a marginal impact toward improving the child's symptoms.
b. Caregiver(s) or provider(s) see child's growth and development as minimally on track; if applicable there has been minimal progress towards rehabilitation goals.
c. Caregiver(s) or provider(s) believe that services are marginally effective in resolving family difficulties or reaching the desired outcome(s) for family difficulties or concerns.
d. Caregiver(s) or provider(s) feel the child and family's future needs have been marginally prepared for.
e. Other _____

5. NOT EFFECTIVE

a. Caregiver(s), child (if relevant) and provider(s) believe that services are not working to improve child's symptoms (e.g., child not sleeping and caregivers are distressed even following interventions).
b. Caregiver(s) and provider(s) see child's growth and development as stalled or worsened; if applicable, no evidence of progress in meeting rehabilitation goals.
c. Caregiver(s) and provider(s) believe that family difficulties or concerns have not improved, and/or no progress has been made towards the desired outcome(s).
d. Caregiver(s) and provider(s) feel there has been no planning for the child and family's future needs.
e. Other _____

INSTRUCTIONS FOR SCORING THE ECSII

Step 1) Using the Scoring Worksheet on page 39, make sure you have a final single summary score for each Domain. The summary score for each Domain should be the highest number chosen among descriptor (anchor) statements. There should be one score for each of the two subscales of Domain III (Caregiving Environment). For each Domain, you may enter anchor points met in the space to the right. Enter the six scores on Domains I-V and add together to arrive at the Total Score. Enter the total score into the Scoring Worksheet.

Step 2) Take the Total Score and choose the appropriate numeric range on the Scoring Worksheet to arrive at the preliminary SI level.

Step 3) Apply the Independent Criteria.

- If Degree of Safety (Domain I) is scored a 5, the SI level will automatically be 5.
- If the score on either Domain II (Child-Caregiver Relationships) or Domain IV (Functional/Developmental Status) is 5, this will raise the SI Level by 1 level. **However, this independent criterion can only be applied once. For example, if both Domains II and IV are rated 5, this will only raise the SI level by only one level. If Safety has also been rated 5, the SI level will already be 5 and the other scores do not change that.**

Step 4) OPTIONAL: Consider increasing SI Level by 1 level if sum of three Services Profile sub-scales is 12 or above.

Additional Considerations: The chart on page 42 explains how Services Profile scores may be interpreted regarding their influence on *intensity of service need*. This is not intended to change SI Level score apart from the abovementioned consideration of a level increase for total Services Profile scores 12 or above. However, in some cases, this may explain the reason for a disposition at an SI Level different from the ECSII-derived SI Level and may enter into other service planning considerations, such as choice of service array.

Step 5) Enter the final ECSII-derived SI level into the worksheet on Page 39. If the final Service Intensity disposition is different from the ECSII-derived SI level, write in explanation at the bottom of the page.

ECSII SERVICE INTENSITY LEVELS		
LEVEL	**0**	Basic health services
LEVEL	**1**	Minimal service intensity (beginning care)
LEVEL	**2**	Low service intensity
LEVEL	**3**	Moderate service intensity
LEVEL	**4**	High service intensity
LEVEL	**5**	Maximal service intensity

ECSII SCORING WORKSHEET

Child's Name _____ DOB_____Rater(s) _____

Date of ECSII rating _____ Rater's judgment of SI Level prior to ECSII rating _____

STEP 1		
DOMAIN	**Score**	**Anchor Points Met / Comments**
I. Degree of Safety		
II. Caregiving Relationships		
III. Caregiving Environment	---	
A. Strengths/Protective Factors		
B. Stressors/vulnerabilities		
IV. Functional/ Developmental Status		
V. Impact of Medical, Developmental or Emotional/Behav. Problems		
TOTAL SCORE on I-V		

STEP 2	**Preliminary SI Level by Total Score on Domains I-V (circle one)**						
	Total score	**6-8**	**9-12**	**13-17**	**18-22**	**23-26**	**27-30**
	SI Level	**0**	**1**	**2**	**3**	**4**	**5**

STEP 3	**Application of Independent Criteria**				
	ECSII Domain	I. Degree of Safety	II. Child-Caregiver Relationships	IV. Functional/ Devel. Status	
	If Score is	5	5	5	
	Action	**Moves to Level 5**	**Moves up 1 Level ***	**Moves up 1 Level ***	***(* only 1 level raised if Domains II and IV are both rated 5)***

STEP 4	**ECSII SERVICE INTENSITY LEVEL**		

STEP 5	**Domain VI. SERVICES ** PROFILE SCORES**	(A) Child Involvement		**(A) Involvement Score (choose one)**	**(B) Fit**	**(C) Effectiveness**
		(A) Caregiver Involvement				
	*(** Consider one SI level increase if sum of three Services Profile scores = 12 or above)*					

Explanation if final disposition differs from the ECSII-derived SI Level _____

_____

STEP 5: Services Profile (SP) scores (Domain VI) do not usually change the ECSII SI Score, but are important considerations for individualized service planning. The SI Level may move up 1 level if the sum of SP scores = 12 or above; SP scores may also explain an assignment of SI Level different from the ECSII-derived level.

WORKSHEET FOR ECSII DOMAIN VI: SERVICES PROFILE	
SI Considerations for A. Caregiver or Child Involvement	
Low Child or Caregiver Involvement (Subscale score of 4-5)	*MAY* impact the service plan, e.g.: ➢ If low involvement is due to poor service fit, then a change in service array may be indicated (e.g. bringing in a parent partner or more linguistically competent provider) ➢ If low involvement is due to family experiencing services as too burdensome, then lowering service intensity may be indicated
SI Considerations for B. Service Fit	
Low Service Fit (Subscale score of 4-5)	*MAY* impact the service plan, e.g.: ➢ If the reason for poor service fit is that more frequent services are needed or another service or support is needed, then increasing service intensity may be indicated ➢ If the reason for poor service fit is restricted access to needed services (e.g. community based wraparound unavailable due to insurance or other funding limitations; family can't get to clinic-based service), then either providing better fitting services is indicated or, if those are unavailable, increasing service intensity may be indicated ➢ If the child requires out-of-home care because in-home and other community supports are not truly available, this may indicate increased service intensity ➢ If the family experiences a high intensity of services as too burdensome or intrusive (possibly interfering with their involvement), then this may indicate lower service intensity ➢ If the reason for a poor service fit can be addressed adequately with a different service array or approach, then service intensity does not need to be increased
SI Considerations for C. Service Effectiveness	
Low Effectiveness (Subscale score of 4-5)	*MAY* impact the service plan, e.g.: ➢ If effectiveness is low because of low child/caregiver involvement in services, then services to enhance child or caregiver involvement should be added (e.g. parent partner, care coordination), which may change service intensity ➢ If effectiveness is low *but* child/caregiver involvement in services and service fit are both adequate, more services may be needed (e.g. additional hours of respite or increased frequency of outpatient therapy), which may change service intensity ➢ If effectiveness is low because the specific service does not fit the problem (e.g. intervention is targeting only the child even though needs exist in the caregiving environment), then the service array should be modified, which may change service intensity

INTRODUCTION TO SERVICE PLANNING

Please note that the ECSII Service Intensity Level alone is not sufficient to develop an individualized service plan. Information derived from scoring all six Domains is essential for identifying the concerns and priorities that should be addressed by the service plan.

HOW TO USE INFORMATION FROM ECSII DOMAIN SCORING:

As indicated above, information as to which specific anchor points are met during ECSII scoring of Domains I-VI is of equal importance to the Service Intensity Score. This crucial information about the specific challenges, vulnerabilities and needs of the child and family, should be used to set priorities and develop a comprehensive individualized service plan. We recommend keeping a record of the specific concerns identified in ECSII Domain scoring for ongoing monitoring of child and family needs and evaluation of how well the service plan is meeting those needs.

DESCRIPTION OF SERVICE PLANNING PROCESS

Service planning with the ECSII is intended to promote an individualized service plan. The service planning process should be guided by the following principles:

a) Interventions should be based on strengths and needs identified by the family, not only professionals' recommendations.
b) Services should be individualized and prioritized, including the timing of service delivery and acceptability to the family and child.
c) Services should respect the family's unique cultural values and beliefs.
d) Consider multiple options before settling on specific interventions
e) Incorporate community and natural supports as well as formal services; these may be added to increase service intensity. In communities with fewer formal services available, higher service intensity levels may need to be formulated through additive use of these services.
f) There should be identified accountability for accomplishing each aspect of the plan

HOW TO USE INFORMATION FROM SERVICES PROFILE DOMAIN:

The ECSII assessment of Domain VI, Services Profile complements the assessment of the other five ECSII Domains, and in some instances may take precedence over scores in the other Domains in determining the eventual service plan. If the service fit is poor, merely increasing the intensity of current services may not result in better outcomes. Rather, the primary focus of the service plan may need to be to promote a better fit between the services offered and the needs and strengths of the individual child and family. For example, if a family is uncomfortable and poorly adherent to a modality of treatment, merely increasing the number or frequency of the service will likely not result in a better outcome. Rather, attention must be focused on alternative supports to the family that may be more acceptable and allow for better engagement, including supports that may enhance engagement and adherence to service interventions recommended by involved professionals.

Similar considerations apply to the subscale of Caregiver/Child Involvement in services. The family may not be adequately involved in services because of linguistic or cultural incompatibility. Parents may also not be adequately involved because they are overwhelmed with the number of services they are

expected to participate in. Lack of coordination among providers can result in multiple service plans that are not only overwhelming in number for the family, but worse, can create conflicting expectations for families.

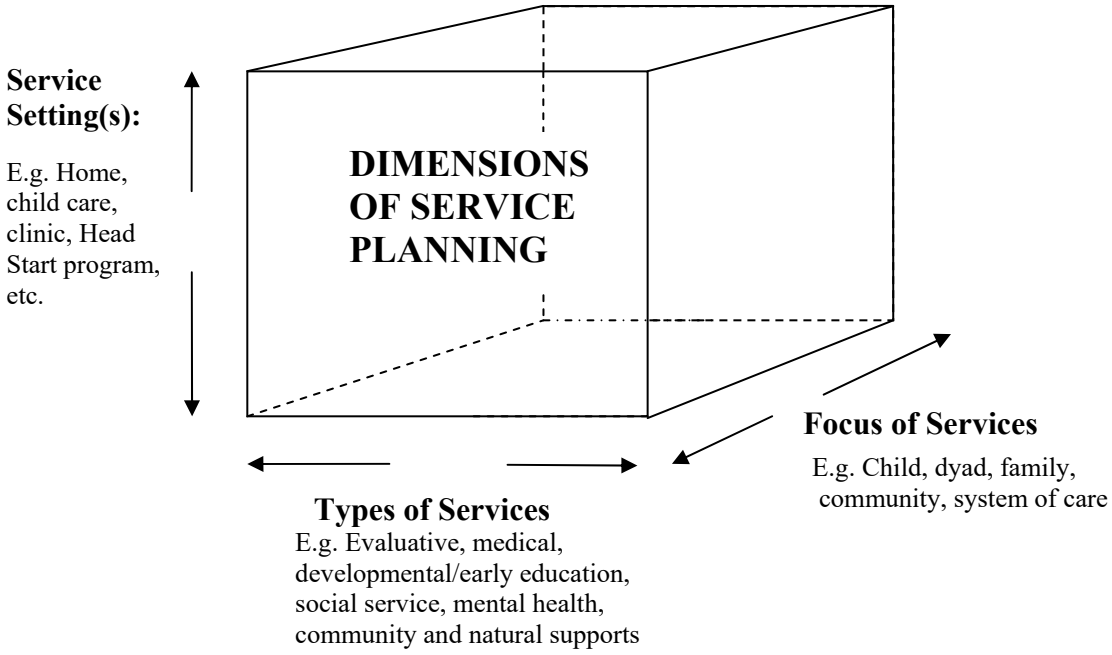
Lack of adequate Service Effectiveness can be the result of deficiencies in the services offered, rather than implying that the lack of effectiveness is due to a limitation within the family. A wraparound approach takes the position that if a service plan has not been successful, that the need is to revise the plan, not to blame the family.

Therefore, careful attention must be paid to each subscale of the Services Profile in creating a successful service plan. To the extent that services are prescribed as treatments by professionals, without sufficient regard to family preferences, needs, and strengths, the risk that the services will not be effective or will have limited benefit increases. Merely increasing service intensity with the same modalities used previously is likely not to be helpful. Shifting the types of services may be essential to promote better outcomes, independent of the level of service intensity that may be necessary.

DIMENSIONS OF SERVICE PLANNING:

As one begins the process of service planning with the family, three key areas will need to be addressed, which we refer to as dimensions of service planning, including:

a) *Focus of services*: where services are targeted, e.g. child, parent-child dyad, family/caregivers, community or neighborhood, and system of care
b) *Types of services*: category of services (see pages 50-56), e.g. evaluation, medical, developmental, educational, social, mental health, care coordination, community / natural supports
c) *Setting in which services are provided:* e.g., home, child care/preschool, Head Start program, mental health or other clinic setting, day treatment program, therapeutic foster care, etc.



Service intensity can be increased or decreased in a variety of ways with respect to: 1) *focus of services, 2) types of services and 3) settings of services*, and is made up of the following elements:

i) Number, frequency, and duration of interventions
ii) Extent of safety assessment and monitoring required
iii) Level of technical or professional consultation
iv) Number of systems and interagency collaboration required; degree of care coordination or case management required
v) Level of support provided for child and/or family's daily functioning or restrictiveness of service setting

SERVICE INTENSITY (SI) LEVELS

What is a Service Intensity Level?

A Service Intensity (SI) Level is the *composite* of all services and supports. It is not a specific service setting such as a hospital, residential center, or day treatment program. There are multiple ways to achieve a particular SI level. For example a higher SI level may be achieved with multiple services of different types (e.g. educational, mental health, child welfare) or a higher level of one service type

Tables 1-7 (pages 50-56) show **examples** of increasing levels of intensity within seven different service categories: 1) Evaluation, 2) Medical, 3) Developmental/Educational, 4) Mental Health, 5) Social Services/Child Welfare, 6) Community and Natural Supports, and 7) Care Coordination/Child and Family Teams. These are intended to be examples of how service intensity may increase within that service type. Since specific services and service available varies widely from community to community, entries in these tables might differ, and space is left in the table for additional entries.

Also, note that levels of intensity are not the same in different service types, i.e. not all service types having comparable frequencies or degree of specialist involvement will be at the same SI level. For example, a single weekly developmental therapy might be considered a starting level of services whereas a weekly mental health session attended by the child or family is considered more intensive in this age group.

Higher service intensity may be achieved by adding specific services that may typically be found at lower levels of service intensity. For example, a parent partner may be used at moderate service intensity or may be added to at a higher level to increase service intensity.

The Service Intensity Level encompasses services across *all* needed service types. THUS, THE SERVICE INTENSITY LEVEL ASSIGNED TO A PARTICULAR CHILD IS A COMPOSITE OF ALL THE SERVICES IN HIS OR HER INDIVIDUALIZED SERVICE PLAN. A particular Service Intensity level may have a high level of services in one service category and a minimal level of services in another service category, but still comprise a high level of overall Service Intensity. General descriptions of Service Intensity Levels 0-5 are provided below. For each Service Intensity Level, six relevant characteristics of service intensity are described at ascending levels to convey what the overall level might look like.

Refer to the Service Intensity Tables 1-7 (pages 49-55) for *examples* of increasing service intensity in each service category, keeping in mind that practice may vary in different localities and from state to state. These tables are not intended to be prescriptive but can be used as stimuli to guide service planning.

Characteristics of Service Intensity Levels

Since Service Intensity in the ECSII is not limited to mental health services, a way of thinking about what an *overall* Service Intensity looks like is needed. The seven elements listed below

describe characteristics of services (or in some cases child and family needs) at different Service Intensity Levels. Each ECSII Service Intensity Level from 0-V is then described according to these characteristics.

When you have scored the ECSII and are developing a service plan at a specific ECSII-derived Service Intensity Level, these descriptions may help to "locate" an appropriate level of overall Service Intensity. In addition, when evaluating an existing service array, these descriptions may be used to help identify the existing Service Intensity Level.

1. **Complexity and impact of problem(s)**
2. **Focus of intervention and setting in which services occur (home, community, office, program)**
3. **Extent of specialized services (evaluation / treatment)**
4. **Number, frequency, and duration of services**
5. **Support for safety and daily functioning**
6. **Number of agencies/systems involved, degree of care coordination and role for the child and family team**
7. **Extent of community and natural supports**

ECSII SERVICE INTENSITY LEVELS		
LEVEL	**0**	Basic health services
LEVEL	**1**	Minimal service intensity (beginning care)
LEVEL	**2**	Low service intensity
LEVEL	**3**	Moderate service intensity
LEVEL	**4**	High service intensity
LEVEL	**5**	Maximal service intensity

SI LEVEL 0. BASIC HEALTH SERVICES

1. At this SI level the child and family are receiving basic health promotion and preventive services that should be available to every child.
2. The child's expected developmental issues are addressed in home, child care, preschool/school, and primary health care settings.
3. Specialized services are not needed at this level. Standard screening for health, development and behavioral needs is available as a routine service (e.g. hearing or vision screening in schools).
4. Routine well child visits occur at the recommended frequency appropriate to age.
5. Coordination needs are not significant and are performed by the family or primary care practitioner. The child serving agencies are typically primary health care and child care or education.
6. Community and natural supports include support from family, kin, and community; child (day) care; informal parent peer support; and faith based community, among others.

SI LEVEL 1. MINIMAL SERVICE INTENSITY (BEGINNING CARE)

1. This SI level represents beginning services or supports given in response to a circumscribed area of concern in the child or family.
2. The child's developmental, emotional or behavioral problems are addressed by the primary care provider or through specialist consultation to the school or child care settings. The focus is most often providing education and skills to caregivers to help them address the problem at home (e.g. a speech therapist coaches the caregiver to increase language in daily activities).
3. At this level there may be a single medical or developmental evaluation and/or treatment (e.g. speech therapy or occupational therapy).
4. Additional services or contacts with providers may be needed to address a specific problem. The frequency is generally weekly or less.
5. Coordination needs are performed by the family in collaboration with the primary service provider (e.g. developmental therapist, primary care practitioner).
6. Community and natural supports are targeted to areas of concern (e.g. home health nurse, trained parent mentor, child socialization group).

SI LEVEL 2. LOW SERVICE INTENSITY

1. This SI level represents added services targeted to one or more significant area(s) of concern, which may be either acute or ongoing.
2. Although the focus may still be on assisting the caregiver(s) in addressing the child's needs, services are more likely to occur in settings other than home or child care. Formal mental health services with the child and family begin at this level.
3. The specialist may take a more direct role in the care of the child at this level. The primary health provider at this level may provide a higher level of care for a specific problem (e.g. diagnosis and medication treatment for ADHD).
4. Increased intensity of services occurs at this level. How this occurs may vary across systems or service categories (e.g. added services, more specialized services, and/or more frequent services). For example, developmental therapy may increase in frequency or formal mental health services are introduced. The frequency of services is up to once a week.
5. Coordination needs are performed by the family in collaboration with the primary service provider. There may be several practitioners involved that requires some communication but there is generally not a need for formal care coordination or a child and family team.
6. Community and natural supports continue to be targeted to areas of concern and can be added to increase intensity. They may increase in number, frequency, and duration (e.g. several contacts per week with a home health nurse or parent mentor, efforts to enhance the family's community supports).

SI LEVEL 3. MODERATE SERVICE INTENSITY

1. This SI level represents moderately intensive services targeted to multiple and/or complex area(s) of concern that are interfering with the child and family's functioning. The concerns

are generally ongoing although a serious problem presenting acutely or may be addressed at this SI level.
2. At this SI level there are multiple foci of intervention, not only to the child and family, but at the level of the providers (e.g. consultation to a provider or additional interagency collaboration).
3. At this level there may be a need for multiple specialty evaluations, and repeated or ongoing treatment contacts. The specialist may assume an increased role in the direct care of the child. At this level mental health needs are generally more complex and require specialty mental health care; however, continued involvement of the primary health provider is important for continuity and coordination of care.
4. Moderate intensity services may be achieved through increased frequency of contacts, multiple types of interventions, or more specialized services within a program. This level may entail multiple mental health sessions per week (e.g. child/family therapy or home-based therapy); multiple or frequent developmental therapies provided by Early Intervention; or child welfare-provided home-based services and/or monitoring. Development of a crisis or safety plan should occur at this level.
5. At this level it is likely that there are more providers or agencies involved with the child and/or the family (e.g. child welfare, parental involvement with the justice system), which will require increasing care coordination. There is an assigned (i.e. formal) care coordinator if multiple providers are involved. A child and family team is desirable at this level; it may occur on an as-needed basis or be time-limited. Alternatively, there may be intensive involvement by one agency making formal care coordination less necessary.
6. Community and natural supports should be increased and are integrated into the comprehensive plan to address areas of concern. Community and natural supports are actively recruited to augment the family's strengths and resources (e.g. respite services, assistance with housing or employment, and other supports to caregivers).

SI LEVEL 4. HIGH SERVICE INTENSITY

1. This SI level targets multiple and complex areas of concern. The concerns are ongoing, although a serious acute problem may need this level of service intensity (e.g. loss of a parent, child abuse or neglect). The child's development and the family's stability will be seriously disrupted without this level of intervention.
2. At this SI level there are multiple foci of intervention to address complex issues involving the child and family that require intensive collaboration among providers. Intervention settings expand to include placement in intensive outpatient programs (e.g. therapeutic nursery, day treatment); or intensive home-based services multiple days per week.
3. At this level there may be increased involvement of specialists in an agency (e.g. a family therapist and assigned care coordinator). There is also need for more specialized interventions addressing multiple domains. For example, a child with autism may receive intensive specialized interventions in the home and/or in a therapeutic day program. The specialist has a primary role in direct care and participates in the child and family team.
4. High intensity services occupy multiple hours, multiple days per week. Home-based services may be delivered by a team rather than single therapist. Safety plans and a capacity for crisis intervention are in place and available at all times (e.g. caregiver at risk of abusing child has immediate access to members of the crisis team).

5. At this level an assigned care coordinator is essential. There should be a child and family team to develop a coordinated, integrated, and comprehensive service plan that addresses the full range of needs. Multiple agency involvement is expected with high level representation from the agencies.
6. Community and natural supports are more intensive and involved in supporting the family's daily functioning. If necessary, flexible funds should be made available to maximize and sustain involvement of supports such as assistance with transportation, respite or emergency financial aid. These supports must be integrated into the comprehensive service plan and should be family-selected.

SI LEVEL 5. MAXIMAL SERVICE INTENSITY

1. This SI level represents maximal intensity services targeted to multiple and complex areas with acute concerns. These concerns pose significant and immediate threats to safety. The child's development and/or the family's stability may be irreversibly disrupted without this level of intervention.
2. At this SI level the complex issues and multiple foci of intervention require significant environmental support and modification. This may involve a therapeutic out-of-home placement (e.g. treatment foster care, parent-child residential, or hospital) or the highest level of in-home services that can ensure safety and provision of necessary treatment. Acute removal from the home for an unsafe environment should trigger an immediate comprehensive assessment of the home and child's needs, which acutely raises intensity to Level V, whereas stable placement in foster care for environmental issues can occur at a lower level.
3. Specialist involvement is more intensive and guides evaluation and treatment at this level. Involvement of multidisciplinary teams and multiple agencies is essential.
4. This level involves 24-hour care, or care of sufficient intensity to ensure safety and comprehensively address the child and family's immediate needs. The safety plan takes priority within the service plan and needs to be frequently re-evaluated. If this SI level involves maximal home-based intervention, crisis intervention and safety maintenance services must be available to the home site on a 24-hour basis.
5. At this level an assigned and specialized care coordinator is mandatory. The child and family team needs to be maintained even if the child is removed from the home, and family input into the child and family team continues to be essential. The child and family team needs to meet frequently to reassess treatment progress and modify the service plan accordingly. Multiple agency involvement is expected. Administrative support from each agency is required to develop and implement an integrated, individualized plan that meets the child and family's needs.
6. Community and natural supports remain essential in the context of maximal care and need to be augmented to support recovery and reintegration into the home and community. If the child is removed from their home this may require additional outreach to maintain the involvement of the child and family's community support system. At this level flexible funds should be available to maximize and sustain involvement of these supports.

Examples of Levels of Service Intensity in Seven Service Categories

The Tables on the following pages describe six levels of service intensity (numbered 0-5) in the following seven categories of services for children 0-5 years old:

1) **Evaluation**
2) **Medical**
3) **Developmental/ Educational**
4) **Mental Health**
5) **Social Service/ Child Welfare**
6) **Care Coordination/ Child and Family Teams**
7) **Community and Natural Supports**

Ascending levels of Service Intensity can be achieved in a variety of ways that are individualized to the needs of the child and family, and may involve, for example, multiple interventions, a higher frequency of services, or increased interagency coordination, rather than a placement in a specific treatment program.

Each table provides *examples* of services that might be provided at that level of service intensity. The examples convey factors or variables involved in progression to the next higher level. In general, Level 0 connotes basic health care and services or natural supports that should be available to all children. Note that not all specific services available within that level are indicated on the table. Also note that a service included in a particular level in one service area may be at a different level in another service category. For example, medical hospitalization is listed as Level IV under medical services, whereas psychiatric hospitalization is considered Level V (i.e. higher level) in the mental health service category.

Table 1. Examples of Increasing Service Intensity in: Evaluation Services

Level of Service Intensity		Service Category: **EVALUATION**
	Check only one box below	
0		• Primary care check-up • Health screening in pre-school settings •
1		• Evaluation in a single service area •
2		• Evaluations from one or more service areas •
3		• Evaluations from multiple service areas, with repeated visits •
4		• Complex, integrated, multidisciplinary evaluation •
5		• Evaluation in inpatient or other 24-hour setting •

Table 2. Examples of Increasing Service Intensity in: Medical Services

Level of Service Intensity		Service Category: **MEDICAL**
	Check only one box below	
0		• Well child care/ primary health care • Standard preschool health monitoring (e.g. Head Start) •
1		• Primary care management of acute common childhood illness (e.g. occasional otitis media, gastroenteritis) • Preschool monitoring of specific health issue, e.g. nutrition, dental care •
2		• Chronic medical conditions manageable by primary care provider (e.g. asthma, recurrent otitis media, atopic dermatitis) • Medications for chronic conditions given in preschool or child care setting •
3		• Chronic medical conditions managed by primary care provider with occasional specialist consultation • Time-limited home-based health care (e.g. completion of course of intravenous antibiotics) •
4		• Chronic medical problems requiring management by specialist or multiple specialist consultation (e.g. poorly controlled diabetes, chronic failure to thrive) • Intermittent hospitalizations for chronic medical condition • Ongoing home-based or school-based health care (e.g. weekly or twice weekly visiting nurse) •
5		• Frequent hospital admissions, secure nursing facility or chronic care facility; medical foster care • Intensive, home-based or school-based health care involving multiple providers (e.g. home ventilation; visiting nurse on a daily basis •

Table 3. Examples of Increasing Service Intensity in: Developmental/Educational Services

Level of Service Intensity		Service Category: **DEVELOPMENTAL/EDUCATIONAL**
	Check only one box below	
0		• Child care, Head Start, or regular preschool • Regular kindergarten or Montessori class • Playgroups •
1		• Single developmental therapy but below Early Intervention eligibility (e.g. speech clinic, home visit w/ developmental specialist (0-3); occupational therapy consult) •
2		• Early Intervention developmental service provided in home with caregiver coaching/skills training • Supports or modifications added to typical classroom/natural environment • More than one developmental therapy in home or clinic setting •
3		• Higher frequency home-based developmental services with caregiver skills training • Special education eligibility w/ Individualized Family Service Plan (IFSP) or Individualized Education Plan for (IEP) if 5 or older • Center-based Early Intervention or Early Childhood Special Education Classroom at a low frequency (e.g. 1-2 half days /wk) and integrated with typical peers • Multiple developmental therapies in a classroom with special education teacher • Specialized kindergarten class for speech and cognitive delays •
4		• Center-based Early Intervention or Early Childhood Special Education multiple days per week, with availability of 1:1 support. (e.g. autism classroom or behavioral kindergarten) • Dual placements, e.g. developmental classroom in morning and Head Start in afternoon • Intensive, home-based developmental support/caregiver skills training •
5		• Self-contained special education placement 4-5 days per week with no typical peers • Intensive 1-to-1 support from multiple specialists in the classroom • Day treatment with psychiatric and educational components • Contained classroom in psychiatric hospital or residential treatment center •

Table 4. Examples of Increasing Service Intensity in: Mental Health Services

Level of Service Intensity		Service Category: **MENTAL HEALTH**
	Check only one box below	
0		• Mental health screening in school or primary care setting •
1		• Parent guidance and support, e.g. parent education/ training • Mental health consultation to Head Start or child care •
2		• Outpatient mental health services once per week or less by a mental health professional (e.g. individual, dyadic, family, or parental therapy; pharmacotherapy for an uncomplicated mental health condition) • Mental health diagnosis and psychotropic medication by a primary care practitioner •
3		• Intensive outpatient (i.e. > 1 session per week) of individual, dyadic, family, or parental therapy • More than one therapy modality concurrently or > 1 mental health professional involved concurrently (e.g. masters' trained therapist, ongoing child psychiatric care) •
4		• Psychiatric day treatment • Very high intensity individual, dyadic or family therapy (multiple sessions per week, some of which may be home-based) • Multiple modalities concurrently, generally requiring multiple agency involvement (e.g. intensive wraparound) •
5		• Therapeutic out-of-home placement (e.g. treatment foster care) • Psychiatric hospitalization (for children > 2 ½) • Residential treatment • Highest intensity home-based services with provisions for evaluation and safety •

Table 5. Examples of Increasing Service Intensity in: Social Services/Child Welfare Services

Level of Service Intensity		Service Category: **SOCIAL SERVICES/CHILD WELFARE**
	Check only one box below	
0		• Public health education • Basic financial assistance, e.g. WIC (Women, Infants, and Children Supplemental Nutrition Program), food stamps, Medicaid and SCHIP (State Children's Insurance Program) • Community home visiting for all members of an identified group (e.g. home visits for first-time mothers) •
1		• Public assistance (e.g. Temporary Assistance for Needy Families [TANF]) with assigned caseworker • Periodic home monitoring for identified area of concern (e.g. visits by home health nurse) •
2		• Parenting education classes for identified concern • Regular home health monitoring or intervention for area of concern (e.g. regular visits by home health nurse) • Low level referrals to child welfare that do not require full investigation but lead to referral for services due to presence of some risk factors •
3		• Beginning home-based family support services (e.g. one day per week of respite) • Voluntary child welfare involvement (if available) for support services • Child welfare monitoring in initial period after reunification • Open child welfare case with higher level services due to significant risk factors but not acute safety risk • Foster care not for protective services reasons (e.g. parent killed); or ongoing stable foster care that is not for child's therapeutic needs •
4		• Intensive home-based services (e.g. family preservation services) • Open child protective services case due to substantiated child maltreatment with child able to remain at home •
5		• Open child protective services case due to substantiated child maltreatment that may require acute removal from the home • Treatment foster care •

Table 6. Examples of Increasing Service Intensity in: Care Coordination Services/Child and Family Teams

Level of Service Intensity		Service Category: **CARE COORDINATION/ CHILD AND FAMILY TEAMS**
	Check only one box below	
0		• Caregiver (s) (e.g. parents) coordinates services as needed •
1		• Caregiver(s) (e.g. parents) coordinates services as needed in collaboration with primary service provider (e.g. primary care physician, therapist) •
2		• Primary service provider (e.g. therapist) performs care coordination as needed in collaboration with caregiver(s) (e.g. parents) •
3		• Separate care coordinator (i.e. not primary service provider) if multiple providers are involved • Development of child and family team (CFT) with active family involvement. CFT may meet on as-needed basis or be time-limited •
4		• Formal care coordination with a child and family team (CFT) that meets regularly •
5		• Formal care coordination with a child and family team (CFT) meeting frequently (e.g. due to ongoing crisis planning needs) •

Table 7. Examples of Increasing Service Intensity in: Community and Natural Supports

Level of Service Intensity		Service Category: **COMMUNITY AND NATURAL SUPPORTS**
	Check only one box below	
0		• Support from family, kin, community • Child (day) care • Informal parent peer support • Faith-based community •
1		• Parent support group or parenting education class • Increased involvement of extended family, kin, community •
2		• Specialized parent education program to address specific need • Provider assistance to enhance family support network, including parent-to-parent support • Increased involvement with community support organizations •
3		• Trained parent mentor; trained parent advocate (e.g. "parent partner") to support family in team process • Parent coaching or skills building by trained provider • Family support services, e.g. respite, home-based assistance to help with child and family's daily functioning •
4		• Intensive home-based support to help with child and family's daily functioning. • Home-based parent coaching or skills building by trained provider multiple times per week •
5		• Intensive in-home support for a greater number of hours and supporting safety in the home •

This SERVICE ARRAY WORKSHEET is a stimulus for a child/family team services planning process.

SERVICE TYPE	*Check if service is recommended*		Comments
Note that different services may be provided by one provider	Necessary	Optional or Future	
Community and natural supports			
Increased involvement of family, kin, friends			
Parent-to-parent support			
Involvement w/ community organization			
Assistance w/ housing or other concrete needs			
Socialization or recreational activities			
Spiritual or other cultural supports			
Financial or material supports			
Other			
Caregiver/family-focused			
Community health nurse			
Parent guidance w/ behavioral or mental health specialist			
Dyadic (caregiver-child) therapy			
Parent MH or SA treatment			
Parent-training (individual or group)			
Respite services			
Parent mentor			
Home-based services			
Couple or family therapy			
Parent/child residential			
Other			
Child-focused			
Individual therapy			
Child care			
Day Treatment or Therapeutic Nursery			
Early Intervention (multi-focal therapies)			
OT, PT, or Speech therapy			
Treatment foster care			
Head Start or Early Head Start			
Inpatient psychiatric hospital			
Psychiatric/MH evaluation			
Psychopharmacology			
Health care intervention			
Socialization or play group			
Other			
System-focused			
Case management/ care coordination			
Interagency collaboration			
Child and family (wraparound) team (CFT)			
Advocacy for services or agency involvement			
Crisis services			
Mental health consultation to another provider or agency			
Other			
Other			

GLOSSARY of TERMS USED IN THE ECSII

Advocacy occurs when an individual actively provides representation of the needs and interests of children and families with serious illnesses or disruptions in the child and family's development, in order to obtain services, assure fair and reasonable accommodations for special needs, and promote opportunities for maximum independence in the community. Advocacy may include interpretation of client needs to providers, consultation and technical assistance in reducing and eliminating barriers, and assertive efforts to assure adaptations and accommodations. Advocacy is considered to be an important element of case management and care coordination.

Assessment is a professional review of child and family needs performed when services are first sought from a professional care provider. The assessment identifies the strengths of the child and family and areas of need or concern. Together, the professional and family decide what kind of treatment and supports, if any, are needed to ensure optimal growth and development of the child and family.

Caregiver is a person with a primary and significant role in providing care and emotional nurturance to a child in the child's primary residential setting. A caregiver may be a biological or adoptive parent, a guardian, or kin.

Care Provider can be used to denote a person who has special training to help children; care providers may include child care workers, teachers, mentors, or providers of mental health care such as social workers, psychologists, and psychiatrists.

Care Coordination is provided by a trained individual who works with a child and family to help organize services from varied child serving systems and to develop a coordinated and integrated service plan. Care coordination provides assistance with identifying and locating community resources, financial services and problem solving.

Case Management is similar to care coordination in that the provider facilitates coordination of patient/client services to assure continuity of care and accountability for service provision. However, case management may imply that the services are more intensive and may involve some counseling and/or home-based services.

Child and Family Team is composed of, at a minimum, the child and his/her family, any foster parents, a behavioral health representative, and any individuals important in the child's life who are identified and invited to participate by the child/family. The size, scope and intensity of involvement of the team members are determined by the objectives established by and for the child/family that culminate in a coordinated individualized and effective service plan.

Child Care is the act of supervising a minor child. Family, kin and formal government and private organizations provide this level of supervision for caregivers in need.

Community and Natural Supports are those individual and unique persons, environments and or services that are available in the community and/or ecology of the child and family. The child

and family use supports that are accessible to all in the community and the enhanced connections in the community foster a sense of more autonomy and empowerment over the course of time.

Continuum of Care implies a progression of services that a child moves through with increasing or decreasing intensity, often but not necessarily one service at a time.

Cultural Competence entails awareness of the impact of culture on child, family, and community development. Cultural competence is evidenced by services that respond appropriately to a person's unique cultural differences, including race and ethnicity, national origin, religion, age, gender, sexual orientation, family's values and customs.

Day Treatment is an integrated service model consisting of special education, counseling, and parent guidance/training. Day treatment may also include vocational training, skill building, crisis intervention, and recreational therapy. It lasts at least 4 hours a day.

Developmental Therapy (also called Rehabilitative Therapy or Service) focuses on remediation of an area of delayed development or one that is at risk. The intervention is typically provided by a specialist in an area of child development such as a Speech and Language Pathologist or Occupational Therapist. Development therapies utilize new skill acquisition, self-help skills, and play skills, to enhance adaptation and development. Developmental therapists can help with areas of development by providing direct therapy or consulting with and providing training to caregivers.

Diagnostic and Classification System 0-3 (DC0-3R) was created in1994 (revised in August, 2005) as a diagnostic classification system that advances the field of infant mental health allowing professionals and parents to use a common language relevant to infants and young children that recognizes biological, psychological and social factors in child development. The system allows professionals to discuss their observations and experiences; and provides a common basis for research and treatment recommendations. The system is strengths-based and acknowledges the significance of the caregiver child relationship.

Diagnostic and Statistical Manual (DSM IV TR -R) is a diagnostic classification system of mental health problems developed by the American Psychiatric Association. Psychiatrists, psychologists, social workers, and other health and mental health care providers use this manual to understand and diagnose mental health problems. Insurance companies and public health care insurance entities and providers use explanations in this book or when discussing mental health problems.

Dyadic Therapy describes a therapeutic intervention that includes counseling with the parent and child, and parental guidance. It is provided to help the caregiver learn to play reciprocally with his or her child, to understand the child's nonverbal cues, and to follow the child's lead, in support of healthy development. Goals of therapy include improving caregiver sensitivity, child and caregiver interaction, behavioral and emotional caregiver and child responsiveness, and affective attunement and exchange.

Early Childhood Intervention (ECI) is state and federally funded program through the Individuals with Disabilities Education Act (IDEA, P.L. 108-446), ECI provides evaluations and assessments at no cost to families, to determine eligibility and need for services. The caregiver and professionals work as a team to plan appropriate dvelopmental services based on the unique needs of the child and family.

Flexible Funds are used to pay for services and supports that are not reimbursed by insurance or other payment sources. They are usually services not included in categorical funding.

Home Based Services are provided in a family's home, either for a defined period of time or for as long as it takes to deal with a mental health problem. Typical elements of such services include parent training, child or youth counseling, and working with family members' community systems to prevent the child or youth from being placed outside of the home.

Home Health Nurse (also called Community Health Nurse) is a nurse who provides services to the child and family in the home. Interventions focus on parent training, supporting child development, and health monitoring.

Individualized Education Plan (IEP) is a school-based service plan that affords the child specific, individualized assessment and interventions to maximize the child's development in cognitive, social and educational areas.

Infant is a child from just after birth to one year of age.

Kinship expands the definition of family, recognizing that in certain culture and ethnic groups family members of a child may derive from important non-blood related caregivers and other supportive individuals.

Level of Care historically refers to treatment along a continuum of care where each level represents a different intensity, restrictiveness (containment), or degree of medical services and medical monitoring.

Mental Health Professional is a professional with specialized training in providing mental health services. Mental health professionals include counselors, social workers, child psychologists and child psychiatrists. Mental health organizations credential mental health professionals at different levels depending on level of training, usually at the B.A. or M.A. level.

Nurse Specialist is a nurse who provides specialized services supporting the dyadic relationship and parent effectiveness in supporting child development.

Parent Guidance includes education, mentoring, skill building, and collaborative review of services that support child and family.

Parent-to-Parent Support is a supportive service in which caregivers who have knowledge and first hand experience in using formal child services as well as natural and community supports, share the knowledge gleaned from their own experience. They assist the caregiver in maintaining

a sense of control in their interactions with service programs, and to apply their abilities to the care of their children while learning new competencies.

Parent Partner is a caregiver who provides intensive individual support by modeling parenting skills and modes of collaboration with providers of services for a child involved in a child-serving system. The mentor models empowerment for the family and serves as a guide for planning and providing services for young children with special needs and their families with the objective of the caregiver becoming more skilled and autonomous in meeting his or her family's own needs.

Partial Hospitalization is an intensive service provided in a hospital setting in which the child is stabilized in the treatment setting but remains at home in the evenings. Services are typically provided for greater than 4 hours a day.

Primary Health Provider is a health care provider who delivers primarily physical health care to the child and is typically recognized by insurance providers as the gatekeeper for referral to other formal specialized health services.

Preschooler is a child who has not entered school yet, typically between the ages of three and five years.

Psychiatric Hospitalization, also referred to as inpatient hospitalization provides: (1) highly structured and safe short-term treatment in a specialized, high staffed hospital facility in cases where a child is in crisis and possibly a danger to his/herself or others, and (2) diagnosis and treatment when the patient cannot be evaluated or treated appropriately at other levels of care.

Psychiatrist is a physician (i.e. medical doctor) who has completed a four-year course of specialized training in general psychiatry after completing four years of medical school. A **child and adolescent psychiatrist** completes a two-year course of specialized training in child and adolescent psychiatry following general psychiatry training. Psychiatrists are trained in use of the biopsychosocial model of understanding mental health problems and are supervised in diagnostic assessment, and administration of psychotherapy and pharmacotherapy

Psychologist is a mental health professional with training in psychology. Training can be at the masters-level or doctoral-level. Psychologists are trained to diagnose and provide psychotherapy. They are generally trained to administer formal psychological test batteries.

Residential Treatment Program provides treatment 24 hours a day and can serve children and adolescents with serious emotional disturbances receive constant supervision and care. Programs may serve 12 or more young people at a time. Treatment may include individual, group, and family therapy; behavior therapy; special education; recreation therapy; and medical services. Residential treatment is usually more long-term than inpatient hospitalization.

Respite Care is offered to caregivers who have a child with a serious health or mental health disturbance. The caregiver receives support in the home or other location from trained parents or

paraprofessionals who care for the child for a specified period of time to give families relief from the strain of caring for the child.

Screening is a process of evaluating populations of children and families or a specific individual child to determine if any services or other resources are indicated to support the healthy development of the child and family.

Social Worker is a mental health professional, usually with a master's (M.A.) degree in social work. The focus of study is often community and systems-oriented but training programs provide a diversity of clinical experiences.

Strengths-based approach to service planning emphasizes identification of the strengths and culture of the child, family, and caregiving environment. The individualized service plan builds on these strengths. A strengths-based approach views the child and family as part of the solution rather than primarily as the cause of the problem.

System of Care is a model of organizing mental health and related services based on the Child and Adolescent Service System (CASSP) principles (see Addendum A). It entails a continuum of community-based services that are child-focused and family centered. The services are culturally competent and are individualized and tailored to the needs of the child and family. Families are collaborators at all levels of the planning process. This model was designed to help a child with serious emotional disturbance and their families to receive services they need; to remain in the community; and assist the family in meeting their needs.

Often local public and private organizations work in teams to implement a set of services unique to that child that looks at the developmental, physical, emotional, social, educational and family needs. Teams include families and representatives from each agency or service the child receives.

Therapeutic Nursery is a specialized childcare center for children under the age of three who are living with their caregiver. It includes a strong mental health component to promote parent-child attachment.

Toddler is a child older than one year of age but less than age three.

Treatment Foster Care is a model of care that provides the child with a combination of the best elements of traditional foster care and residential treatment centers. In treatment foster care, foster care providers with specialized training offer the positive aspects of the nurturing and therapeutic family environment combined with active and structured treatment.

Wraparound Process is a unique set of community services and natural supports based on a defined planning process in which the child and caregiver defined needs that preserve and enhance family functioning and the child development while maintaining the child in the home and community. Wraparound is a process within a system of care that individualizes services for children and youth with complicated multi-dimensional problems; often such youth are those with emotional/behavioral disturbances having multi-system needs.

APPENDIX A

CHILD AND ADOLESCENT SERVICE SYSTEM PROGRAM (CASSP) VALUES AND PRINCIPLES FOR THE SYSTEM OF CARE

Core Values

1. The system of care should be child centered and family focused, with the needs of the child and family dictating the types and mix of services provided.
2. The system of care should be community based, with the locus of services as well as management and decision making responsibility resting at the community level.
3. The system of care should be culturally competent, with agencies, programs, and services which are responsive to the cultural, racial, and ethnic differences of the populations they serve.

Guiding Principles

1. Children with emotional disturbances should have access to a comprehensive array of services that address the child's physical, emotional, social and educational needs.
2. Children with emotional disturbances should receive individualized services in accordance with the unique needs and potentials of each child and guided by an individualized service plan.
3. Children with emotional disturbances should receive services within the least restrictive, most normative environment that is clinically appropriate.
4. The families and surrogate families of children with emotional disturbances should be full participants in all aspects of the planning and delivery of services.
5. Children with emotional disturbances should receive services that are integrated, with linkages between child-caring agencies and programs and mechanisms for planning, developing and coordinating services.
6. Children with emotional disturbances should be provided with case management or similar mechanisms to ensure that multiple services are delivered in a coordinated and therapeutic manner and that they can move through the system of services in accordance with their changing needs.
7. Early identification and intervention for children with emotional disturbances should be promoted by the system of care in order to enhance the likelihood of positive outcomes.
8. Children with emotional disturbances should be ensured smooth transitions to the adult service system as they reach maturity.
9. The rights of children with emotional disturbances should be protected, and effective advocacy efforts for children and youth with emotional disturbances should be promoted.
10. Children with emotional disturbances should receive services without regard to race, religion, national origin, sex, physical disability, or other characteristics, and services should be sensitive and responsive to cultural differences and special needs.

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ECSII TRAINING MATERIALS

PART I:
SAMPLE VIGNETTES WITH SCORING AND DISCUSSION OF SERVICE PLANNING

PART II:
INTERVIEW QUESTIONS AND OBSERVATIONS NEEDED TO RATE ECSII DOMAINS

PART III:
DESCRIPTION OF ECSII DEVELOPMENT AND PSYCHOMETRIC DATA

I. SAMPLE VIGNETTES

CASE 1: CARL

Carl is a 3 year-old boy who presents with his mother to his new primary care provider, referred from his day care center because of concerns regarding hyperactive, oppositional and defiant behavior towards staff at his day care center. The day care staff is especially concerned about his aggressive behavior toward other children, which now threatens his continued placement there.

Carl moved three months ago with his mother and his 14 month-old sister from another state across the country, to the home of a maternal aunt. The move was related to his mother leaving an abusive relationship with his father. Carl's mother has recently started a full time job as a receptionist and is looking for her own apartment. Other than her sister, who is supportive, she does not have friends or family nearby.

Carl's mother states that he has been extremely active and has had difficulty following directions since before 2 years of age. In addition, before they moved, his previous pediatrician suggested he get a speech and language evaluation, because by 2 ½ years he was only starting to put two words together. She notes that Carl has progressed very little in his talking since then. Because of his behavioral problems and limited ability to express himself, she has learned to be accommodating to him to reduce his frustration and anger outbursts at home. Her other concern is that although Carl was not abused himself, he did observe some of the violence between her and his father. He also heard considerable verbal conflict between them for many months prior to her leaving. Carl has had no contact with his father since they moved out. He has asked about his father and his mother isn't sure how to answer his questions.

She reports that Carl has had no physical health problems and other than his speech delay his development has been normal. Although his behavior can be challenging for her, she identifies a number of Carl's strengths, including being affectionate and funny. Overall, she feels they have a good relationship.

DISCUSSION OF ECSII SCORING FOR CASE 1

NAME: Carl
AGE: 3

DOMAIN I: DEGREE OF SAFETY **SCORE= 3**
Moderate degree of safety: Carl's mother moved the family to another state 3 months ago to flee an abusive relationship. Carl has experienced moderate disruptions in caretaking, living and support systems, etc. (meets anchor point 3b). This is scored 3 rather than 4 because the family has achieved some stability following this move.

DOMAIN II: CHILD-CAREGIVER RELATIONSHIPS **SCORE=2**
Adequate relationship: Carl's primary relationship rated is with his mother, since he is not in contact with his father. This relationship is rated as adequate since Carl's mother has a general understanding of his emotional needs and is taking appropriate steps to get him help. She appreciates his positive traits. The relationship is not rated optimal because she does not have an optimal understanding of how to respond to his emotional needs and tends to accommodate his demanding behaviors to avoid conflict. (Meets anchor points 2 a,d).

DOMAIN III: CAREGIVING ENVIRONMENT—STRENGTHS AND PROTECTIVE FACTORS **SCORE=3**
Limited strengths in the caretaking environment: Carl is having behavioral difficulties in his day care center and with his speech/language delay. His former pediatrician suggested a speech/language evaluation, but the family's need to move delayed this. Currently, the caretaking environment (including his day care setting shows a limited ability to respond appropriately to his developmental needs (Meets anchor point 3a).

DOMAIN III: CAREGIVING ENVIRONMENT—STRESSORS AND VULNERABILITIES **SCORE=3**
Moderate stressors in the caretaking environment: Carl has experienced a moderate disruption of his family/social milieu including the absence of his father (meets anchor point 3b). Although a rating of 4 was considered, the score of 3 was chosen because the family's situation has improved and become more stable over the past three months.

DOMAIN IV: FUNCTIONAL/DEVELOPMENTAL STATUS **SCORE=4**
Moderate functional/developmental impairment: Carl is having moderate impairment in age appropriate social skills; because of his aggressive behavior there is a risk he will be expelled from his day care program (meets anchor point 4d). He also meets anchor point 4e because of his significant speech delay which is likely contributing to his level of frustration and behavioral difficulties.

DOMAIN V: IMPACT OF CHILD'S MEDICAL, DEVELOPMENTAL, OR EMOTIONAL/BEHAVIORAL PROBLEMS **SCORE=4**
Moderate impairment: Carl's emotional and behavioral problems are currently interfering with his daily functioning in day care and threatening his placement (meets anchor point 4c).

DOMAIN VI: SERVICES PROFILE –CAREGIVER'S INVOLVEMENT IN SERVICES **SCORE= (2)**

Adequate level of involvement: Carl's mother's willingness to follow up with the day care's recommendation to take him to the pediatrician for evaluation indicates a positive level of involvement, but the nature of Carl's involvement with day care is the higher score and more influential at this time and is thus used for scoring purposes.

DOMAIN VI: SERVICES PROFILE—CHILD'S INVOLVEMENT IN SERVICES **SCORE= 4**

Minimal: Carl's behavioral disturbance is interfering with development of a working relationship with the day care providers (meets anchor point 4b). Carl's involvement score is used as the final score for the Involvement scale since it is the higher of the two and he is the primary client of services.

DOMAIN VI: SERVICES PROFILE—SERVICE FIT **SCORE=3**

Limited fit: Current day care services are not addressing all of Carl's needs (meets anchor point 3b). The recommendation to see the pediatrician begins the process of evaluating his emotional/behavioral problems, and is the reason for scoring Limited Fit rather than Minimal Fit.

DOMAIN VI: SERVICES PROFILE—SERVICE EFFECTIVENESS **SCORE=4**

Minimal effectiveness: Currently the providers believe that the services are having a marginal impact toward improving the child's symptoms (meets anchor point 4a). Also meets anchor point 4b. Not scored 5 because the Carl does seem to be making some developmental progress and can be managed by his mother at home.

TOTAL SCORE DOMAINS I-V: 19

RECOMMENDED LEVEL OF SERVICE INTENSITY: LEVEL 3 (MODERATE SERVICE INTENSITY)

DISCUSSION OF SERVICE PLANNING:

Carl has multiple needs that should be addressed with services and supports. He needs speech/language intervention as soon as possible as he is already 3 years old and is several years behind in his speech. He needs a more supportive and therapeutic daily milieu, with mental health services available as opposed to regular child care, to help him with his oppositional and aggressive behavior. The referral to a pediatrician may yield a diagnosis of ADHD with a recommendation for medication. It is likely, however, that he will also need additional mental health services such as individual play therapy, given his exposure to the trauma of domestic violence followed by the loss of his father and the transition of the family move. His mother would benefit from some supportive services for herself because of her experience of domestic violence. Given her own trauma history, having a son who is aggressive may trigger emotional responses from her that cause her to be overly accommodating, overly punitive or emotionally unavailable to her son. Therefore she is likely to need ongoing help in parenting Carl and finding positive adult male role models for him. She would benefit from involvement of a "parent partner" to help her navigate the service system for Carl. The parent partner could also help

Carl's mother to take care of her own needs and she may also need her own therapy to address her history of domestic violence. In summary, Carl and his family need multiple services at this time, targeted to multiple areas of concern, representing Moderate Service Intensity.

CASE 2: KIRA

Kira is a 1 year, 9 month old female who has always been a "light sleeper". She sleeps for 3-4 hours per night before she wakes up, settling only after being rocked by her mother for a half hour or more. Her mother, who is on temporary disability following a car accident, is chronically tired, as Kira will only settle for her. Kira's father is very supportive of his wife and has taken over many of the household chores following his wife's accident. However, Kira is only slowly allowing him to play a role in her care. She is sensitive to loud noises and quick transitions, both of which can precipitate tantrums. The family has spoken to their pediatrician about these issues, but he says that she will "grow out of it." The family is not satisfied with their pediatrician's response and, on the advice of a friend with a special needs child, they are contacting a developmental pediatrician to take over Kira's care. She was born at term and has had no major medical problems since birth.

Kira is developmentally "on track" except for mild delay in expressive language. Access to speech therapy is not available through the public early intervention system due to the mild nature of her delays, but her parents are concerned that her delays will not improve without intervention. Because of this concern, the family is searching for a speech therapist, who will work with Kira and are willing to pay "out-of-pocket" if needed to ensure that their daughter receives the therapy she needs.

Her parents are under some financial stress due to mother's disability (related to her chronic headaches and need for physical therapy). However, they have good community support; the family has relatives and friends who will babysit Kira so that her parents can run errands or go to dinner together. The family is confident that with their circle of support, they can handle Kira's challenges.

DISCUSSION OF ECSII SCORING FOR CASE 2

NAME: Kira
AGE: One year, nine months

DOMAIN I: DEGREE OF SAFETY **SCORE = 2**
Adequate degree of safety: Kira's mother's injury and continued disability represent a minor disruption in family equilibrium as they continue to be able to meet her needs despite the ongoing stress (anchor point b).

DOMAIN II: CAREGIVING RELATIONSHIPS **SCORE = 2**
Adequate child-caregiver relationship: Kira's primary relationship is with her mother, as she refuses to settle for anyone else. Though her father is willing to provide care for Kira, she is only slowly engaging with him. Extra support is clearly required to maintain the child-caregiver relationship (anchor point a).

DOMAIN III: CAREGIVING ENVIRONMENT – STRENGTHS AND PROTECTIVE FACTORS **SCORE = 3**

Limited strengths and protective factors: Community resources have been of limited help to Kira and her family thus far. The pediatrician has not recognized the need for intervention and the local Early Intervention Program is not able to serve her due to the relatively mild nature of her delays (anchor point e). The lack of assistance from community resources is counter-balanced by the parent's willingness to change pediatric providers and pay for her speech therapy "out-of-pocket."

DOMAIN III: CAREGIVING ENVIRONMENT – STRESSORS AND VULNERABILITIES **SCORE = 3**

Moderate stressors and vulnerabilities: Again, the formal caregiving system (the pediatrician and the Early Intervention Program) have not provided needed support to the family (anchor point d). However, the family does receive informal, non-professional support as they have friends and family members who are willing to help them with Kira's care. In addition, there is financial stress on the family due to mother's inability to work due to her injuries in the car accident (anchor point c).

DOMAIN IV: FUNCTIONAL/DEVELOPMENTAL STATUS **SCORE = 4**

Moderate Functional/Developmental Impairment: Kira has significant difficulty with transitions, which can result in tantrums (anchor point b). She also has significant sleep disturbance, requiring soothing by her mother for a half hour or more in order to settle for sleep after awakening during night. Kira's mild speech delays are also rated in this domain, but as the speech delay is mild (anchor point 3e), it would not figure in the final rating for this domain.

DOMAIN V: IMPACT OF THE CHILD'S MEDICAL, DEVELOPMENTAL OR EMOTIONAL/BEHAVIORAL PROBLEMS **SCORE = 3**

Mild Impact: Kira will only allow her mother to soothe her and rock her back to sleep during the night, resulting in chronic fatigue for her mother (anchor point d). In addition, there is financial stress on the family due to her mother's current disability. The financial stress will increase when the family begins to pay for Kira's speech therapy themselves (anchor point e).

DOMAIN VI: SERVICES PROFILE – CAREGIVER INVOLVEMENT IN SERVICES **SCORE = 3**

Limited involvement in services: The family and the pediatrician are not in agreement about whether there is a developmental concern and whether or not treatment is necessary. The pediatrician believes that Kira's sensory issues are a normal developmental variant that requires no intervention and the family believes that intervention is needed to help their daughter to develop optimally (anchor point c). Due to Kira's young age, her involvement in services is not rated.

DOMAIN VI: SERVICES PROFILE – SERVICE FIT **SCORE = 4**

Minimal Service Fit: The pediatrician's limited understanding of Kira's condition limits his ability to work well with the family and necessitates their decision to take Kira to a

Developmental Pediatrician (anchor point b). The family lack of access to speech therapy services through the local Early Intervention Program is also rated here (anchor point d).

DOMAIN VI: SERVICES PROFILE – EFFECTIVENESS OF SERVICES SCORE =4
Minimal Effectiveness: Kira's parents do not believe that their pediatrician has been helpful to hem (anchor point a) nor do they believe that Kira's future needs have been prepared for (anchor point d).

TOTAL SCORE FOR DOMAINS I – V: 17

RECOMMENDED LEVEL OF SERVICES INTENSITY: LEVEL 2 (LOW SERVICE INTENSITY)

DISCUSSION OF SERVICE PLANNING:
Kira is most appropriately diagnosed with the Diagnostic Classification: Zero to Three (DC: 0 – 3) diagnosis of Regulation Disorder of Sensory Processing, which results in her over-sensitivity to transitions and loud noises. She requires appropriate diagnosis from a knowledgeable Developmental Pediatrician, Child Psychiatrist or other Infant Mental Health Professional. Kira also needs a referral to the appropriate out-patient or in-home therapist to assist the family by providing information about her condition and the appropriate interventions for the parents to use during their interactions with their child. Kira would also benefit from linkage to a speech therapist. High scores on the Services Profile would be reduced significantly by putting these interventions into place.

CASE 3: JACK

Jack is a 5 year-old boy whose unmarried parents separated eight months ago. He and his mother live in a two-bedroom apartment. They receive public assistance and his mother is in a job training program part-time. Jack's speech and motor skills are age appropriate and he was toilet trained successfully. His general health has been fine. Over the past six months Jack has developed steadily worsening escalating behavior problems. He has been overactive, distractible, and won't follow directions. He seems to be irritable most of the time, loses his temper frequently and often breaks things. He bites himself and hits his mother when frustrated. He has trouble getting to sleep at night most nights. Earlier this week he threatened to kill himself when his mother reprimanded him. He recently found a lighter at a neighborhood park and set a fire in the house, which fortunately was extinguished before much damage was done.

Jack had been attending Head Start on week days until recently. Despite the involvement of a mental health consultant to Head Start and medication trials by his pediatrician for hyperactivity and aggression, they were unable to contain his behavior at Head Start and are not allowing him to return until his behavior is stabilized. Several appointments have been scheduled at the local mental health center but these have not been kept allegedly because of transportation problems.

The parents broke up because the father would hit Jack and his mother when he was drinking. Jack saw the father hitting the mother, once resulting in noticeable facial bruising. She has custody but the father takes Jack at times for visitation. The Head Start teacher contacted child

protective services because of concerns about Jack's safety during these visits, but their evaluation is pending and no action has yet been taken. Jack's mother has struggled with depression in the past and made a non-serious suicide attempt by a pill overdose two years ago. She was hospitalized briefly but elected not to pursue ongoing mental health treatment after discharge. She denies any history of substance abuse.

DISCUSSION OF ECSII SCORING FOR CASE 3

NAME: Jack
AGE: 5

DOMAIN I: DEGREE OF SAFETY **SCORE = 5**
Low degree of safety: Jack found a lighter in a neighborhood park and set fire in his house. Father would hit Jack and his mother while drinking, bruising mother's face. Father sees Jack for visitation. A Protective Services report was made about Jack's safety during these visits but their evaluation is pending and no action has yet taken. Very recently Jack threatened to kill himself when mother reprimanded him. Meets anchor points 5a,c,d.

DOMAIN II: CHILD-CAREGIVER RELATIONSHIPS **SCORE=4**
Moderate impairment: Jack has steadily worsening escalating behavior problems. He is irritable most of the time, loses his temper frequently, often breaks things and hits his mother when frustrated. He has trouble getting to sleep most nights. Meets anchor points 4a,b.

DOMAIN III: CAREGIVING ENVIRONMENT-STRENGTHS AND PROTECTIVE FACTORS **SCORE=4**
Minimal: On the positive side, his mother has public assistance, a two bedroom apartment and is in part time job training. However, his Head Start program will not allow him to return until his behavior is stabilized and mother has not kept appointments with the mental health center allegedly because of transportation problems. Father hits Jack and mother when drunk. Mother has history of depression, suicide attempt, and hospitalization and did not pursue follow up mental health treatment. Meets anchor point 4a.

DOMAIN III: CAREGIVING ENVIRONMENT-STRESSORS AND VULNERABILITIES **SCORE=4**
Serious: Intermittent aggression in the family with father hitting Jack and his mother while drunk with Jack witnessing father hitting mother, once bruising mother's face. Father continues to see Jack for visitation. Mother has history of depression, suicide attempt, and hospitalization and did not pursue follow up mental health treatment. Meets anchor point 4a.

DOMAIN IV: FUNCTIONAL/DEVELOPMENTAL STATUS **SCORE=4**
Moderate impairment: Jack has trouble getting to sleep most nights. Jack has been asked to leave his Head Start program. He is overactive, distractible, and won't follow directions. His affect is poorly modulated. He is irritable most of the time, loses his temper frequently, often breaks things, and bites himself. Meets anchor points 4a,c,d.

DOMAIN V: IMPACT OF CHILD'S MEDICAL, DEVELOPMENTAL, OR EMOTIONAL/BEHAVIORAL PROBLEMS SCORE=4

Moderate impairment: Emotional and behavioral problems are of moderate severity and are interfering with Jack's daily functioning. He can not return to his Head Start program until his behavior is stabilized. Meets anchor point 4c.

DOMAIN VI: SERVICES PROFILE-CAREGIVERS INVOLVEMENT IN SERVICES SCORE=4

Minimal: Jack has seen a pediatrician but mother has not kept appointments with mental health center for Jack. Mother did not follow through with mental health treatment for herself for depression in past. Meets anchor point 4a.

DOMAIN VI: SERVICES PROFILE-CHILD'S INVOLVEMENT IN SERVICES SCORE=4

Minimal: Jack's escalating behavior difficulties with refusal to follow directions and frequent lose of temper could make his involvement in treatment difficult. Meets anchor point 4b.

DOMAIN VI: SERVICES PROFILE-SERVICE FIT SCORE=4

Minimal: Services address Jack's needs poorly. Behavior is escalating with lose of his Head Start program despite mental health consultation to Head Start and medication trials by his pediatrician. Mother is not keeping appointments at mental health center allegedly due to transportation problems. Protective Services has not yet taken any action despite referral. Meets anchor point 4b.

DOMAIN VI: SERVICES PROFILE-SERVICE EFFECTIVENESS SCORE=5

None: Services are not working to improve Jack's symptoms; his symptoms are getting worse and his growth and development are stalled. Meets anchor points 5 a,b,c.

SCORING: TOTAL SCORE=25 = Level 4

Note: INDEPENDENT CRITERIA MET BY DEGREE OF SAFETY SCORE=5. THEREFORE, RECOMMENDED LEVEL OF SERVICE INTENSITY= 5 (MAXIMAL SERVICE INTENSITY)

DISCUSSION OF SERVICE PLANNING: There are significant and immediate threats to Jack's safety. He still visits with his father who hits Jack and his mother. Jack has witnessed his father hitting his mother and bruising mother's face. Referral has been made to Protective Services, but they have not yet taken any action. Supervision of Jack at home is a major concern since he recently found a lighter in a neighborhood park and set his house on fire. He recently threatened suicide when reprimanded by mother. His behavior is becoming more aggressive and uncooperative, leading to his inability to return to his Head Start program until his behavior improves. Jack needs an immediate evaluation in a setting that can provide immediate safety, assess his needs, stabilize his behavior, and begin to develop his plan of care. Depending on what is available in a community, this could be accomplished in a variety of settings such as an inpatient hospital setting or a highly supervised foster or kinship care home with consideration of 24 hour one to one support. Since medication prescribed by his pediatrician and mental health

consultation to his Head Start program did not improve his symptoms, he may need a more intensive day treatment program like a therapeutic nursery before a return to his regular Head Start program. Child Protective Services should open a case on Jack and consider stopping visitation with father until Jack's safety with father can be ensured. Formal care coordination with a child and family team needs to be initiated with regular meetings. The team should consider recommending evaluation of mother's possible depression and substance abuse treatment and anger management for father. When Jack is ready to return home with mother, intensive home-based support with in-home parent coaching and skill building should be available to mother initially several times a week. Similar parent coaching and skill building should be available to father.

II. INTERVIEW QUESTIONS/OBSERVATIONS FOR USE IN RATING ECSII DOMAINS

DOMAIN I: DEGREE OF SAFETY		
Degree of Safety:	***(a) Environment***	
Severity Level	**Score**	
Optimal	**1**	The child's environment is safe and protective, and there are no significant environmental dangers, instabilities, or risks placing the child at risk for abuse, neglect, or harm (e.g., stable, safe and protective community setting).
Adequate	**2**	The child's environment is generally safe and protective, but there are some environmental dangers, instabilities or risks that could place the child at risk for harm, abuse or neglect (e.g., stable, safe and protective community setting but housing is old with need to repair old window guards).
Moderate	**3**	The child's environment is not optimally safe and protective, i.e. there are several significant environmental dangers, instabilities, or risks that caregivers cannot fully address that could place the child at risk for harm, abuse or neglect (e.g., the child lives in high crime neighborhood).
Impaired	**4**	The child's environment is often not safe and protective, and there are multiple significant environmental dangers, instabilities and risks that place the child at risk of harm, abuse or neglect (e.g. the child is exposed to multiple potentially unsafe adults in the home).
Low	**5**	The child's environment is rarely safe and protective, and there are multiple serious environmental dangers, instabilities and risks that place the child at risk of harm, abuse or neglect (e.g., the child lives in home that is used for illicit purposes such as drugs and/or prostitution).

1. How safe is the environment?
2. What are the safety risks to the child in home, e.g. abusive or unsafe parenting practices, violence in the home, lack of supervision of the child, structural safety hazards such as broken windows?
3. How are the caregivers addressing these safety risks in the home?
4. Is the child exposed to violence or unsafe conditions in the community? How able are the caregivers to protect the child?

DOMAIN I: DEGREE OF SAFETY		
Degree of Safety:	***(b) Stability of caretaking***	
Severity Level	**Score**	
Optimal	**1**	The child is experiencing constancy in caretaking, living and support systems with no recent experience of loss, trauma, abuse and/or disruptive family changes (e.g., stable nuclear and/or extended family network).
Adequate	**2**	The child is experiencing overall stability in caretaking, living and support systems with minimal recent experience of loss, trauma, abuse and/or disruptive family and environmental changes (e.g., generally stable nuclear and/or extended family network but caregiver experiences episodic conflicts in their relationship).
Moderate	**3**	The child is experiencing moderate disruptions in caretaking, living and support systems, with recent experience of loss, trauma, abuse and/or disruptive family and environmental changes (e.g., existence of persistent tension and conflict in between family members; recent death or departure of grandparent).
Impaired	**4**	The child is experiencing considerable instability in caretaking, living and support systems with significant recent experiences of loss, trauma, abuse and/or disruptive family and environmental changes (e.g., child witnesses domestic violence incidents; has been in multiple foster placements).
Low	**5**	The child is experiencing serious instability in caretaking, living and support systems with severe recent experiences of loss, trauma, abuse and/or disruptive family and environmental changes (e.g., child has been abandoned by the primary caregiver, death of primary caregiver, has been physically beaten).

1. How consistent and stable is the child's experience of caregiving?
2. Have there been recent or current experiences of loss, trauma, abuse and/or disruptive/conflicted relationships in the home?

DOMAIN I: DEGREE OF SAFETY		
Degree of Safety:	***(c) Caregiver attention to the child***	
Severity Level	**Score**	
Optimal	**1**	The caregiver demonstrates a capacity to respond with attention to safety across normative environmental conditions (e.g., mother intervenes sensitively to the child's challenging behaviors).
Adequate	**2**	The caregiver exhibits brief and/or only limited lapses in ability to respond with attention to safety across normative environmental conditions (e.g., caregiver does not use appropriate child safety seats while driving).
Moderate	**3**	The caregiver exhibits moderate and/or periodic lapses in ability to respond with attention to safety across normative environmental conditions (e.g., caregiver locks overactive child in room at night).
Impaired	**4**	The caregiver exhibits substantial and/or frequent lapses in ability to respond with attention to safety across one or more normative environmental conditions (e.g., caregiver takes drugs while caring for the child).
Low	**5**	The caregiver is disorganized and / or shows minimal capacity to respond with attention to safety across normative environmental conditions (e.g., caregiver neglects the child).

1. Is there adequate supervision and capacity for developmentally appropriate response to the child's needs?
2. Is the child left unsupervised, unattended for long periods, or left with an unsafe caregiver?
3. Is the child neglected in other ways?

DOMAIN I: DEGREE OF SAFETY		
Degree of Safety:	***(d) Caregiver risk behaviors or conditions***	
Severity Level	**Score**	
Optimal	**1**	The caregiver exhibits no conditions or risk behaviors that present risk of endangerment of self or child.
Adequate	**2**	The caregiver exhibits conditions or risk behaviors with minimal risk of endangerment to self or other (e.g., caregiver smokes cigarettes in the home).
Moderate	**3**	The caregiver exhibits conditions or risk behaviors with moderate risk of endangerment of self or others (e.g., caregiver drive with youngster in car after drinking at a party).
Impaired	**4**	The caregiver exhibits conditions or risk behaviors with substantial risk of endangerment of self or others (e.g., depressed parent is experiencing suicidal ideation and is not seeking help).
Low	**5**	The caregiver exhibits persistent and/or serious conditions or risk behaviors that present significant risk of endangerment of self or child (e.g., caregiver has severe and persistent mental illness and/or substance abuse with periods of psychotic preoccupation and delusions).

1. Does the caregiver demonstrate behaviors or conditions that pose a threat to the child's health or safety?
2. Does the caregiver's use of drugs or alcohol impact the child's safety or well-being?
3. Is the caregiver depressed or have another mental health condition that impacts the child's safety or well-being?
4. Does the caregiver have a medical condition that impacts the child's safety or well-being?

DOMAIN I: DEGREE OF SAFETY		
Degree of Safety:	***(e) Caregiver expectations of the child***	
Severity Level	**Score**	
Optimal	**1**	The caregiver's knowledge base, beliefs or behaviors involving the child are developmentally appropriate to the needs of the child (e.g., caregivers' expectations of youth match child's capacity in all major functional realms such as feeding, toileting, and walking).
Adequate	**2**	The caregiver's knowledge base, beliefs or behaviors involving the child are mildly developmentally inappropriate and place child at low risk of harm, i.e., caregivers' expectations of youth match child's capacity in most major functional realms such as feeding, toileting, and walking (e.g. caregiver expects child to be toilet trained before developmentally appropriate).
Moderate	**3**	The caregiver's knowledge base, beliefs or behaviors involving the child are often developmentally inappropriate and place child at moderate risk of harm.
Impaired	**4**	The caregiver's knowledge base, beliefs or behaviors involving the child are frequently developmentally inappropriate and place the child at substantial risk of harm (e.g. caregiver leaves the child in the care of another young child for long periods of time).
Low	**5**	The caregiver's knowledge base, beliefs or behaviors involving the child are typically developmentally inappropriate and place the child at significant risk of harm (e.g., caregiver leaves the child unattended at home or in a locked car while shopping; the caregiver is unwilling to get the child clearly needed medical services).

1. Are the caregiver's knowledge, beliefs and behaviors regarding caregiving and the needs of the child developmentally appropriate?
2. Does the caregiver believe that the young child's difficult or challenging behaviors are done deliberately to upset the caregiver?
3. Does the caregiver believe the child is capable of greater independent, unsupervised activity than is appropriate or safe?

DOMAIN I: DEGREE OF SAFETY		
Degree of Safety:		***(f) Child's developmentally appropriate ability to maintain safety***
Severity Level	**Score**	
Optimal	**1**	The child exhibits developmentally appropriate ability to maintain physical safety and/or use environment for safety (e.g., a preschool-aged child does not run into impulsively into the street).
Adequate	**2**	The child exhibits some developmental challenges in maintaining physical safety and/or making use of the environment for safety (e.g., the child usually seeks adult assistance when appropriate).
Moderate	**3**	The child exhibits moderate developmental difficulties in maintaining physical safety and/or making use of the environment for safety (e.g., the child does not respond to limits and persists in potentially dangerous behavior when told not to, such as touching a hot stove or climbing in an unsafe way).
Impaired	**4**	The child exhibits significant developmental difficulties in maintaining physical safety and/or making use of the environment for safety (e.g., the child is highly impulsive and does not understand the dangers of running out of the home and into street).
Low	**5**	The child exhibits substantial developmental inability to maintain physical safety and/or use the environment for safety (e.g., a child with developmental delay is extremely self-abusive).

1. Is the child's capacity to maintain physical safety developmentally appropriate?
2. Describe any specific unsafe behaviors of the child that puts his/her safety at risk e.g. running impulsively into the street, wandering out of the house, self-abusive behaviors?
3. How does the child seek assistance when in need of support in order to maintain safety?
4. How does the child respond to the caregiver's setting of limits intended to maintain safety?

DOMAIN I: DEGREE OF SAFETY		
Degree of Safety:	***(g) Child's risk to harm self or others***	
Severity Level	**Score**	
Optimal	**1**	No current indication of self-harming or other-directed aggressive behaviors by the child (e.g., child has never harmed self or others).
Adequate	**2**	Indication in child's present situation of occasional self-harming or of other-directed aggressive behaviors with minimal physical or emotional consequences for self or others (e.g., child has history of throwing objects during tantrums).
Moderate	**3**	Indication in child's present situation of periodic self-harming or other-directed aggressive behaviors with moderate physical or emotional consequences for self or others (e.g., child bangs head against floor when limits are set by caregiver).
Impaired	**4**	Indication in child's present situation of self-harming or other-directed aggressive behaviors with significant physical or emotional consequences for self or others (e.g., child with history of having been sexually abused and reenacts inappropriate touching behaviors with peers).
Low	**5**	Indication in child's present situation of persistent and extremely dangerous self-harming or other-directed aggressive behaviors (e.g., child repeatedly injures new-born sibling).

1. Does the child demonstrate self-injurious behaviors, e.g. head banging, self-biting?
2. Does the child demonstrate aggressive behaviors towards others, e.g. hitting or biting siblings, other children or adults?
3. Does the child demonstrate sexualized behaviors towards others?
4. How have the child's above-described behaviors affected the child or others, e.g. injuries, emotional distress, caregiver burden?

DOMAIN I: DEGREE OF SAFETY		
Degree of Safety:	***(h) Other (write in)***	
Severity Level	**Score**	
Optimal	**1**	
Adequate	**2**	
Moderate	**3**	
Impaired	**4**	
Low	**5**	

DEGREE OF SAFETY SCORE _____ (Highest number circled above)

DOMAIN II: CHILD-CAREGIVER RELATIONSHIPS

NOTE: RATE UP TO 3 PRIMARY RELATIONSHIPS AND ASSIGN A FINAL COMPOSITE SCORE AS EXPLAINED IN USER'S MANUAL.

Use the following considerations to rate this domain:

1. Which relationships with caregivers do you think are most important to the child, at present and in the past?
2. With which of the caregivers does the child spend the most time?
3. Who does the child seem most attached to? Who do you think is most important to the child?
4. If the child is in foster care, it would make sense to rate the relationship with foster parent(s) depending on how long the child has been in foster care, and 1 or more relationships with birth or adoptive parents if they are involved in the child's life and you have information about the quality of the relationship.
5. Rating this domain should be based on a) the caregiver's responses to questions about the relationship; b) direct observation of the child and the caregiver(s) interacting; and c) historical information about the child's relationship with the caregiver(s). Note that there may need to be different sources for this information, e.g. the child welfare worker may have spent more time observing the interaction, whereas a speech/language therapist know more about how the relationship has helped the child's development.

DOMAIN II: CHILD-CAREGIVER RELATIONSHIPS

Child-Caregiver Relationships: *(a) Degree of satisfaction*

Severity Level	Score	
Optimal	**1**	The relationship is functioning well and is consistently satisfying to both caregiver and child.
Adequate	**2**	The relationship is largely adequate and satisfying to both caregiver and child, but extra support may be required to maintain the quality of the relationship (e.g., a temperamentally fussy child who requires extra soothing).
Mild Impairment	**3**	Strains in the relationship are apparent and are beginning to adversely affect the subjective experience of the caregiver and/or the child.
Moderate Impairment	**4**	The relationship is characterized by significant distress in the child and/or caregiver (e.g., the child becomes significantly withdrawn and unresponsive in response to repeated angry outbursts by the caregiver; a caregiver becomes overwhelmed by the child's temper outbursts or unresponsiveness)
Severe Impairment	**5**	The relationship is severely disturbed and distressing to the caregiver and child such that the child is in imminent danger of physical harm (e.g., from physical abuse, sexual abuse, neglect, or malnutrition).

1. Ask the caregiver the following questions:
    a. Tell me about your relationship with your child?
    b. What are the satisfying parts of your relationship? What parts are challenging?
    c. Rate how satisfying on a scale of 1-10?
    d. How has the relationship affected your sense of well-being?
2. Observe the following:
    a. Do the child and caregiver seem predominantly happy or distressed when they are interacting?
    b. What do you observe about body language, facial expressions, and vocal tone of both partners? Is it predominantly positive or does there seem to be tension?
3. Historical information:
    a. Has the parent used physical discipline with the child? Has there been abuse of some kind of threats of physical harm?
    b. Does the relationship help the child to be emotionally regulated and able to explore in an age-appropriate manner, or does the child seem to become disorganized emotionally around the caregiver?
    c. Has the relationship with the child seemed to be a positive experience for the caregiver or can it sometimes appear to be disturbing to him/her?

DOMAIN II: CHILD-CAREGIVER RELATIONSHIPS		
Child-Caregiver Relationships: *(b) Quality of interactions*		
Severity Level	**Score**	
Optimal	**1**	Interactions are consistently reciprocal, warm, and flexible.
Adequate	**2**	Interactions are usually, but not always, reciprocal and warm for both partners (e.g., caregiver occasionally doesn't have the energy to engage with an active, high-spirited child).
Mild Impairment	**3**	Some interactions are conflictual (e.g., the caregiver and child engage in power struggles on a regular basis).
Moderate Impairment	**4**	A significant portion of interactions are conflicted and show limited response to interventions.
Severe Impairment	**5**	Interactions are consistently disturbed in all areas and are resistant to change.

1. Ask the caregiver the following questions:
    a. When you interact with your child how responsive is your child to you?
    b. Do you feel your personalities are a good match?
    c. Do you and your child sometimes get into conflict when you interact? If so how often does this happen? Are you able to make up afterwards?
2. Observe the following in the child-caregiver interaction:
    a. Do the child and caregiver seem to have a warm, mutual relationship where each person is participating and responding to the other? Or, does the relationship seem more one-sided?
    b. Do you notice distress in either party during the interaction? Do you observe conflict or power struggles?
    c. Does one of the two seem more engaged in the interaction than the other?
3. Historical information?
    a. Is there a history of distress or conflict in the child-caregiver interactions?
    b. Is there a history of difficult separations?
    c. If there is conflict how much and how quickly does it escalate? What is the aftermath for each party?
    d. If there have been interventions to try to reduce conflict or power struggles, has there been improvement?

DOMAIN II: CHILD-CAREGIVER RELATIONSHIPS		
Child-Caregiver Relationships: ***(c) Impact on child / caregiver functioning***		
Severity Level	**Score**	
Optimal	**1**	The relationship supports the child's development and enhances the caregiver's functioning.
Adequate	**2**	Disturbances if present are transient and have minimal impact on developmental progress (e.g., child wants to use a bottle again or engages in attention-seeking behavior after the birth of the sibling).
Mild Impairment	**3**	The relationship disturbance presents some risk to the developmental progress of the child or to the caregiver's functioning.
Moderate Impairment	**4**	The disturbance in the relationship is moderately impacting the child's physical, emotional, or cognitive/language development and/or the caregiver's ability to function (e.g., the child's language development is lagging because of lack of verbal interaction with the caregiver).
Severe Impairment	**5**	The disturbance in the relationship is severely impacting the child's development (physical, emotional, or language) and/or the caregiver's ability to function (e.g., a caregiver who becomes clinically depressed and is unresponsive to the child).

1. Ask the caregiver the following questions:
    a. How has your relationship with your child affected your life and the way you view your future?
    b. How has your relationship with your child affected your own mental health?
    c. If the caregiver has not been with the child since birth: How do you feel your child's growth and development been going since s/he has been with you?
2. Observe the following:
    a. If the child has some known developmental delays, does the interaction with the caregiver help the child to function better (e.g. if child has language delay, does the interaction help the child to communicate?)?
    b. Are there aspects of the interaction between the caregiver and child that interfere with the child's development? (E.g., a caregiver who doesn't speak much with the child or encourage him to speak; a caregiver who has child mostly on her/his lap and doesn't allow the child to walk freely or explore the area; a caregiver who gets very tense if the child shows any negative emotion and doesn't allow the child to express feelings)
3. Historical information:
    a. How has the child's emotional, cognitive, physical, and motor development been progressing in the care of the caregiver?
    b. Is there a history of the caregiver interfering with the child's development? (E.g., not paying enough attention to the child, not playing with the child, not responding to the child's cues to respond or provide assistance)

c. Is there a history of the child-caregiver relationship causing distress in the caregiver such that his or her functioning is affected?

DOMAIN II: CHILD-CAREGIVER RELATIONSHIPS		
Child-Caregiver Relationships: (d) *Caregiver empathy towards child*		
Severity Level	**Score**	
Optimal	**1**	The caregiver consistently shows empathy for the child and understanding of his or her emotional needs.
Adequate	**2**	The caregiver has a general understanding of the child's emotional needs but may not have an in-depth understanding of his or her emotional experience (e.g., the caregiver does not understand why his/her anxious child is so upset over not choosing the right clothing).
Mild Impairment	**3**	The caregiver's empathy for the child and understanding of his or her emotional needs is disturbed when the caregiver is under stress, or is impaired in one area (e.g., the caregiver may have his/her own conflict in an area such as eating, and finds it difficult to empathize with the child's experience).
Moderate Impairment	**4**	The caregiver displays limited empathy for the child and has an impaired understanding of the child's emotional needs in most situations (e.g., he /she may take personally the child's emotions and become angry with the child).
Severe Impairment	**5**	The caregiver's empathy for the child is negligible and he/she shows little understanding of the child's emotional needs (e.g., uses cruelty, humiliation, or excessive punishment).

1. Ask the caregiver the following questions:
    a. Can you tell what your child wants, or how s/he is feeling?
    b. What are the signals s/he shows you to help you understand what's on his mind or how he feels?
    c. How do you figure out what to do or say to him when he seems unhappy or is not his usual self? Could you give an example of a time you remember?
2. Observe the following:
    a. Does the caregiver show that s/he understands the child's emotions and intentions during their interaction?
    b. When the child is distressed and/or not responding as the caregiver expects, does s/he understand why this is happening from the child's point of view, or is s/he more likely to focus on the child's disobedience or difficulty for her/him to manage?
    c. When the child misbehaves does the caregiver express the feeling that the child is deliberately trying to upset them?
3. Historical information:
    a. Has the caregiver generally been an empathic adult in the sense of tuning into what the child experiences and making an attempt to understand the child's point of view?

b. Have the caregiver's expectations of the child been developmentally appropriate or is s/he sometimes reacting as if the child understands more or is more deliberate than is possible for his developmental level?
c. Has the caregiver expressed the belief that the child's misbehavior is a deliberate attempt to upset them?
d. Has the caregiver been angry, harsh, or excessively punitive with the child? (E.g., yelling at or ignoring a crying infant; putting a young toddler alone in an excessive time out)

DOMAIN II: CHILD-CAREGIVER RELATIONSHIPS		
Child-Caregiver Relationships: ***(e) Other (write in)***		
Severity Level	**Score**	
Optimal	**1**	
Adequate	**2**	
Mild Impairment	**3**	
Moderate Impairment	**4**	
Severe Impairment	**5**	

CHILD-CAREGIVER RELATIONSHIPS SCORE _____ (Highest number circled above)

DOMAIN III: CAREGIVING ENVIRONMENT— Strengths and Protective Factors

Strengths and Protective Factors in the Caregiving Environment:
(a) Ability to address child's developmental and material needs

Severity Level	Score	
Optimal	**1**	The family and/or community resources are optimal to address the child's developmental and/or material needs.
Adequate	**2**	The family and/or community resources are sufficient to address the child's developmental and/or material needs.
Limited	**3**	The family and/or community resources have limited ability to respond appropriately to the child's developmental and/or material needs.
Minimal	**4**	The family and/or community resources are minimally responsive to the child's developmental and/or material needs.
None	**5**	The family and/or community are unable to meet the child's developmental and/or material needs.

1) Are there enough people in the home or extended care giving environment to provide for the child's needs? If so, how available and capable are they?
2) Is the family income stable and sufficient to support the developmental and material needs of the child?
3) Does the family have stable and adequate housing?
4) If the child has specific developmental needs (e.g. speech and language, motor, cognitive, social/emotional), are the resources in the home and community sufficient to support these needs?
5) Is the family able to access existing community resources that could address developmental needs (e.g. barriers related to language, transportation, lack of insurance)?
6) Has there been disruption of community-based resources (e.g. move of the family)?

DOMAIN III: CAREGIVING ENVIRONMENT— Strengths and Protective Factors

Strengths and Protective Factors in the Caregiving Environment:
(b) Continuity of caregivers

Severity Level	Score	
Optimal	**1**	There is continuity of active, engaged family and community caregivers.
Adequate	**2**	The continuity of family, extended family (or other family supports), and community caregivers is only occasionally disrupted (e.g., the father is absent a few days a week due to business.)
Limited	**3**	The continuity of family and community caregivers is often disrupted. (e.g., a sibling who is periodically hospitalized).
Minimal	**4**	The continuity of family and community caregivers is usually disrupted.
None	**5**	There is no continuity of family and community caregivers.

1) Are there enough people in the home or extended care giving environment to provide for the child's needs? If so, how available and capable are they?
2) Is the family income stable and sufficient to support the developmental and material needs of the child?
3) Does the family have stable and adequate housing?
4) If the child has specific developmental needs (e.g. speech and language, motor, cognitive, social/emotional), are the resources in the home and community sufficient to support these needs?
5) Is the family able to access existing community resources that could address developmental needs (e.g. barriers related to language, transportation, lack of insurance)?
6) Has there been disruption of community-based resources (e.g. move of the family)?

DOMAIN III: CAREGIVING ENVIRONMENT— Strengths and Protective Factors

Strengths and Protective Factors in the Caregiving Environment:
(c) Caregivers' use of resources and services

Severity Level	Score	
Optimal	**1**	Caregivers readily use potentially helpful or enriching resources.
Adequate	**2**	Caregivers are willing and able to make use of recommended resources and services (e.g., clinician recommends child care or therapeutic play group that parents access).
Limited	**3**	Caregivers make use of resources and services episodically (e.g., parents do not attend well baby visits regularly).
Minimal	**4**	Caregivers have serious disagreements with resources and services (e.g., parents disagree with pediatrician's recommendation for specialized mental health assessment of the child).
None	**5**	Caregivers actively refuse needed resources and services.

1) What are the caregivers' views about the need for community-based supports and services for the family to help support the health and development of the child?
2) What is the history of the family's use of recommended services and supports (e.g. well-child care, services aimed at specific developmental needs of the child)?
3) If the family has not made adequate use of recommended services and supports, how is the lack of use of recommended services understood (e.g. cultural/linguistic, financial, transportation, caregiver impairment such as substance abuse, mental illness)?

DOMAIN III: CAREGIVING ENVIRONMENT— Strengths and Protective Factors

Strengths and Protective Factors in the Caregiving Environment:
(d) Support for stability of home environment

Severity Level	Score	
Optimal	**1**	The caregiving system supports a stable home environment for the child.
Adequate	**2**	The caregiving system is able to respond to a challenge or crisis to maintain a stable home environment (e.g., placement of child with family member is arranged when a parent goes into treatment; housing with extended family is available when family loses home).
Limited	**3**	The caregiving system has limited ability to respond quickly and competently in a crisis that puts the home environment at risk (e.g. family loses housing and moves in with friends living in chaotic circumstances).
Minimal	**4**	The caregiving system's lack of ability to respond to family needs results in a change of home placement (e.g., family becomes homeless when evicted from housing).
None	**5**	The home environment is unstable in a way that is dangerous to the child (e.g., child maltreatment in a foster care setting)

1) Has there been instability in the child's home environment? If so, what has the impact been on the child and family?
2) Has there been a loss of housing, or a threatened loss? If there has been a loss of housing, what precipitated this loss?
3) If there has been a loss of housing, what alternate housing has been identified and how adequate is it to meet the needs of the child?
4) Is the safety of the child and/or caregiver at risk (e.g., through maltreatment or domestic violence) related to homelessness or other inadequacies of housing?

DOMAIN III: CAREGIVING ENVIRONMENT— Strengths and Protective Factors

Strengths and Protective Factors in the Caregiving Environment:
(e) Availability of resources and services

Severity Level	Score	
Optimal	**1**	The caregiving system provides optimal resources and services to support the family (e.g., sufficient respite care for the child and sufficient supports for the needs of the primary caregivers).
Adequate	**2**	The caregiving system provides basic resources and services to support the family (e.g., a single parent is enrolled in medical assistance).
Limited	**3**	The caregiving system provides limited resources and services to support the family (e.g., there is limited or no access to specialized care).
Minimal	**4**	The caregiving system provides few resources and services to support the family (e.g., there is a long waiting time for basic services).
None	**5**	The caregiving system provides no resources to support the family (e.g., disenrollment from insurance or no access to basic services).

1) Are services and supports that may be needed for the child available in the community?
2) Is the child and family's health care insurance coverage adequate?
3) Does the family have transportation to allow access to community-based services?
4) Are home-based supports and services available?
5) How long is the waiting list for needed supports and services?
6) How great is the threat to the child's health and development if needed supports and services cannot be accessed?

DOMAIN III: CAREGIVING ENVIRONMENT— Strengths and Protective Factors

Strengths and Protective Factors in the Caregiving Environment:
(f) Other (write in)

Severity Level	Score	
Optimal	**1**	
Adequate	**2**	
Limited	**3**	
Minimal	**4**	
None	**5**	

CAREGIVING ENVIRONMENT: STRENGTHS AND PROTECTIVE FACTORS
SCORE_____ (Highest number circled above)

DOMAIN III: CAREGIVING ENVIRONMENT— Stressors and Vulnerabilities

Stressors and Vulnerabilities in the Caregiving Environment:
(a) Exposure to stressors in the home or community

Severity Level	Score	
Absent	**1**	Absence of family or community stressors (e.g., family members are in good health and there are no threats of violence in the home or neighborhood).
Mild	**2**	Intermittent or short-term exposure to non-violent stressors in the home or community (e.g. exposure to occasional parental arguments, problems with other children in the neighborhood).
Moderate	**3**	Frequent exposure to non-violent stressors (e.g. caregiver mental health or other condition that interferes with active, engaged parenting); or some exposure to verbal aggression or threats.
Serious	**4**	Frequent exposure to threats of violence or intermittent aggression in the family; or serious conditions in the caregiver (e.g. mental, developmental, physical, or substance use disorders) that significantly compromise his/ her ability to care for the child.
Severe	**5**	Constant exposure to serious family violence; conditions in the caregiver (e.g. mental, developmental, physical, or substance use disorders) that make him/ her unable to safely care for the child; or safety-compromising criminal activity (e.g., child living in a drug-involved house).

1) What nonviolent stressors is the child exposed to in the home (e.g. parental arguments, parental or sibling threats of violence, chronic parental physical and/or parental mental illness/substance abuse, multiple comings and goings of visitors or foster children in the home, living in a home where drug dealing occurs)?
2) What violent stressors is the child exposed to in the home (e.g. domestic violence, child maltreatment by caregivers, sibling assaults, break-ins)?
3) What stressors are the child exposed to in the community (e.g., violence/shootings, threats from neighbors, civil unrest/rioting)?
4) How frequent and severe are the stressors? How much do they impact the caregiver's ability to provide support to the child?

DOMAIN III: CAREGIVING ENVIRONMENT— Stressors and Vulnerabilities

Stressors and Vulnerabilities in the Caregiving Environment:
(b) Transitions and losses

Severity Level	Score	
Absent	**1**	Absence of recent transitions or losses of consequence (e.g., no change in composition of family, residence, marital status of caretakers, or no birth/death of family member).
Mild	**2**	Minor transition or loss that has an effect on the child and family such as change in residence, caregiver at day care, or composition of the family such as the death of a distant family member (e.g., birth of a second child).
Moderate	**3**	Moderate disruption of family/social milieu (e.g., family moves to a significantly different living situation, change of day care, absence of a caregiver).
Serious	**4**	Serious disruption of family/social milieu (e.g., due to death, divorce, or separation of caregiver and child).
Severe	**5**	Fragmentation of the family (e.g., death of both caregiver in an accident; single caregiver who is incarcerated).

1) Has the child experienced a change in the family composition (e.g. resulting from death, divorce, or separation due to work requirements or incarceration)?
2) Have the child and family experienced loss of supports from extended family and/or community supports (e.g. friends, neighbors, or professional supports such as therapists, and/or all of the above) due to a move to a different community, or another transition such as loss of a family member?
3) How much adverse impact do identified losses and transitions have on the child directly and/or indirectly due to the impact on caregivers?

DOMAIN III: CAREGIVING ENVIRONMENT— Stressors and Vulnerabilities

Stressors and Vulnerabilities in the Caregiving Environment:
(c) Financial stressors

Severity Level	Score	
Absent	**1**	Material needs are being met without concern that they may diminish in the near future (e.g., family income is stable).
Mild	**2**	Material resources are adequate but not optimal (e.g. family is making ends meet but has little left over at the end of the month).
Moderate	**3**	Family is experiencing finances as a stressor due to significant financial challenges or concerns about loss of resources in the future (e.g. paying off a large hospital bill, parent underemployment).
Serious	**4**	Loss or absence of material resources has a significant impact on child and family (e.g., parent is laid off or fired, and/or loss of family health insurance).
Severe	**5**	Loss or absence of material resources has a significant impact on child and family; and community supports and services are absent, resulting in the inability of family to care for the child.

1) What are the sources of income for the family?
2) How adequate are the financial resources to the family to support the needs of the child?
3) How stable is the family's income? Has there been a recent loss of income?
4) Have there been recent increased financial obligations that threaten the financial stability of the family (e.g. hospital bills, medication bills, increased housing costs, increased fuel costs)?
5) How much of a threat to the health and development of the child do the identified financial stressors create?

DOMAIN III: CAREGIVING ENVIRONMENT— Stressors and Vulnerabilities

Stressors and Vulnerabilities in the Caregiving Environment:
(d) Availability of community supports

Severity Level	Score	
Absent	**1**	Family receives sufficient supports and services from the community (e.g., adequate respite care, availability of other formal and informal supports such as medical care for the child and family, availability of childcare and/or preschool).
Mild	**2**	Community supports and services are available with some limitations (e.g., intermittent availability of family members to provide back-up child care.
Moderate	**3**	Community supports and services are minimal but do not threaten the stability of the family (e.g., no childcare program available in area).
Serious	**4**	Community supports and services are rarely available and this threatens stability of the family (e.g., family in rural setting with infrequent mental health consultation available).
Severe	**5**	Community supports and services needed to maintain safety or stability are unavailable (e.g., community or insurance plan does not offer a specific service essential for family stability such as adult substance abuse treatment).

1) What community supports and services are being accessed by the child and family? How are these supports and services working to meet the identified needs of the child and family?
2) What community supports and services that are needed to meet identified needs of the child and family are lacking either because they do not exist in the community or the family can not access them?
3) How much of a threat to the health and development of the child does the lack of availability of needed community supports and services create?

DOMAIN III: CAREGIVING ENVIRONMENT— Stressors and Vulnerabilities

Stressors and Vulnerabilities in the Caregiving Environment:
(*e) Recognition of cultural needs*

Severity Level	Score	
Absent	**1**	Community recognizes and supports family's cultural needs (e.g., bilingual services available).
Mild	**2**	Community partially recognizes and supports family's cultural needs (e.g., community center is available but does not acknowledge ethnic diversity).
Moderate	**3**	Community inconsistently recognizes family's cultural needs (e.g., some service staff understand child culture while others don't).
Serious	**4**	Community is insensitive to family's cultural needs (e.g., clinicians or other providers ignore cultural norms).
Severe	**5**	Severe cultural stigmatization in the community (e.g., severe discrimination and hostility in neighborhood).

1) Do the child and family have a minority status within their community (e.g. due to race, caregiver sexual orientation, religion, language, etc.)?
2) How does the family's minority status impact their well-being (e.g. what is the extent of stigmatization, prejudice and/or isolation experienced by the family)?
3) Are there culturally compatible supports in the community?
4) How similar to or different from their community are the family's values and beliefs? Do their values and beliefs with regard to diagnosis or services for their child's needs differ from those of their community or service providers?
5) How adequate is the understanding by people providing supports and services to the family of the cultural beliefs and sensitivities of the family?
6) Has the family recently immigrated from another country and/or culture?
7) If the family has immigrated from another country, does their immigration status impact the availability of services and supports?
8) If the family has immigrated from another country, how significant is the stress of acculturation to the new dominant culture?

DOMAIN III: CAREGIVING ENVIRONMENT— Stressors and Vulnerabilities

Stressors and Vulnerabilities in the Caregiving Environment:
(f) Family's attention to child's needs

Severity Level	Score	
Absent	**1**	Family is optimally able to meet the developmental needs of the child (e.g., parent talks and reads to infant; or parents recognize speech delay of child and arrange for appropriate assessment).
Mild	**2**	Family is adequately able to meet child's developmental needs (e.g., caregiver takes child to well baby visits and/or usually understands child's developmental limitations).
Moderate	**3**	Family is erratic in meeting the child's developmental needs (e.g., caregiver inconsistently takes child to speech therapy sessions; child does not attend therapeutic nursery regularly).
Serious	**4**	Family poorly meets the child's developmental needs and is often neglectful (e.g., caregiver works night shift and sleeps during the day with inconsistent substitute care; depressed parent is unable to respond to the cues of the child).
Severe	**5**	Family constantly neglects the child (e.g., caregiver leaves child in car or home alone on a regular basis or exposes child to dangerous situations).

1) Describe the caregivers' understanding of the child's developmental needs.
2) How able are the caregivers to respond positively to the child's expected developmental needs (e.g. time for play, positive attention from each parent, sufficient supervision and limits, provision of food, shelter and clothing)?
3) Are there specific needs of the child that caregivers are not recognizing? If recognized, how do the caregivers respond to those needs?
4) Do the caregivers' views of the needs of the child correspond to the view of others involved in supporting the child?
5) Are caregivers able to engage with recommended services for the child?
6) How consistent are the caregivers in supporting their child's involvement in specialized services?

DOMAIN III: CAREGIVING ENVIRONMENT— Stressors and Vulnerabilities

Stressors and Vulnerabilities in the Caregiving Environment:
(f) Other (write in)

Severity Level	Score	
Absent	**1**	
Mild	**2**	
Moderate	**3**	
Serious	**4**	
Severe	**5**	

CAREGIVING ENVIRONMENT: STRESSORS AND VULNERABILITIES SCORE

_____ (Highest number circled above)

DOMAIN IV: FUNCTIONAL/DEVELOPMENTAL STATUS		
Functional/Developmental Status: ***(a) Affective state and state regulation***		
Severity Level	**Score**	
Optimal	**1**	Ability to maintain a calm, alert, and affectively available state. Displays the full range of affect. Able to regulate affect.
Adequate	**2**	Able to maintain calm, affectively available state with limited environmental modification by caregivers. Affect may be constricted or reactive under stress, but improves with support from caregivers.
Mild Impairment	**3**	Significant, but not overwhelming disturbance in the child's ability to maintain calm, affectively available state requiring additional support and environmental modification by caregivers. Some restriction of affect noted outside of most familiar situations or difficulties modulating affect.
Moderate Impairment	**4**	Affect constricted or poorly modulated in most circumstances. Intensive caregiver support required for normative interaction, e.g. daily tantrums or withdrawal except when all the child's needs and demands are immediately gratified.
Severe Impairment	**5**	Profound inability to regulate internal affective state present in all settings (e.g. overwhelmed by normative sensory experience even with maximal support; severe constriction of affect and interest in the environment that is minimally responsive to intensive attempts to engage the child.) Tantrums are frequent and severe and unresponsive to caregiver's interventions.

1) Does the young child have temper tantrums? If yes, with what frequency and duration?
2) Is the young child able to maintain eye contact with his/her caregiver without becoming overstimulated or averting his/her gaze?
3) What triggers the young child's tantrums? Are there typical antecedents? Or are they due to strong stimuli such as bright lights or loud noises, or sensory hypersensitivity?
4) Is the child's affect normally reactive to interaction with caregivers? Is there constriction of affect under stress? Is there constriction of affect under normal, everyday circumstances?
5) Do activities of daily living such as bathing, combing of hair or brushing of teeth or putting on clothes with the wrong texture cause the child marked distress or to have tantrums?

DOMAIN IV: FUNCTIONAL/DEVELOPMENTAL STATUS

Functional/Developmental Status: ***(b) Adaptation to change***

Severity Level	Score	
Optimal	**1**	Adapts easily to change. Flexible during transitions. Developmentally appropriate level of curiosity about the environment. Tolerance for age appropriate separations.
Adequate	**2**	Requires some support for transitions. Flexibility occasionally compromised under stress. Able to explore environment with encouragement by caregivers.
Mild Impairment	**3**	Flexibility compromised under stress (e.g., able to transition, but requires frequent cueing and more intensive caregiver support). Requires added caregiver support for exploration of environment.
Moderate Impairment	**4**	Requires intensive support to transition (e.g., multiple cues for an extended period.) Transitions often result in tantrums or tearfulness. Hesitant, easily derailed exploration of environment, also requiring intensive caregiver support for success.
Severe Impairment	**5**	Transitions poorly regardless of caregiver's interventions. Small changes in routine result in severe behavioral disruption.

1) How easily does the child adapt to change?
2) Is the child "slow to warm up"? How does he or she react to new situations or to strange people?
3) Does the child accept change in routine with minimal protest? With tantrums?
4) Is the child normally inquisitive about his or her environment? Is the child hesitant to explore?
5) How does the child handle separation from his or her caregiver(s)? Is there minimal protest? Is there tantrumming?

DOMAIN IV: FUNCTIONAL/DEVELOPMENTAL STATUS		
Functional/Developmental Status: ***(c) Biological patterns***		
Severity Level	**Score**	
Optimal	**1**	Settles easily for sleep with developmentally appropriate support. No appetite disturbance. Toileting ability is age appropriate.
Adequate	**2**	Requires some efforts by caregivers to soothe child for sleep. Appetite varies under stress. Occasional regression in toileting.
Mild Impairment	**3**	Routinely needs environmental modification for sleep, eating, or toileting. E.g., awakens easily and frequently during the night; requires additional feeding time or other basic interventions (e.g. adding high calorie formula) due to picky eating or inadequate weight gain; is somewhat behind in developing age appropriate toileting behavior.
Moderate Impairment	**4**	Serious disturbance in age-appropriate patterns of sleep, feeding or toileting. E.g., requires more than one hour to fall asleep, awakens frequently during the night, and requires presence of caregiver to return to sleep (but not throughout the night); feeding is significantly disrupted and difficulty maintaining age-appropriate weight continues despite preliminary interventions; lacks age-appropriate toileting behavior.
Severe Impairment	**5**	Profound disturbance in age-appropriate patterns of sleep, feeding or toileting. E.g., requires caregiver presence throughout the night to sleep or unable to sleep more than a few hours per night, even with caregiver presence; wakes with minimal environmental stimulation and requires maximal effort by caregivers to return to sleep; profound feeding disturbance resulting in severe failure to thrive; severe problems with toileting such as smearing or ingesting feces.

1) How easily does the child fall asleep? How frequently does the child wake up during the night? Does the child's caregiver have to be present for the child to fall asleep?
2) Does the child's appetite change under stress? Does the child maintain weight under stress? Is there evidence of failure to thrive? Is the child described as a "picky eater?"
3) Is the child's toileting age appropriate? Is there regression in toileting under stress? Has the child ever engaged in smearing of feces or other unusual behavior associated with toileting?

DOMAIN IV: FUNCTIONAL/DEVELOPMENTAL STATUS		
Functional/Developmental Status: *(d) Social interaction*		
Severity Level	**Score**	
Optimal	**1**	Developmentally appropriate relationships with others. Intact ability to control impulses. Does not initiate aggressive behavior.
Adequate	**2**	Engages with peers successfully with caregiver support. Occasional impulsive behavior or aggression typical of developmental age, requiring slight increase in monitoring of interactions by caregivers.
Mild Impairment	**3**	Mild impairment in age-appropriate social skills (e.g., engages with peers successfully only in structured, well-supervised situations with caregiver intervention and support). Impulse control impaired, but increased environmental supports help caregivers to maintain safety in most circumstances. Intermittent aggressive behavior, managed by heightened caregiver supervision. Warm interactions possible primarily with trusted caregivers, others with significant support.
Moderate Impairment	**4**	Moderate impairment in age-appropriate social skills. Child requires intensive input from caregivers for most social interactions, and successful peer interactions are infrequent. Aggressive behavior has caused injury to others or threatens placement (e.g., child may have been expelled or is at risk of expulsion from one-day care setting for aggressive behavior.) Frequent compromise of safety due to impulsivity despite close caregiver supervision and support.
Severe Impairment	**5**	Severe impairment of age-appropriate social skills. Unable to exercise developmentally appropriate impulse control, even with maximal support (e.g., endangers self by running away from caregivers without age-appropriate regard for safety). Aggressive behavior has resulted in removal from multiple childcare settings. Near complete withdrawal from interaction with environment, even with maximal supports.

1) How able is the child to engage in nonverbal or verbal reciprocal interactions with caregivers? With peers?
2) Does the child's difficulty with impulse control interfere with the development of age appropriate social skills? Does the child's lack of impulse control necessitate close supervision by adults at all times to prevent serious injury?
3) Does the child engage in aggressive behavior towards peers? Has the child ever been asked to leave a day care setting due to his or her aggressive behavior?
4) Does the child need support from caregivers for normal engagement with peers? Is the child excessively shy?

DOMAIN IV: FUNCTIONAL/DEVELOPMENTAL STATUS		
Functional/Developmental Status: ***(e) Language, motor, and cognitive development***		
Severity Level	**Score**	
Optimal	**1**	Communication, motor, and cognitive capacities (e.g. problem-solving) are age appropriate.
Adequate	**2**	Although some areas of development may be uneven, developmental progress in communication, motor, and cognitive capacities is generally appropriate and does not require formal intervention (e.g., speech delays occasionally interfere with the child's ability to communicate needs, but the child succeeds with persistence; the child successfully masters fine and gross motor tasks with persistence).
Mild Impairment	**3**	Developmental delay is associated with some impairment in functioning (e.g., speech delay intermittently impairs the child's ability to communicate and may result in periodic frustration, but without significant behavioral problems; motor or cognitive delays impact age appropriate tasks or activities but do not prevent the child from participating.)
Moderate Impairment	**4**	Developmental delay is associated with significant impairment in functioning (e.g., extra time and support is needed to help child with speech delay make his or her needs known, and without these supports, the child becomes angry or aggressive; child with gross or fine motor delay frequently gives up on age appropriate motor tasks, even with significant support, and is unable to complete or participate in age appropriate tasks or activities).
Severe Impairment	**5**	Marked delays result in severe impairment of developmental progress (e.g. marked delays in speech present in multiple settings, resulting in extreme frustration and tantrums secondary to the child's inability to communicate needs, even with supports; severe impairment in gross and/ or fine motor skills, resulting in the child being unable to participate in age-appropriate tasks or activities.)

1) Are the child's language skills age-appropriate? Are the child's communication skills delayed to the extent that he or she becomes frustrated and/or aggressive due to his/her difficulty expressing their needs?
2) Are the child's gross and fine motor skills age-appropriate? Are there significant delays in either fine or gross motor skills? Do these delays in motor skills interfere with the child's engagement in age appropriate activities?
3) Is there evidence of developmental delays in multiple domains (language, motor, cognitive, social)? Are these delays severe enough that the child has been referred to Early Intervention? To state services for the Developmentally Disabled?

DOMAIN IV: FUNCTIONAL/DEVELOPMENTAL STATUS		
Functional/Developmental Status: ***(f) Other (write in)***		
Severity Level	**Score**	
Optimal	**1**	
Adequate	**2**	
Mild Impairment	**3**	
Moderate Impairment	**4**	
Severe Impairment	**5**	

FUNCTIONAL/DEVELOPMENTAL STATUS SCORE: _____ (Highest number circled above)

DOMAIN V: IMPACT OF CHILD'S MEDICAL, DEVELOPMENTAL, or EMOTIONAL/BEHAVIORAL PROBLEMS

Impact of Child's Medical, Developmental, or Emotional/Behavioral Problems: ***(a) Medical problems***

Severity Level	Score	
Optimal Functioning	**1**	No medical problems in the child.
Adequate Functioning	**2**	Minor medical problems typically seen in primary car (e.g., mild asthma, occasional ear infections).
Mild Impairment	**3**	Chronic medical problems that may require specialist consultation and have some impact on functioning, but are responsive to interventions (e.g., well controlled diabetes).
Moderate Impairment	**4**	Serious medical problem requiring multiple interventions and causing ongoing functional impairment in child (e.g., poorly controlled asthma that limits child's activities and may result in occasional acute hospitalization).
Severe Impairment	**5**	Severe medical disorder causing severe functional impairment in the child and multiple hospitalizations, or specialized care facility (e.g., congenital heart disease requiring multiple hospitalizations and severely limiting activity).

1. Does the child have any medical problems now? How serious is the problem/problems?
2. If the child has no medical conditions now, has he or she had any in the past? If so, how serious? Has the problem/problems resolved completely or are there continuing issues, at least in the view of the primary caregiver(s)?
3. If the child has a medical problem, what kind of medical evaluation or medical interventions have been needed?
4. Has the child needed to be hospitalized or required intensive medical support to remain at home?
5. How has the medical problem affected the child's functioning, including his self-esteem?

DOMAIN V: IMPACT OF CHILD'S MEDICAL, DEVELOPMENTAL, or EMOTIONAL/BEHAVIORAL PROBLEMS

Impact of Child's Medical, Developmental, or Emotional/Behavioral Problems: ***(b) Developmental problems***

Severity Level	Score	
Optimal Functioning	**1**	No developmental problems in the child.
Adequate Functioning	**2**	Developmental disturbance is mild and improving with natural supports (e.g. a "late talker" whose language delay improves with increased stimulation form family and preschool).
Mild Impairment	**3**	Developmental disturbance is mild and is not improving with natural supports alone (e.g., cerebral palsy with low muscle tone requiring physical therapy).
Moderate Impairment	**4**	Moderate developmental delays requiring more frequent and intensive interventions (e.g., severe cerebral palsy requiring braces and frequent physical therapy).
Severe Impairment	**5**	Severe developmental delays which threaten the child's developmental progress and require constant interventions (e.g., severe cerebral palsy requiring assistance in activities of daily living such as feeding and moving).

1. Does the child have any developmental challenges or delays? If so, what are they and how significant is the delay?
2. To what extent does the developmental delay affect the child's daily functioning?
3. To what extent has the developmental delay affected the child's overall growth and development (e.g. a significant speech delay may affect the child's social/emotional development)
4. What kind of supports or interventions for the developmental delay does the child need to help him function in an age-appropriate way?
5. To what extent is the child's self-esteem compromised by his or her developmental delay?

DOMAIN V: IMPACT OF CHILD'S MEDICAL, DEVELOPMENTAL, or EMOTIONAL/BEHAVIORAL PROBLEMS

Impact of Child's Medical, Developmental, or Emotional/Behavioral Problems: ***(c)***
Emotional or behavioral problems

Severity Level	Score	
Optimal Functioning	**1**	No emotional or behavioral problems in the child.
Adequate Functioning	**2**	Emotional or behavioral disturbances are minor and/or transient (e.g., occasional temper tantrums).
Mild Impairment	**3**	Emotional or behavioral problems of mild severity needing interventions (e.g., temper tantrums that are frequent and may disrupt family activities).
Moderate Impairment	**4**	Emotional or behavioral problems of moderate severity, which interfere with the child's daily functioning (e.g., daily temper tantrums that are prolonged and intense) and may threaten a school or child care placement.
Severe Impairment	**5**	Emotional or behavioral problems severe enough to threaten the child's current home placement.

1. Does the child have emotional or behavioral problems? How long have you or others been aware of the child's emotional/behavioral problem?
2. How significant are the emotional/behavioral problem/problems, e.g. does it occur only occasionally or is it frequent?
3. To what extent does the child's emotional/behavioral problem interfere with his daily functioning at home or in other settings such as preschool or child care?
4. Have the child's emotional problems been severe enough to threaten a school, child care or home placement? Describe?
5. Is there evidence of low self-esteem in the child due to the child's emotional or behavioral problems?

DOMAIN V: IMPACT OF CHILD'S MEDICAL, DEVELOPMENTAL, or EMOTIONAL/BEHAVIORAL PROBLEMS

Impact of Child's Medical, Developmental, or Emotional/Behavioral Problems: ***(d) Emotional stress on family related to child's problem***

Severity Level	Score	
Optimal Functioning	**1**	No emotional stress on family related to the child's medical, developmental or emotional/behavioral problem.
Adequate Functioning	**2**	Caregivers are able to cope with the child's medical, developmental, or emotional/behavioral problem with their natural support system.
Mild Impairment	**3**	Caregivers display mild symptoms of anxiety, distress or fatigue due to the child's medical, developmental, or emotional/behavioral problem.
Moderate Impairment	**4**	Caregivers periodically feel hopeless or helpless about the child's medical, developmental, or emotional/behavioral problem and/or experience adverse impact on caregiver's relationship with other adults, community activities or work..
Severe Impairment	**5**	Caregiver is overwhelmed and experiences persistent hopelessness and helplessness due to the child's medical, developmental, or emotional/behavioral problem which threatens or severely compromises necessary care for the child.

1. How have the child's caregivers been affected by the child's medical, developmental or emotional problems?
2. How have the caregivers coped with the problems?
3. Are there caregivers of the child that has been particularly stressed by the problem? How has the stress affected them, e.g. has it caused anxiety, depression or other emotional difficulties?
4. Have the child's medical, developmental or emotional/behavioral problems caused a caregiver or caregivers to become so overwhelmed that they feel hopeless or lose their temper with the child or others? Has it affected their daily functioning at home, work, or in other settings?
5. What is the caregiver(s)' ability to acknowledge to their child that the child is in distress related to the child's emotions or behavior, without conveying a negative, critical view regarding the child as a whole person?
6. Does the child's medical, developmental or emotional/behavioral problem evoke difficulty feelings and memories related to previous similar problems in the child or other members of the caregiver(s)' family? Do these evoked feelings interfere with the caregiver(s)' response to the child?

DOMAIN V: IMPACT OF CHILD'S MEDICAL, DEVELOPMENTAL, or EMOTIONAL/BEHAVIORAL PROBLEMS

Impact of Child's Medical, Developmental, or Emotional/Behavioral Problems: ***(e) Financial impact***

Severity Level	Score	
Optimal Functioning	**1**	No financial stress on family related to the child's medical, developmental, or emotional/behavioral problem.
Adequate Functioning	**2**	Costs related to the child's medical, developmental, or emotional/behavioral problem can be met by family resources and/or health insurance.
Mild Impairment	**3**	Costs related to the child's medical, developmental, or emotional/behavioral problem cause budgetary challenge (e.g., due to cost of needed services not adequately covered by insurance).
Moderate Impairment	**4**	The cost of interventions for the child's medical, developmental, or emotional/behavioral problem requires caregivers to actively increase income or intensity of care giving requirements requires caregivers to decrease work.
Severe Impairment	**5**	The cost of interventions related to the child's medical, developmental, or emotional/behavioral problem is catastrophic and leads to loss of home or relinquishment of custody of the child.

1. In what ways and to what extent have the child's medical, developmental, or emotional/behavioral problems affected the family financially?
2. Does the family have adequate health insurance or other resources to afford costs of the treatment the child needs? If not has the family had to cut back on the care the child gets? Have they had to take on extra jobs?
3. Has the family experienced any serious impacts because of the cost of treatment, such as loss of a job, or loss of housing? Have they had to relinquish custody of the child to get him or her needed care?
4. Has the caregiving system (including formal and informal supports) provided any assistance to prevent serious impacts to the family?

DOMAIN V: IMPACT OF CHILD'S MEDICAL, DEVELOPMENTAL, OR EMOTIONAL/BEHAVIORAL PROBLEMS

Impact of Child's Medical, Developmental, or Emotional/Behavioral Problems: ***(f) Other (write in)***

Severity Level	Score	
Optimal Functioning	**1**	
Adequate Functioning	**2**	
Mild Impairment	**3**	
Moderate Impairment	**4**	
Severe Impairment	**5**	

IMPACT OF THE CHILD'S MEDICAL, DEVELOPMENTAL OR EMOTIONAL/BEHAVIORAL PROBLEMS SCORE:_____
(Highest number circled above)

DOMAIN VI: SERVICES PROFILE—
Caregiver(s) Involvement in Services

Caregiver(s) Involvement in Services: *(a) Engagement*

Severity Level	Score	
Optimal	**1**	All caregivers and providers agree that there is optimal engagement, i.e. both respect each other and view the other as having knowledge and expertise necessary for the treatment of the child
Adequate	**2**	One caregiver is fully engaged with all needed services and providers and communicates effectively with all other caregivers.
Limited	**3**	One caregiver is engaged with all services and providers but another significant caregiver isn't engaged, e.g. this schism could be between divorced parents, parent and foster parent, or other significant extended family members.
Minimal	**4**	Caregiver(s) engages with essential services and interacts with providers only during crises.
None	**5**	There is no engagement between caregiver(s) and providers. There is a pervasive lack of respect between caregiver(s) and providers and neither views the other as having knowledge and expertise necessary for the treatment of the child.

1) Is each of the child's primary caregivers involved in treatment/service planning?
2) Is there agreement by all members of the child's family that the child and family should be receiving services/be in treatment?
3) How much confidence do the child's caregivers have that the treatment providers are able to help their child?
4) Do the child's caregivers respect the opinions of the treatment providers?
5) Do all treatment providers respect the child's caregivers? Is there respect for the family's cultural and religious beliefs?
6) Are there any barriers to the child's caregivers' engagement in treatment, e.g. need to provide care to siblings of the young child, unmet mental health needs in the caregivers, lack of hopefulness by the caregivers that services available can be helpful?

DOMAIN VI: SERVICES PROFILE— Caregiver(s) Involvement in Services		
Caregiver(s) Involvement in Services: *(b) Communication*		
Severity Level	**Score**	
Optimal	**1**	Caregiver(s) routinely meets and or communicates with providers regarding the child and family's needs.
Adequate	**2**	Caregiver(s) communicates often enough with providers to maintain the service plan.
Limited	**3**	Caregiver(s) communicates with selected providers only.
Minimal	**4**	Caregiver(s) communicate with selected providers only when contacted by providers.
None	**5**	Caregiver(s) and providers fail to meet and or communicate.

1) Is there good communication between the parents/caregivers and others involved in the care and treatment of the child? Is there mutual respect between the parents/caregivers and providers?
2) Are there any language barriers that prevent the child's caregivers from communicating effectively with service providers/the treatment team? Are translators available when needed?
3) Is there adequate transportation so that parents/caregivers can attend appointments with service provides and team meetings?
4) Do the beliefs of the service providers interfere with their ability to understand the needs of the child and his/her caregivers?
5) Are the service providers flexible enough with their work hours to meet at times that allow them to meet with the child when needed?
6) Are meetings with the child's caregivers held in places that are convenient for them?

DOMAIN VI: SERVICES PROFILE—
Caregiver(s) Involvement in Services

Caregiver(s) Involvement in Services: ***(c) Agreement***

Severity Level	Score	
Optimal	**1**	Caregiver(s) and providers have complete agreement about the child and family's strengths and needs regarding the child's service plan.
Adequate	**2**	Caregiver(s) and providers generally agree about the child and family's strengths and needs regarding the child's service plan.
Limited	**3**	Caregiver(s) and providers are in disagreement about some aspect of the service plan.
Minimal	**4**	Caregiver(s) and providers are in disagreement about many aspects of the service plan.
None	**5**	Caregiver(s) and providers have complete disagreement about the child and family's strengths and needs regarding the child's service plan.

1) Are the child's caregivers able to identify the child's strengths? Are the service providers able to recognize the child's strengths as identified by his/her caregivers, or other strengths that may not yet be appreciated by the caregivers?
2) Are the service providers able to recognize strengths in the caregivers?
3) Is there agreement between the child's parents/caregivers and the service providers regarding the family's strengths? Their service needs?
4) Can parents/caregivers and providers for the child reach consensus on all parts of the service plan?
5) Are all of the child's caregivers and service providers in agreement about the child's strengths and needs? If there are divergent opinions, is there a mechanism such as a care planning team, or child and family team, that can resolve differences and develop a mutually agreed upon plan?

DOMAIN VI: SERVICES PROFILE—
Caregiver(s) Involvement in Services

Caregiver(s) Involvement in Services: ***(d) Other (write in)***

Severity Level	Score	
Optimal	**1**	
Adequate	**2**	
Limited	**3**	
Minimal	**4**	
None	**5**	

CAREGIVERS' INVOLVEMENT IN SERVICES SCORE:_____ (Highest number circled above)

Note that either Caregivers' Involvement or Child's Involvement is entered into the final score.

DOMAIN VI: SERVICES PROFILE—
Child's Involvement in Services

Child's Involvement in Services: ***(a) Engagement***

Severity Level	Score	
Optimal	**1**	Child is fully engaged during all interactions with provider(s) in an age appropriate manner.
Adequate	**2**	Child is engaged with provider(s) during most interactions.
Limited	**3**	Child is intermittently engaged with provider(s) during interactions.
Minimal	**4**	Child is rarely engaged with provider(s) during interactions.
None	**5**	Child is not engaged during any interactions with provider(s).

1) Does the child's overall developmental status allow him/her to be engaged with his/her service providers?
2) Is the child able to remain calm and focused enough to engage in treatment?
3) Does the child have a pervasive developmental disorder that may interfere in engagement with treatment?
4) Has the child been traumatized or neglected to the extent that he/she has difficulty in developing trust with his/her service providers?
5) Are there factors related to service providers that interfere with their ability to engage with the child? (This may include such factors as the size of the service provider's caseload, the extent of workplace stress and personal issues).

DOMAIN VI: SERVICES PROFILE—
Child's Involvement in Services

Domain of Child's Involvement in Services: ***(b) Communication***

Severity Level	Score	
Optimal	**1**	Child and provider(s) are able to meet regularly. Child is able to express his or her needs and have them understood by provider(s).
Adequate	**2**	Child and provider(s) are able to able to meet when needed. Child is able to express his or her needs and have them understood by some, but not all, providers.
Limited	**3**	Child and provider(s) are able to meet infrequently. Child is intermittently unable to express his or her needs and have them understood by provider(s). The child's social, emotional or behavioral disturbance intermittently interferes with the development of a working relationship with provider(s).
Minimal	**4**	Child and provider(s) are unable to meet regularly or meet during crises only. Child is rarely able to express his or her needs and have them understood by provider(s). The child's persistent social, emotional or behavioral disturbance interferes with the development of a working relationship with provider(s).
None	**5**	Child and provider(s) are unable to meet even during crises. Child is unable to express his or her needs and/or have them understood by provider(s).

1) Does the child's social, emotional, or behavioral disturbance interfere with development of a working relationship with the service providers?
2) Are there any language barriers that prevent the child from communicating effectively with his/her service providers? Are translators available when needed?
3) Is there adequate transportation for the child to participate in needed services, or if not, can services be provided in the home?

DOMAIN VI: SERVICES PROFILE— Child's Involvement in Services		
Child's Involvement in Services: ***(c) Cooperation***		
Severity Level	**Score**	
Optimal	**1**	Child is fully cooperative with provider(s)' interventions.
Adequate	**2**	Child is cooperative with provider(s)' interventions most of the time.
Limited	**3**	Child is intermittently cooperative with provider(s)' interventions.
Minimal	**4**	Child is rarely cooperative with provider(s)' interventions
None	**5**	Child is routinely not cooperative with provider(s)' interventions.

1) Is the child oppositional to the extent that it interferes with his/her ability to cooperate in treatment?
2) Is the child frightened/traumatized (or have other emotional barriers) to the extent that he/she has difficulty cooperating with treatment?
3) Does the child's affective state or ability to self-regulate interfere with his/her ability to cooperate with treatment?
4) Does the child have a medical condition, developmental disability, or other disability that interferes with his/her ability to cooperate with treatment?
5) Are the caregivers of the child ambivalent about the value of available services and/or reluctant to separate from the child such that the child is influenced to protest involvement in services?

DOMAIN VI: SERVICES PROFILE—
Child's Involvement in Services

Child's Involvement in Services: ***(d) Other (write in)***

Severity Level	Score	
Optimal	**1**	
Adequate	**2**	
Limited	**3**	
Minimal	**4**	
None	**5**	

CHILD'S INVOLVEMENT IN SERVICES SCORE: _____ (Highest number circled)

OVERALL INVOLVEMENT IN SERVICES SCORE
(*Choose either caregiver or child's score*, according to instructions in the manual and enter into Scoring Worksheet on 39) _____

DOMAIN VI: SERVICES PROFILE—
Service Fit

Service Fit: ***(a) Agreement***

Severity Level	Score	
Optimal	**1**	Caregiver(s) and provider(s) agree that all services and supports offered are appropriate for the needs of the child and family.
Adequate	**2**	Caregiver(s) and provider(s) agree that most of the services and supports offered are appropriate for the child and family's needs (e.g., clinic is not able to honor caregiver's request for a specific therapist but assigns a competent therapist for the problem).
Limited	**3**	Caregiver(s) and provider(s) disagree about the services and supports offered (e.g., caregiver(s) requests sensory integration therapy but only traditional occupational is offered).
Minimal	**4**	Caregiver(s) and provider(s) have minimal agreement about the services and supports offered.
None	**5**	Total mismatch of services with caregiver(s) perception of child and family's problems and needs.

1) Is there agreement between the child's parents/caregivers and the service providers on which services and supports are needed by the young child and his/her family?
2) Are the parents/caregivers' wishes for treatment of their child respected and included in the plan of care?
3) To what extent do the opinions of the professional service providers carry more "weight" than those of the family?

DOMAIN VI: SERVICES PROFILE—
Service Fit

Service Fit: ***(b) Appropriateness to the problem(s)***

Severity Level	Score	
Optimal	**1**	Services optimally address the child's developmental, social/emotional, or medical needs.
Adequate	**2**	Services address the majority, but not all of the child's developmental, social/emotional, or medical needs.
Limited	**3**	Services address one aspect of the child's developmental, emotional, or medical needs, but do not fit in one significant area (e.g., a 3-year-old child is receiving individual therapy for oppositional behavior, but no services for a significant speech/language delay).
Minimal	**4**	Services address the child's developmental, emotional, or medical needs poorly, (e.g., play therapy as a single modality for a child with autism.)
None	**5**	Services are mismatched to the child's developmental, emotional, or medical needs and may therefore be harmful (e.g., antidepressant medication for a 2-year old child who is described as depressed by a caregiver with Munchausen's By Proxy).

1) Do the services and supports offered to the young child and child's family draw on their strengths and meet their needs?
2) What services would better address the child's developmental needs?
3) What services would better address the child's social and behavioral needs?
4) What services would better address the child's medical needs?
5) What services would better support the child's strengths?
6) What services would better address the family's needs?
7) What services would better support the family's strengths?

DOMAIN VI: SERVICES PROFILE—
Service Fit

Service Fit: ***(c) Climate in which services are provided***

Severity Level	Score	
Optimal	**1**	Services are provided in a respectful and supportive manner, promoting active participation.
Adequate	**2**	Services are provided competently but without creating a climate for optimal participation by the child and/or family (e.g., the provider is generally supportive but does not provide enough time to answer questions).
Limited	**3**	The climate in which services are provided promotes only limited participation (e.g., the clinician is supportive but does not have toys or chairs appropriate for the child).
Minimal	**4**	The climate in which services are provided promotes minimal participation (e.g., child and/or family feel blamed for lack of progress).
None	**5**	The climate in which services are offered is experienced as totally disrespectful and unsupportive, preventing any meaningful participation.

1) Are the services and supports offered to the young child and his/her family provided in a respectful and collaborative manner?
2) Are the child's family/caregivers full partners in the direction and planning of the child's treatment?
3) Is the family, to the extent possible, able to choose the service provider for their young child?
4) Do the child's family/caregivers experience the child's providers as being able to "walk in their shoes"/understand their unique experience?

DOMAIN VI: SERVICES PROFILE—
Service Fit

Service Fit: ***(d) Access to needed services***

Severity Level	Score	
Optimal	**1**	There is full access to needed services, including appropriate flexible services (e.g., respite, in-home services, parent-to-parent support, mentoring).
Adequate	**2**	There is access to most, but not all, needed services (including flexible services).
Limited	**3**	There is lack of access to or delay in availability of some needed services (e.g., overly long waiting time for needed services).
Minimal	**4**	Access to needed supports and services is minimal (e.g., child does not have access to a needed specialty evaluation such as child and adolescent psychiatry or psychological testing).
None	**5**	Lack of access to services prevents the child and family from getting needed care (e.g., family is unable to attend office-based sessions due to caregiver disability and in-home services are unavailable).

1) Are the child and his/her family able to access all needed services? If not, which ones are not accessible? Why not?
2) Are the child and/or family on a waiting list for any needed services?
3) Are home-based services available in the community?
4) Are needed transportation services available in the community?
5) Are services provided in locations convenient to the young child and his/her family?

DOMAIN VI: SERVICES PROFILE— Service Fit		
Service Fit: ***(e) Cultural competence***		
Severity Level	**Score**	
Optimal	**1**	All services are culturally competent (e.g., having a clinician who speaks the same language or has personal experience or knowledge of the family's culture).
Adequate	**2**	Most services are culturally competent. (e.g., a language interpreter is available most times but not for all services on a consistent basis).
Limited	**3**	Services do not address diverse cultural needs (e.g., services do not incorporate culturally recognized traditional systems of care such as native elders, traditional healers, religious sponsored programs, kinship support).
Minimal	**4**	Services do not recognize significant aspects of the family's culture (e.g., the family's cultural beliefs do not include the service as it is being offered; the therapist is unfamiliar with non-traditional families such as gay couples, single by choice, or extended family; language translation is available only infrequently and not in all services).
None	**5**	Services are incompatible with critical cultural issues of the family resulting in services not being viable (e.g., condemnation of a normative family structure that is different from the clinician's own culture; language translators are never available leading to linguistic incompatibility of caregiver and/or child with service provider).

1) Does the treating clinician or other involved service providers have an understanding of the young child and his/her family's unique cultural perspective and values?
2) Are needed language interpretation services available?
3) Do the service providers have any attitudes or personal beliefs that interfere with their ability to be respectful of the child and his/her family's cultural traditions?
4) Are there generational differences in acculturation? Are the parents more traditional? Does the younger generation (e.g. siblings) identify more with contemporary American culture than the culture of their parents?

DOMAIN VI: SERVICES PROFILE—
Service Fit

Service Fit: *(f) Collaboration and coordination*

Severity Level	Score	
Optimal	**1**	There is active collaboration among providers, involved agencies, and the family; services are well coordinated.
Adequate	**2**	Collaboration and coordination of services occurs most of the time.
Limited	**3**	Collaboration and coordination of services only occurs intermittently. (e.g., meetings are held only on an as-needed basis)
Minimal	**4**	Services are in place (some of which may be appropriate), but they are not coordinated with each other and may be duplicative
None	**5**	Services are totally uncoordinated or duplicative.

1) To what extent do the providers from the involved agencies coordinate their care to the young child and his/her family?
2) Do the involved agencies allow their employees to participate in team care planning or other interagency treatment planning meetings?
3) Are the young child's parents included as full members of the treatment team? As leaders of the treatment team?
4) Do service plans from different providers set up conflicting expectations for the parents/caregivers?
5) Does conflict between providers about the treatment plan result in increased distress or loss of hopefulness in the parents/caregivers?

DOMAIN VI: SERVICES PROFILE—
Service Fit

Service Fit: ***(g) Other (write in)***

Severity Level	Score	
Optimal	**1**	
Adequate	**2**	
Limited	**3**	
Minimal	**4**	
None	**5**	

SERVICE FIT SCORE _____ **(Highest score circled)**

DOMAIN VI: SERVICES PROFILE—
Service Effectiveness

Service Effectiveness: ***(a) Resolution of child's symptoms***

Severity Level	Score	
Optimal	**1**	Caregiver(s), child (if relevant), and provider(s) believe that services are completely effective (e.g., caregiver reports that child sleeps through the night following interventions).
Adequate	**2**	Caregiver(s), child (if relevant) and provider(s) believe that services are mostly effective, as evidenced by significant improvement in child's symptoms (e.g., a child with feeding problems is still a fussy eater but is now gaining weight).
Limited	**3**	Caregiver(s), child (if relevant) or provider(s) believe that services are helping improve some of the child's symptoms (e.g., caregiver reports that child sleeps through night following interventions, but that falling asleep is still a problem).
Minimal	**4**	Caregiver(s), child (if relevant) or provider(s) believe that services are having a marginal impact toward improving the child's symptoms.
None	**5**	Caregiver(s), child (if relevant) and provider(s) believe that services are not working to improve child's symptoms (e.g., child is not sleeping and caregivers are distressed even following interventions).

1) Does the family feel that the current intensity of services is appropriate?
2) Do the service providers feel that the current intensity of services is appropriate?
3) Does the family feel that the current mix of services is effective? Which services are effective? Which services are not?
4) Do the service providers feel that the current mix of services is effective? Which services do they feel are effective? Which ones are not?
5) Do the family and service providers agree on the changes needed in service intensity or service mix in order to serve the child and family better?

DOMAIN VI: SERVICES PROFILE—
Service Effectiveness

Service Effectiveness: ***(b) Child's development back on track***

Severity Level	Score	
Optimal	**1**	Caregiver(s) and provider(s) see child's growth and development as age appropriate or fully back on track; if applicable, rehabilitation goals have been fully met.
Adequate	**2**	Caregiver(s) and provider(s) see child's growth and development as largely back on track; if applicable, substantial progress has been made toward rehabilitation goals.
Limited	**3**	Caregiver(s) or provider(s) see child's growth and development as partially on track; if applicable, rehabilitation goals have been partially met.
Minimal	**4**	Caregiver(s) or provider(s) see child's growth and development as minimally on track; if applicable there has been minimal progress towards rehabilitation goals.
None	**5**	Caregiver(s) and provider(s) see child's growth and development as stalled or worsened; if applicable, no evidence of progress in meeting rehabilitation goals.

1) Do the parents/caregivers believe that their child's development is "on track?" If not, which areas of development continue to need support?
2) Do the service providers believe that the young child's development is "on track?" If not, which areas of development are not felt to be "on track?"
3) Do the parents/caregivers believe that the child's goals for rehabilitation are being met? If not, which goals do they believe are being met? Which goals are not?
4) Do the service providers believe that the child's goals for rehabilitation are being met? If not, which goals do they believe are being met? Which goals are not?
5) Is there agreement between family and service providers on the child's developmental status? On meeting the goals of rehabilitation?

DOMAIN VI: SERVICES PROFILE—
Service Effectiveness

Service Effectiveness: ***(c) Resolution of family concerns***

Severity Level	Score	
Optimal	**1**	Caregiver(s) and provider(s) believe that family difficulties or concerns have resolved or reached the desired outcome(s).
Adequate	**2**	Caregiver(s) and provider(s) believe that family difficulties or concerns have largely resolved or largely reached the desired outcome(s).
Limited	**3**	Caregiver(s) or provider(s) believe that family difficulties or concerns have only partially resolved or partially reached the desired outcome(s).
Minimal	**4**	Caregiver(s) or provider(s) believe that services are marginally effective in resolving or reaching the desired outcome(s) for family difficulties or concerns.
None	**5**	Caregiver(s) and provider(s) believe that family difficulties or concerns have not improved, and/or no progress has been made towards the desired outcome(s).

1) Does the family feel that their concerns have been addressed? Do they feel that their concerns have been resolved?
2) Do the service providers feel that the child and family's concerns have been addressed? Do they feel that the child and family's concerns have been resolved?
3) Can the family and service providers reach consensus on whether the child's concerns have been addressed or resolved? On whether the family's concerns have been addressed?

DOMAIN VI: SERVICES PROFILE— Service Effectiveness		
Service Effectiveness: ***(d) Preparing for child and family's future needs***		
Severity Level	**Score**	
Optimal	**1**	Caregiver(s) and provider(s) feel the child and family's future needs have been well prepared for.
Adequate	**2**	Caregiver(s) and provider(s) feel the child and family's future needs have been mostly prepared for.
Limited	**3**	Caregiver(s) or provider(s) feel the child and family's future needs have been partially prepared for.
Minimal	**4**	Caregiver(s) or provider(s) feel the child and family's future needs have been marginally prepared for.
None	**5**	Caregiver(s) and provider(s) feel there has been no planning for the child and family's future needs.

1) Is there agreement between the family and service providers regarding the child's future needs? Regarding the family's future needs?
2) Is there agreement between the family and service providers regarding the preparation needed now in order to meet the child's future needs? To meet the family's future needs?
3) Is there a shared vision between the family and service provides for the child and family's future?

DOMAIN VI: SERVICES PROFILE— Service Effectiveness		
Service Effectiveness: ***(e) Other (write in)***		
Severity Level	**Score**	
Optimal	**1**	
Adequate	**2**	
Limited	**3**	
Minimal	**4**	
None	**5**	

SERVICE EFFECTIVENESS SCORE _____ (Highest score circled)

III. SUMMARY OF ECSII DEVELOPMENT AND PSYCHOMETRIC DATA

Background:

In the late 1990s, the AACAP Work Group on Systems of Care developed and tested the Child and Adolescent Level of Care System (CALOCUS); the empirically tested AACAP version is now called the Child and Adolescent Service Intensity Instrument (CASII). The CASII instrument is a tool to determine the appropriate level of care placement for a child or adolescent. It takes into consideration child development and the importance of the parents and the community in supporting the child. Use of the CASII began in 2000. Since then, Work Group members have trained over 1500 clinicians around the country on the instrument. The AACAP Department of Clinical Practice works with state agencies to arrange trainings and Work Group members continue to train clinicians around the country

It soon became apparent that the states were seeing younger and younger children with mental health needs. The Work Group began to get requests for an instrument for the early childhood population (ages 0-5, not covered by the CASII). In 2003, the work group began developing the Early Childhood Service Intensity Instrument (ECSII) and received funding from McNeil Pharmaceuticals for its development and testing.

Development of the ECSII:

The following is a description of steps in the development and testing of the ECSII from 2003-2009.

1) Infancy experts were consulted on the design of the ECSII, including Neil Boris, M.D. and Bob Harmon, M.D., in the early stage of instrument development around conceptual issues. Dr. Harmon provided substantial and very wise guidance during multiple meetings of the Work Group, and the ECSII is dedicated to Dr. Harmon for his profound guidance and support.
2) The ECSII added several features not present in the CASII, including a domain for Child-Caregiver Relationships, a Services Profile section that can be used in services planning, Tables listing ascending levels of service intensity in 7 different service types, and a services planning worksheet.
3) Initial trainings were done in Arizona (to obtain early feedback on the tool) and in Oregon, where inter-rater reliability data was collected.
4) The psychometric study was designed by Dr. Winters with statistical and methodological consultation from Bentson McFarland, M.D., Ph.D. The studies included inter-rater reliability, construct validity, empirically-based scoring algorithm development, and concurrent validity.
5) The ECSII subgroup (five members of the full Work Group) developed 20 standardized clinical vignettes. These were then scored by individually by all 11 Work Group members, and consensus scores were arrived at, which were the basis of the "gold standard" scores. The vignettes were the basis of trainings, criterion validity testing, development of the scoring algorithm, and data on concurrent validity.

6) As a part of development of an empirically-based scoring algorithm, we asked a number of infancy experts to rate the standardized clinical vignettes according to their service needs. These experts included: Charlie Zeanah, M.D., Marty Drell, M.D., Tom Anders, M.D., David Pruitt, M.D., Hellen Egger, M.D., Jean Thomas, M.D., and Brain Stafford, M.D.
7) Subsequently, a focus group of local Washington, DC early infancy clinicians was convened for to develop service need ratings on the standardized vignettes. (Note that the latter ratings were not ECSII scores, but were intensity of service needs based on ECSII Tables of ascending intensity of services in 7 service categories).
8) Clinicians from Nevada provided data for the concurrent validity component of the psychometric study. They provided electronic data on 205 cases comparing the ECSII with the CBCL (for children 18 months and older) or Infant Characteristics Questionnaire (children under 18 months), and the Parenting Stress Index.

SUMMARY OF PSYCHOMETRIC DATA:

Inter-rater Reliability

To test inter-rater reliability, an Oregon group of early childhood clinicians was trained for 1 ½ days on the ECSII. Fifty-two clinicians from four service areas (mental health, child welfare, primary health nursing, early education) scored 15 standardized vignettes after the ECSII training. The group composition is described below:

System (agency category)	(#)	(%)
– Mental Health	38	(73)
– Early education	7	(13.5)
– Child welfare/soc. service	6	(11.5)
– Public health nursing	1	(2)
Education		
– Bachelors degree	3	(5.8)
– Nursing	2	(3.8)
– Masters degree	44	(84.6)
– Doctoral degree	3	(5.8)

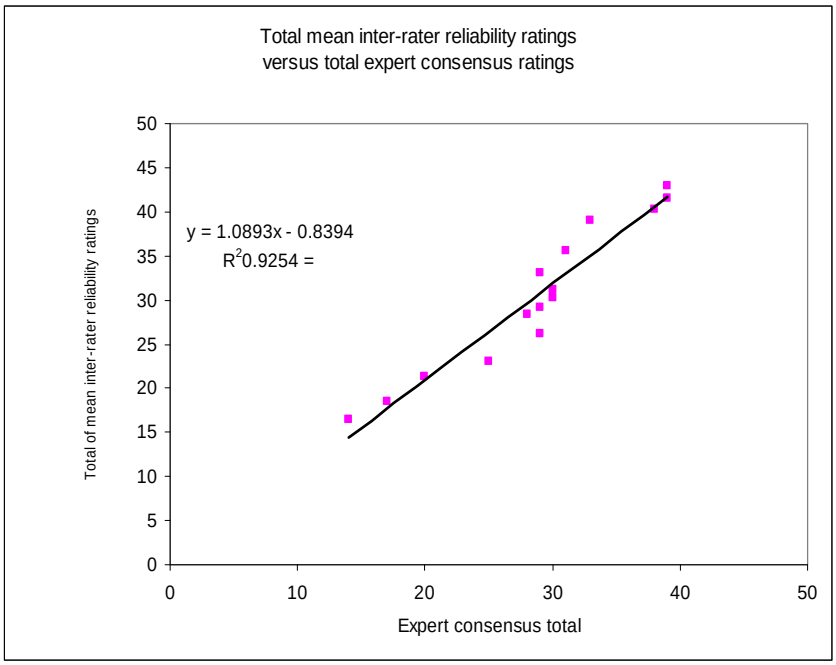
The 52 Oregon clinicians' ECSII scores on the standardized vignettes were analyzed for intra-class correlations, yielding the following data:

	ECSII Domain	**Intra-class correlation**
I.	Safety	0.829
II.	Child-caregiver relationships	0.763
III.	Caregiving Environment	
	a. Environmental supports	0.777
	b. Environmental stressors	0.763
IV.	Functioning	0.675
V.	Impact of problems	0.709
VI.	Services Profile	

a. Service involvement 0.595
b. Service fit 0.696
c. Service effectiveness 0.442

Criterion-Based Construct Validity

Construct validity was established by meeting a predicted criterion. Scores of the Oregon inter-rater reliability sample (52 clinicians, described above) on 15 standardized vignettes were correlated with the "gold standard" ECSII scores on the same vignettes. This yielded an intra-class correlation coefficient of .9254. (See graph below.)



Concurrent Validity

This part of the study was done with early childhood clinicians in the state of Nevada. Early childhood mental health clinicians scored the ECSII on 205 actual new cases of children ages 0-5. The following charts indicate the age, gender, and ethnicities of the sample.

Age of child	Frequency	Percent
Under 18 months	20	10%
18 through 23 months	10	5%
Two years	14	7%
Three years	72	35%
Four years	52	25%
Five years	39	19%
Total no.	207	100%

Gender / Ethnicity	Frequency (%)
Male	63.9
Female	36.1
Caucasian	43.9
Hispanic or Latino	14.1
Asian/Pacific Islander	2.4
African-American	24.4
Mixed	15.1

The children's living situations are depicted in the table below:

Child's Living Situation	%
Birth or adoptive parents	37.1
Informally established extended family care	9.8
Foster care (relative placement)	17.6
Regular foster care (non-family)	30.2
Therapeutic foster care	5.4

Along with scoring the ECSII, the Nevada clinicians administered the following questionnaires on all the cases: Achenbach Child Behavior Checklist (CBCL) for children 18 months and older, (or the Infant Characteristics Questionnaire for children under 18 months), and the Parenting Stress Index (PSI).

The following table shows correlation coefficients of the ECSII Domains (I-V) with the CBCL Internalizing, Externalizing and Total Problem Scores. Note that the number of children under 18 months was not adequate for the statistical analysis, therefore the Infant Characteristics Questionnaire data is not included below.

Correlation Coefficients: ECSII Domains with CBCL

ECSII Domains			
	CBCL Int.	CBCL Ext.	CBCL Total
Deg Safety	.183*	.238**	.241**
Child CG Relationships	.151*	.333**	.259**
CG Envt / Strengths	-.062	.104	.043
CGf Envt/ Stressors	.154*	.176*	.227**
Funct/ Devel Status	.416**	.456**	.489**
Impact	.335**	.360**	.392**
Total ECSII Score	.266**	.392**	.388**
ECSII SI Level	.227**	.354**	.347**

** Correlation is significant at the 0.01 level (2-tailed); * Correlation is significant at the 0.05 level (2-tailed)

The next table shows the correlation coefficients of the ECSII subscales I-V with the subscales of Parenting Stress Index. (Highest correlations are in bold).

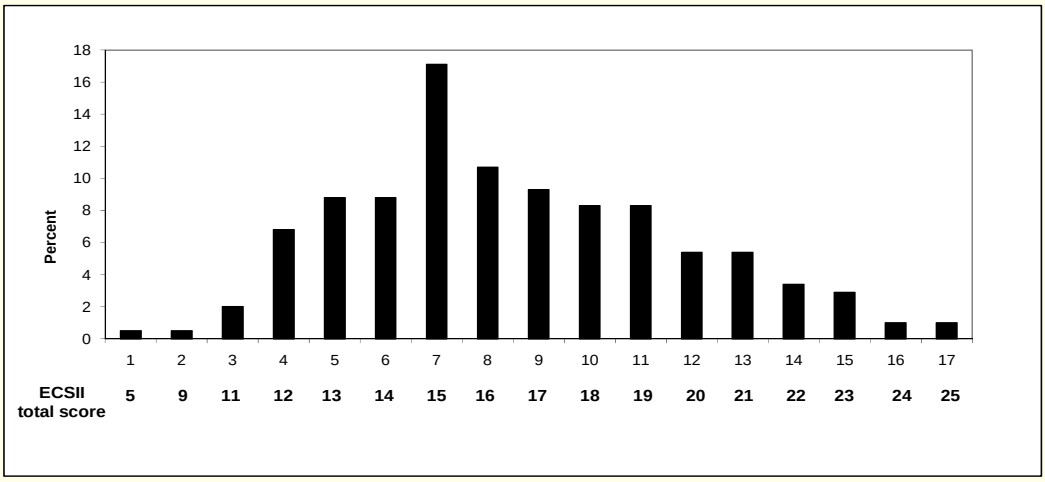
Correlation Coefficients: ECSII Domains with Parenting Stress Index (PSI)

PSI	Safety	Ch-CG Rela.	CE strengths	CE stressors	Func /dev	Impact	Total Score	SI Level
Total Stress	0.23	**0.38**	0.17	0.16	**0.41**	**0.39**	**0.39**	**.364****
Parent distress	0.24	**0.31**	0.21	0.27	0.22	0.15	**0.32**	**.317****
Dysfunct interact	0.22	0.29	0.12	0.15	**0.36**	**0.33**	**0.34**	**.307****
Difficult child	0.12	**0.30**	0.09	-0.00	**0.39**	**0.42**	0.29	.255**

Distribution of ECSII Total Scores in the Nevada sample:

The following bar graph shows the frequency of children scoring at specific ECSII Service Intensity Levels. For example, 3% of children scored at SI Levels 0-1. Level 2 scores were given to 54.7% of children. Levels 3-5 occurred in 46.5% of children with the majority of those (39.1%) on Level 3. Only 3.2% of children scored at levels 4 and 5.

Nevada data: Distribution of Total Scores



SI Level	0	I	II	III	IV	V
Total score	5-8	9-12	13-17	18-22	23-26	27-30

Level 0= Health Maintenance; Level 1= Minimal SI (beginning care); Level 2=Low SI; Level 3= Moderate SI; Level 4= High SI; Level 5 = Maximal SI.

Summary:

The ECSII has excellent inter-rater reliability, with correlation coefficients on Domains I-V (those used to derive the Service Intensity score) from 0.676-0.829. Reliability scores on the Services Profile subscale are somewhat lower, as expected because vignettes had limited information about the services the children were receiving.

The data also demonstrate excellent criterion validity with a correlation of 0.93.

Concurrent validity data obtained from correlations of the ECSII with the Achenbach CBCL and the Parenting Stress Index (PSI) show statistically significant correlations in directions that would be predicted. For example, the ECSII Domains of Functional/Developmental Status and Impact of Child's Problems showed the strongest correlations with all CBCL scales. This would be expected since these are the ECSII Domains relating most strongly to the child's problems, which is what the CBCL measures.

On the PSI, the Total Parenting Stress score correlates significantly with the ECSII Domains Child-Caregiver Relationships, Functional/Developmental Status, and Impact of the Child's Problems; it also correlates with the ECSII Total Score and assigned SI Level, but not as highly with Safety or Caregiving Environment. There are also significant correlations between the child's perceived difficulty on the PSI and the ECSII domains of Child-Caregiver Relationships, Functional/Developmental Status, and Impact of the Child's Problems, and others as shown in the table.

ECSII ANCHOR POINTS QUICK REFERENCE SHEET

Domain I. Degree of Safety

1. Optimal Safety	2. Adequate Safety	3. Moderate Safety	4. Impaired Safety	5. Low Safety (S. I. = Level 5)
A. Child's environment is safe and protective, no significant dangers, instabilities or risks. B. Constancy in caretaking, living and support systems, no recent loss, trauma, abuse, disruption. C. Caregiver demonstrates capacity to respond with attention to safety. D. Caregiver exhibits no conditions or risks that present endangerment. E. Caregiver's knowledge base, beliefs or behaviors are dev appropriate to child's needs. F. Child exhibits developmentally appropriate ability to maintain physical safety. G. Child exhibits no current indication of self-harming or other-directed aggression. H. Other	A. Child's environment is generally safe and protective, but some environmental dangers, instabilities, or risks. B. Overall stability in caretaking, living and support systems with minimal recent loss, trauma, abuse and/or disruption. C. Caregiver demonstrates brief/limited lapses in ability to respond with attention to safety. D. Caregiver exhibits conditions or behaviors with minimal risk of endangerment. E. Caregiver's knowledge base, beliefs or behaviors mildly dev inappropriate, place child at low risk of harm. F. Child exhibits some developmental challenges in maintaining physical safety. G. Indication of occasional self-harming or other-directed aggression with minimal consequences for self or others. H. Other	A. Child's environment is not optimally safe and protective (i.e., several environmental dangers, instabilities, or risks that caregivers cannot fully address). B. Moderate disruptions in caretaking, living, support systems with recent loss, trauma, abuse, and/or disruption. C. Caregiver exhibits moderate and/or periodic lapses in ability to respond with attention to safety. D. Caregiver exhibits conditions or risk behaviors with moderate risk of endangerment to self or others. E. Caregiver's knowledge base, beliefs, or behaviors often dev inappropriate and place child at moderate risk of harm. F. Child exhibits moderate developmental difficulties in maintaining safety. G. Indication of periodic self-harming or other-directed aggression with moderate consequences for self or others H. Other	A. Child's environment is often not safe and protective, multiple substantial dangers, instabilities, risks. B. Substantial instability in caretaking, living, support systems with significant recent loss, trauma, abuse. C. Caregiver demonstrates substantial and/or frequent lapses in ability to respond with attention to safety. D. Caregiver exhibits conditions or risk behaviors with substantial risk of endangerment to self or others. E. Caregiver's knowledge base, beliefs, or behaviors frequently dev inappropriate, place child at substantial risk of harm. F. Child exhibits substantial developmental difficulties in maintaining physical safety. G. Indication of self-harming or other-directed aggression with substantial consequences for self or others. H. Other	A. Child's environment is rarely safe and protective, multiple serious and/or persistent dangers, instabilities, risks. B. Persistent instability in caregiving, living, support systems with recent severe loss, trauma, abuse, disruption. C. Caregiver is disorganized and/or shows minimal capacity to respond with attention to safety. D. Caregiver exhibits persistent and/or serious conditions or risk behaviors that present significant risk of endangerment. E. Caregiver's knowledge base, beliefs, behaviors typically dev inappropriate and place child at serious and/or persistent risk. F. Child exhibits persistent developmental inability to maintain physical safety. G. Indication of persistent and extremely dangerous self-harming or other-directed aggression. H. Other

ECSII ANCHOR POINTS QUICK REFERENCE SHEET

Domain II. Child-Caregiver Relationships

1. Optimal Relationship	2. Adequate Relationship	3. Mild Impairment of Relationship	4. Moderate Impairment of Relationship	5. Severe Impairment of Relationship (S.I. Level+1)
A. Relationship is functioning well and is consistently satisfying to both caregiver and child. B. Interactions are consistently reciprocal, warm, and flexible. C. The relationship supports child's development and enhances caregiver's functioning. D. Caregiver consistently shows empathy for child and understanding of emotional needs. E. Other	A. Relationship is largely adequate and satisfying to both caregiver and child, but extra support may be needed to maintain quality of relationship. B. Interactions are usually but not always reciprocal and warm for both. C. Disturbances if present are transient and have minimal impact on developmental progress. D. Caregiver has general understanding of child's emotional needs but may not have in depth understanding of emotional experience. E. Other	A. Strains in relationship are apparent and beginning to adversely affect subjective experience of caregiver and child. B. Some interactions are conflictual. C. Relationship disturbance presents some risk to the developmental progress of child or to caregiver's functioning. D. Caregiver's empathy for child and understanding of emotional needs is disturbed when caregiver is under stress. E. Other	A. Relationship is characterized by substantial distress in child and/or caregiver. B. Substantial proportion of interactions are conflicted, and show limited response to intervention. C. Disturbance in relationship is substantially impacting child's physical, emotional, cognitive development and/or caregiver's ability to function. D. Caregiver displays limited empathy for child and impaired understanding of child's emotional needs in most situations. E. Other	A. Relationship is severely and/or persistently disturbed and distressing to CG and child such that the child is in imminent danger of physical harm. B. Interactions consistently disturbed in all areas and are resistant to change. C. Disturbance in relationship severely and/or persistently impacts child's development and/or caregiver's ability to function. D. Caregiver's empathy for child is negligible and shows little understanding of child's emotional needs. E. Other

ECSII ANCHOR POINTS QUICK REFERENCE SHEET

Domain III A. Caregiving Environment: Strengths and Protective Factors

1. Optimal	2. Adequate	3. Limited	4. Minimal	5. None
A. Family and/or community resources optimal to address dev/material needs. B. Continuity of active, engaged family and community caregivers. C. Caregivers readily use potentially helpful/enriching resources. D. Caregiving system supports stable home environment. E. Caregiving system provides optimal resources and services to support family. F. Other	A. Family and/or community resources sufficient to meet dev or material needs. B. Continuity of fam, extended family, comm caregivers only occasionally disrupted. C. Caregivers willing and able to make use of recommended resources and services. D. Caregiving system able to respond to challenge or crisis to maintain stable home. E. Caregiving system provides basic resources and services to support family. F. Other	A. Fam +/or comm resources have limited ability to respond appropriately to dev/material needs. B. Continuity of family/comm caregivers is often disrupted. C. Caregivers make use of resources and services episodically. D. Caregiving system has limited ability to respond quickly and competently in crisis that puts home at risk. E. Caregiving system provides limited resources and services to support family. F. Other	A. Family and/or community resources minimally responsive to dev/material needs. B. Continuity of family/caregivers is usually disrupted. C. Caregivers have substantial disagreements with resources and services. D. Caregiving system's lack of ability to respond to family needs results in change of home placement. E. Caregiving system provides few resources and services to support family. F. Other	A. Family/comm unable to meet dev/material needs. B. No continuity of family and community caregivers. C. Caregivers actively refuse needed resources and services. D. Caregiving system is unable to respond to dangerous conditions. E. Caregiving system provides no resources to support the family. F. Other

ECSII ANCHOR POINTS QUICK REFERENCE SHEET

Domain III B. Caregiving Environment: Stressors and Vulnerabilities

1. Absent	2. Mild	3. Moderate	4. Serious	5. Severe
A. Absence of family or community stressors. B. Absence of recent transitions or losses. C. Material needs met without concern for near future. D. Family receives sufficient supports + resources from community. E. Community recognizes and supports family cultural needs. F. Family optimally able to meet dev. needs. G. Other	A. Intermittent or short-term exposure to non-violent stressors. B. Minor transition or loss e.g. change in residence, CG in daycare, death of distant family member. C. Material resources adequate but not optimal. D. Community supports available with some limitations. E. Community partially recognizes and supports cultural needs. F. Family adequately able to meet child's dev. needs. G. Other	A. Frequent exposure to non-violent stressors. B. Moderate disruption of family/social milieu. C. Family experiencing financial stressors/challenges, and concerns about resources in future. D. Community supports are minimal but do not threaten family stability. E. Community inconsistently recognizes cultural needs. F. Family is erratic in meeting child's needs. G. Other	A. Freq exposure to threats of violence; agg in fam; or serious conditions in CG that significantly compromise ability to care. B. Substantial disruption of family/social milieu. C. Loss or absence of material resources has substantial impact. D. Community supports rarely available and this threatens family stability. E. Community insensitive to cultural needs. F. Family poorly meets dev needs and is often neglectful. G. Other	A. Constant exposure to serious fam violence; conditions in CG that make them unable to safely care; safety compromising criminal activity. B. Fragmentation of family (e.g. death of both CGs; single CG is incarcerated). C. Loss or absence of material resources has persistent impact; comm supports are absent, resulting in inability of fam to care for child. D. Community supports needed for safety or stability unavailable. E. Persistent cultural stigmatization in community. F. Family constantly neglects child. G. Other

ECSII ANCHOR POINTS QUICK REFERENCE SHEET

Domain IV. Functional Developmental Status

1. Optimal	2. Adequate	3. Mild Impairment	4. Moderate Impairment	5. Severe Impairment
A. Ability to maintain calm, alert, affectively available state. Displays full range of affect. Able to regulate affect. B. Adapts easily to change. Flexible during transitions. Dev appropriate level of curiosity about the environment. Tolerance for age appropriate separations. C. Settles easily for sleep with developmentally appropriate support. No appetite disturbance. Toileting ability is age appropriate. D. Developmentally appropriate relationships with others. Intact ability to control impulses. Does not initiate agg behavior. E. Communication, motor, and cognitive capacities (e.g. problem-solving) are age app. F. Other	A. Able to maintain calm, affectively available state with limited environmental mod by CGs. Affect may be constricted or reactive under stress, but improves w/ CG support. B. Requires some support for transitions. Flexibility occasionally compromised under stress. Able to explore environment w/ encouragement by CGs. C. Requires some efforts by CGs to soothe for sleep. Appetite varies under stress. Occ regression in toileting. D. Engages with peers successfully with CG support. Occasional impulsive beh or agg typical of dev age, requiring slight increase in monitoring of interactions. E. Some areas of dev may be uneven, but dev progress in communication, motor, and cognitive capacities is generally app and does not require formal intervention. F. Other	A. Occasional but not overwhelming disturbance in ability to maintain calm, affectively available state requiring additional support/environmental mod by CGs. Some restriction of affect noted outside of familiar situations or difficulties modulating affect. B. Flexibility compromised under stress (e.g., able to transition, but requires frequent cueing and more intensive support). Requires added support. C. Routinely needs environ mod for sleep, eating, or toileting; requires additional feeding time or other basic interventions due to picky eating or inadequate wt gain; is somewhat behind in developing age appropriate toileting beh. D. Mild impairment in age-app soc skills. Impulse control impaired, but increased environmental supports help CGs to maintain safety in most circumstances. Intermittent agg beh, managed by heightened supervision. Warm interactions possible primarily with trusted CGs, others with significant support. E. Dev delay is associated with some impairment in functioning; motor or cognitive delays do not prevent from participating. F. Other	A. Affect constricted or poorly modulated in most circumstances. Intensive CG support required for normative interaction. B. Requires intensive support to transition. Transitions often result in tantrums or tears. Hesitant, easily derailed exploration of environ. C. Substantial dist in age-app patterns of sleep, feeding or toileting; feeding is substantially disrupted + diff maintaining age-app wt despite preliminary interventions; lacks age-app toileting beh. D. Substantial impairment in age-app soc skills. Requires intensive input for most soc interactions, + successful peer interactions are infrequent. Agg beh has caused injury to others or threatens placement; Freq compromise of safety due to impulsivity despite close supervision + support. E. Dev delay is associated with substantial impairment in functioning (e.g., extra time and support is needed to help with speech delay to make needs known,; child w/ gross or fine motor delay freq gives up on age app motor tasks, even with substantial support, and is unable to complete or participate in age app tasks or activities). F. Other	A. Persistent and/or severe inability to regulate internal affective state in all settings. Tantrums are frequent/severe, unresponsive to interventions. B. Transitions poorly regardless of CG's interventions. Small changes in routine result in severe behavior disruption. C. Persistent and severe disturbance in age-app patterns of sleep, feeding or toileting; wakes w/ minimal environmental stimulation + requires max effort to return to sleep; profound feeding disturbance resulting in severe Failure to thrive; persistent and severe problems w/ toileting). D. Severe impairment of age-app soc skills. Unable to exercise developmentally app impulse control, with max support. Agg beh resulted in removal from multiple childcare settings. Near complete withdrawal from interaction with environment, even with max supports. E. Marked delays result in persistent impairment of dev progress; persistent impairment in motor skills, preventing participation in age-app tasks or activities. F. Other

ECSII ANCHOR POINTS QUICK REFERENCE SHEET

Domain V. Impact of Medical, Developmental, or Emotional/Behavioral Problems

1. Optimal Functioning	2. Adequate Functioning	3. Mild Impairment of Functioning	4. Moderate Impairment of Functioning	5. Severe Impairment of Functioning
A. No medical problems in the child. B. No developmental problems in the child. C. No emotional or behavioral problems in the child. D. No emotional stress on family related to medical, developmental or emotional/behavioral problem. E. No financial stress on family related to medical, developmental, or emotional/behavioral problem. F. Other	A. Minor med problems typically seen in primary care (e.g., mild asthma, occasional ear infections). B. Dev disturbance is mild + improving w/ natural supports (e.g. a "late talker" whose lang delay improves w/ increased stimulation from fam + preschool. C. Emot or beh disturbances are minor +/or transient (e.g., occ temper tantrums). D. Caregivers are able to cope with med, dev, or emot/beh problem w/ natural supports. E. Costs related to med, dev, or emot/beh problem can be met by fam resources +/or health ins. F. Other	A. Chronic med problems that may require specialist consultation + have some impact on functioning, but are responsive to interventions (e.g., well controlled diabetes). B. Dev disturbance is mild + is not improving w/ natural supports alone (e.g., cerebral palsy with low muscle tone requiring PT). C. Emotional or behavioral problems of mild severity needing interventions (e.g., temper tantrums that are frequent and may disrupt fam activities). D. Caregivers display mild symptoms of anxiety, distress or fatigue due to the child's med, dev, or emot/beh problem. E. Costs related to med, dev, or emot/beh problem cause budgetary challenge (e.g., due to cost of needed services not adequately covered by insurance). F. Other	A. Substantial medical illness requiring multiple interventions + causing ongoing functional impairment (e.g., poorly controlled asthma that limits activities + may result in occasional acute hospitalization). B. Moderate dev delays requiring more frequent + intensive interventions (e.g., severe cerebral palsy requiring braces and frequent PT). C. Emot or beh problems of moderate severity, which interfere w/ daily functioning (e.g., daily temper tantrums that are prolonged and intense) + may threaten a school or child care placement. D. CGs periodically feel hopeless or helpless about med, dev, or emot/beh problem +/or exp adverse impact on CG's relationship w/ other adults, comm activities or work. E. The cost of interventions for med, dev, or emot/beh problem requires CGs to actively increase income or intensity of care giving requirements requires CGs to decrease work. F. Other	A. Chronic med condition causing severe functional impairment + many hospitalizations, or specialized care facility (e.g., congenital heart disease requiring many hospitalizations + severely limiting activity). B. Severe and/ persistent dev delays that threaten dev progress + require constant interventions (e.g., severe cerebral palsy requiring assistance in ADLs such as feeding + moving). C. Emot or beh problems severe enough to threaten current home placement. D. CG is overwhelmed + experiences persistent hopelessness/helplessness due to ch's med, dev, or emot/beh problem which threatens or severely compromises necessary care for the child. E. The cost of interventions related to med, dev, or emot/beh prob is catastrophic + leads to loss of home or relinquishment of custody of the child. F. Other

ECSII ANCHOR POINTS QUICK REFERENCE SHEET

Domain VI A. Services Profile – Caregiver(s) Involvement in Services

1. Optimal	2. Adequate	3. Limited	4. Minimal	5. None
A. All caregivers and providers agree that there is optimal engagement, i.e. both respect each other and view the other as having knowledge and expertise necessary for the treatment of the child. B. Caregiver(s) routinely meets +/or communicates with providers regarding the child + family's needs. C. Caregiver(s) and providers have complete agreement about the child and family's strengths and needs regarding the child's service plan. D. Other	A. One caregiver is fully engaged with all needed services and providers and communicates effectively with all other caregivers. B. Caregiver(s) communicates often enough with providers to maintain the service plan. C. Caregiver(s) and providers generally agree about the child and family's strengths and needs regarding the child's service plan. D. Other	A. One caregiver is engaged with all services and providers but another significant caregiver isn't engaged (e.g. this schism could be between divorced parents, parent and foster parent, or other significant extended family members). B. Caregiver(s) communicates with selected providers only. C. Caregiver(s) and providers are in disagreement about some aspect of the service plan. D. Other	A. Caregiver(s) engages with essential services and interacts with providers only during crises. B. Caregiver(s) communicate with selected providers only when contacted by providers. C. Caregiver(s) and providers are in disagreement about many aspects of the service plan. D. Other	A. No engagement between CG(s)+ providers. There is a pervasive lack of respect between CG(s) + providers + neither views the other as having knowledge + expertise necessary for tx of the child. B. Caregiver(s) and providers fail to meet and or communicate. C. Caregiver(s) and providers have complete disagreement about the child and family's strengths and needs regarding the child's service plan. D. Other

ECSII ANCHOR POINTS QUICK REFERENCE SHEET

Domain VI A. Services Profile – Child's Involvement in Services

1. Optimal	2. Adequate	3. Limited	4. Minimal	5. None
A. Child is fully engaged during all interactions with provider(s) in an age appropriate manner. B. Child and provider(s) are able to meet regularly. Child is able to express his or her needs and have them understood by provider(s). C. Child is fully cooperative with provider(s)' interventions. D. Other	A. Child is engaged with provider(s) during most interactions. B. Child and provider(s) are able to able to meet when needed. Child is able to express his or her needs and have them understood by some, but not all, providers. C. Child is cooperative with provider(s)' interventions most of the time. D. Other	A. Child is intermittently engaged with provider(s) during interactions. B. Child and provider(s) are able to meet infrequently. Child is intermittently unable to express his or her needs and have them understood by provider(s). The child's social, emotional or behavioral disturbance intermittently interferes with the development of a working relationship with provider(s). C. Child is intermittently cooperative with provider(s)' interventions. D. Other	A. Child is rarely engaged with provider(s) during interactions. B. Child and provider(s) are unable to meet regularly or meet during crises only. Child is rarely able to express his or her needs and have them understood by provider(s). C. Child is rarely cooperative with provider(s)' interventions. D. Other	A. Child is not engaged during any interactions with provider(s). B. Child and provider(s) are unable to meet even during crises. Child is unable to express his or her needs and/or have them understood by provider(s). C. Child is routinely not cooperative with provider(s)' interventions. D. Other

ECSII ANCHOR POINTS QUICK REFERENCE SHEET

Domain VI B. Services Profile – Service Fit

1. Optimal	2. Adequate	3. Limited	4. Minimal	5. None
A. Caregiver(s) and provider(s) agree that all services and supports offered are appropriate for the needs of the child and family. B. Services optimally address the child's developmental, social/emotional, or medical needs. C. Services are provided in a respectful and supportive manner, promoting active participation. D. There is full access to needed services, including appropriate flexible services (e.g., respite, in-home services, parent-to-parent support, mentoring). E. All services are culturally competent (e.g., having a clinician who speaks the same language or has personal experience or knowledge of the family's culture). F. There is active collaboration among providers, involved agencies, and the family; services are well coordinated. G. Other	A. Caregiver(s) and provider(s) agree that most of the services and supports offered are appropriate for the child and family's needs (e.g., clinic is not able to honor caregiver's request for a specific therapist but assigns a competent therapist for the problem). B. Services address the majority, but not all of the child's developmental, social/emotional, or medical needs. C. Services are provided competently but without creating a climate for optimal participation by the child and/or family (e.g., the provider is generally supportive but does not provide enough time to answer questions). D. There is access to most, but not all, needed services (including flexible services). E. Most services are culturally competent. F. Collaboration and coordination of services occurs most of the time. G. Other	A. Caregiver(s) and provider(s) disagree about the services and supports offered (e.g., caregiver(s) requests sensory integration therapy but only traditional occupational is offered). B. Services address one aspect of the child's developmental, emotional, or medical needs, but do not fit in one area. C. The climate in which services are provided promotes only limited participation (e.g., the clinician is supportive but does not have toys or chairs appropriate for the child). D. There is lack of access to or delay in availability of some needed services. E. Services do not address diverse cultural needs (e.g., services don't incorporate culturally recognized traditional SOC such as native elders, traditional healers, religious sponsored programs, kinship support). F. Collaboration and coordination of services only occurs intermittently. G. Other	A. Caregiver(s) and provider(s) have minimal agreement about the services and supports offered. B. Services address the child's developmental, emotional, or medical needs poorly, (e.g., play therapy as a single modality for a child with autism.) C. The climate in which services are provided promotes minimal participation (e.g., child and/or family feel blamed for lack of progress). D. Access to needed supports and services is minimal (e.g., child does not have access to a needed specialty evaluation). E. Services do not recognize aspects of the family's culture (e.g., the therapist is unfamiliar with non-traditional families; language translation is available only infrequently and not in all services). F. Services are in place and may be appropriate but they are not coordinated with each other and may be duplicative. G. Other	A. Total mismatch of services with caregiver(s) perception of child and family's problems and needs. B. Services are mismatched to the child's developmental, emotional, or medical needs and may therefore be harmful (e.g., antipsychotic medication for a 4-year old child with agg as the only intervention). C. The climate in which services are offered is experienced as totally disrespectful and unsupportive, preventing any meaningful participation. D. Lack of access to services prevents the child and family from getting needed care (e.g., family is unable to attend office-based sessions due to caregiver disability and in-home services are unavailable). E. Services are incompatible with critical cultural issues of the family resulting in services not being viable. F. Services are not appropriate and/or are not acceptable to the parents and are not coordinated totally uncoordinated or duplicative. G. Other

A Domain VI score of 12 or higher indicates consideration of increasing the total SI Level by 1.

ECSII ANCHOR POINTS QUICK REFERENCE SHEET

Domain VI C. Services Profile – Service Effectiveness

1. Optimal	2. Adequate	3. Limited	4. Minimal	5. None
A. Caregiver(s), child (if relevant), and provider(s) believe that services are completely effective (e.g., caregiver reports that child sleeps through the night following interventions). B. Caregiver(s) and provider(s) see child's growth and development as age appropriate or fully back on track; if applicable, rehabilitation goals have been fully met. C. Caregiver(s) and provider(s) believe that family difficulties or concerns have resolved or reached the desired outcome(s). D. Caregiver(s) and provider(s) feel the child and family's future needs have been well prepared for. E. Other	A. Caregiver(s), child (if relevant) and provider(s) believe that services are mostly effective, as evidenced by significant improvement in child's symptoms (e.g., a child with feeding problems is still a fussy eater but is now gaining weight). B. Caregiver(s) and provider(s) see child's growth and development as largely back on track; if applicable, substantial progress has been made toward rehabilitation goals. C. Caregiver(s) and provider(s) believe that family difficulties or concerns have largely resolved or largely reached the desired outcome(s). D. Caregiver(s) and provider(s) feel the child and family's future needs have been mostly prepared for. E. Other	A. Caregiver(s), child (if relevant) or provider(s) believe that services are helping improve some of the child's symptoms (e.g., caregiver reports that child sleeps through night following interventions, but that falling asleep is still a problem). B. Caregiver(s) or provider(s) see child's growth and development as partially on track; if applicable, rehabilitation goals have been partially met. C. Caregiver(s) or provider(s) believe that family difficulties or concerns have only partially resolved or partially reached the desired outcome(s). D. Caregiver(s) or provider(s) feel the child and family's future needs have been partially prepared for. E. Other	A. Caregiver(s), child (if relevant) or provider(s) believe that services are having a marginal impact toward improving the child's symptoms. B. Caregiver(s) or provider(s) see child's growth and development as minimally on track; if applicable there has been minimal progress towards rehabilitation goals. C. Caregiver(s) or provider(s) believe that services are marginally effective in resolving or reaching the desired outcome(s) for family difficulties or concerns. D. Caregiver(s) or provider(s) feel the child and family's future needs have been marginally prepared for. E. Other	A. Caregiver(s), child (if relevant) and provider(s) believe that services are not working to improve child's symptoms (e.g., child is not sleeping and caregivers are distressed even following interventions). B. Caregiver(s) and provider(s) see child's growth and development as stalled or worsened; if applicable, no evidence of progress in meeting rehabilitation goals. C. Caregiver(s) and provider(s) believe that family difficulties or concerns have not improved, and/or no progress has been made towards the desired outcome(s). D. Caregiver(s) and provider(s) feel there has been no planning for the child and family's future needs. E. Other

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