Early Childhood Service Intensity Instrument (ECSII) - Table of Criteria for Domains I.-VI.

I. Degree of Safety:

		1	2	3	4	5
Criteria		**Optimal**	**Adequate**	**Moderate**	**Impaired**	**Low**
Environment	**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).	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).	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).	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).	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).
Stability Of Caretaking	**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).	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).	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).	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).	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)
Caretaker attention to the child	**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).	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).	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).	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).	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)
Caretaker risk behavior or conditions	**d.**	The caregiver exhibits no conditions or risk behaviors that present risk of endangerment of self or child.	The caregiver exhibits conditions or risk behaviors with minimal risk of endangerment to self or other.	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).	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).	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)

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I. Degree of Safety – cont'd

		1	2	3	4	5
Criteria		**Optimal**	**Adequate**	**Moderate**	**Impaired**	**Low**
Caretaker expectations of the 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).	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).	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).	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).	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).
Childs developmentally appropriate ability to maintain safety	**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).	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).	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).	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).	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).
Child's risk to harm self or others	**g.**	No current indication of self-harming or other-directed aggressive behaviors by the child. (e.g., child has never harmed self or others).	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).	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).	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).	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).
Other	**h.**	Other	Other	Other	Other	Other

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II. Child-Caregiver Relationship:

		1	2	3	4	5
Criteria		**Optimal**	**Adequate**	**Mild Impairment**	**Moderate Impairment**	**Severe Impairment**
Degree of satisfaction	**a.**	The relationship is functioning well and is consistently satisfying to both caregiver and child.	The relationship is largely adequate and satisfying to both caregiver and child, but extra support may required to maintain the quality of the relationship (e.g. a temperamentally fussy child who requires extra soothing).	Strains in the relationship are apparent and are beginning to adversely affect the subjective experience of the caregiver and/or the child.	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).	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).
Quality of Interactions	**b.**	Interactions are consistently reciprocal, warm, and flexible.	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).	Some interactions are conflictual (e.g., caregiver and child engage in power struggles on a regular basis).	A significant proportion of interactions are conflicted, and show limited response to interventions.	Interactions are consistently disturbed in all areas and are resistant to change.
Impact on child/ caregiver functioning	**c.**	The relationship supports the child's development and enhances the caregiver's functioning.	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).	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).	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).	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).
Caregiver Empathy towards child	**d.**	The caregiver consistently shows empathy for the child and understanding of his or her emotional needs.	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).	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).	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).	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).
Other	**e.**	Other	Other	Other	Other	Other

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III. Caregiving Environment: A. Strengths & Protective Factors:

		1	2	3	4	5
Criteria		**Optimal**	**Adequate**	**Limited**	**Minimal**	**None**
Ability to address the child's developmental and material needs	**a.**	The family and/or community resources are optimal to address the child's developmental and/or material needs.	The family and/or community resources are sufficient to address the child's developmental and/or material needs.	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).	The family and/or community resources are minimally responsive to the child's developmental and/or material needs.	The family and/or community are unable to meet the child's developmental and/or material needs.
Continuity of Caregivers	**b.**	There is continuity of active, engaged family and community caregivers.	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).	The continuity of family and community caregivers is often disrupted. (e.g., a sibling who is periodically hospitalized).	The continuity of family and community caregivers is usually disrupted.	There is no continuity of family and community caregivers.
Caregivers use of resources and services	**c.**	Caregivers readily use potentially helpful or enriching resources.	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).	Caregivers make use of resources and services episodically (e.g., parents do not attend well baby visits regularly).	Caregivers have serious disagreements with resources and services (e.g., parents disagree with pediatrician's recommendation for specialized mental health assessment of the child).	Caregivers actively refuse needed resources and services.
Support for stability of home environment	**d.**	The caregiving system supports a stable home environment for the child.	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).	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).	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).	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).
Availability of Resources & Services	**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).	The caregiving system provides basic resources and services to support the family (e.g., a single parent is enrolled in medical assistance).	The caregiving system provides limited resources and services to support the family (e.g., there is limited or no access to specialized care).	The caregiving system provides few resources and services to support the family (e.g., there is a long waiting time for basic services).	The caregiving environment is unstable is a way that is dangerous to the child (e.g., child maltreatment in a foster care setting).
Other	**f.**	Other	Other	Other	Other	Other

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III. Caregiving Environment: B. Stressors and Vulnerabilities:

		1	2	3	4	5
Criteria		**Absent**	**Mild**	**Moderate**	**Serious**	**Severe**
Exposure to stressors in the home or community	**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).	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).	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.	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.	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 house).
Transitions and Losses	**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).	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 disruption of family/social milieu (e.g., family moves to a significantly different living situation, change of day care, absence of a caregiver).	Serious disruption of family/ social milieu (e.g., due to death, divorce, or separation of caregiver and child).	Fragmentation of the family (e.g., death of both caregiver in an accident; single caregiver who is incarcerated).
Financial stressors	**c.**	Material needs are being met without concern that they may diminish in the near future (e.g., family income is stable).	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).	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).	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).	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.
Availability of community supports	**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).	Community supports and services are available with some limitations (e.g., intermittent availability of family members to provide back-up child care).	Community supports and services are minimal but do not threaten the stability of the family (e.g., no childcare program available in area).	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).	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).
Recognition of cultural needs	**e.**	Community recognizes and supports family's cultural needs (e.g., services available in the family's language).	Community partially recognizes and supports family's cultural needs (e.g., community center is available but does not acknowledge ethnic diversity).	Community inconsistently recognizes family's cultural needs (e.g., some service staff understand child culture while others don't).	Community is insensitive to family's cultural needs (e.g., clinicians or other providers ignore cultural norms).	Severe cultural stigmatization in the community (e.g., severe discrimination and hostility in the neighborhood).
Family's attention to child's needs	**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).	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).	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).	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).	Family constantly neglects child (e.g., caregiver leaves child in car or home alone on a regular basis or exposes child to dangerous situations).
Other	**g.**	Other	Other	Other	Other	Other

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IV. Functional/Developmental Status:

		1	2	3	4	5
Criteria		**Optimal**	**Adequate**	**Mild Impairment**	**Moderate Impairment**	**Severe Impairment**
Affective state and state regulation	**a.**	Ability to maintain a calm, alert, and affectively available state. Displays the full range of affect. Able to regulate affect.	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.	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.	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.	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.
Adaptation to change	**b.**	Adapts easily to change. Flexible during transitions. Developmentally appropriate level of curiosity about the environment. Tolerance for age appropriate separations.	Requires some support for transitions. Flexibility occasionally compromised under stress. Able to explore environment with encouragement by caregivers.	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.	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).	Transitions poorly regardless of caregiver's interventions. Small changes in routine result in severe behavioral disruption.
Biological patterns	**c.**	Settles easily for sleep with developmentally appropriate support. No appetite disturbance. Toileting ability is age appropriate.	Requires some efforts by caregivers to soothe child for sleep. Appetite varies under stress. Occasional regression in toileting.	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.	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.	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.)

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IV. Functional/Developmental Status –Cont'd

		1	2	3	4	5
Social interaction	**d.**	Developmentally appropriate relationships with others. Intact ability to control impulses. Does not initiate aggressive behavior.	Engages with peers successfully with caregiver support. Occasional impulsive behavior or aggression typical of developmental age, e. requiring slight increase in monitoring of interactions by caregivers.	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 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 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.
Language, motor, and cognitive development	**e.**	Communication, motor, and cognitive capacities (e.g. problem-solving) are age appropriate.	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).	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).	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).	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.)
Other	**f.**	Other	Other	Other	Other	Other

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V. Impact of the Child's Medical, Developmental, or Emotional/Behavioral Problems:

		1	2	3	4	5
Criteria		**Optimal**	**Adequate**	**Mild Impairment**	**Moderate Impairment**	**Severe Impairment**
Medical Problems	**a.**	No medical problems in the child.	Minor medical problems typically seen in primary care (e.g., mild asthma, occasional ear infections).	Chronic medical problems that may require specialist consultation and have some impact on functioning, but are responsive to interventions (e.g., well controlled diabetes).	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 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).
Developmental Problems	**b.**	No developmental problems in the child.	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)	Developmental disturbance is mild and is not improving with natural supports alone (e.g., cerebral palsy with low muscle tone requiring physical therapy).	Moderate developmental delays requiring more frequent and intensive interventions (e.g., severe cerebral palsy requiring braces and frequent physical therapy).	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)
Emotional or Behavioral Problems	**c.**	No emotional or behavioral problems in the child.	Emotional or behavioral disturbances are minor and/or transient (e.g., occasional temper tantrums).	Emotional or behavioral problems of mild severity needing interventions (e.g., temper tantrums that are frequent and may disrupt family activities).	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.	Emotional or behavioral problems severe enough to threaten child's current home placement.
Emotional stress on family related to child's problem	**d.**	No emotional stress on family related to the child's medical, developmental, or emotional/behavioral problem.	Caregivers are able to cope with the child's medical, developmental, or emotional/behavioral problem with their natural support system.	Caregivers display mild symptoms of anxiety, distress or fatigue due to the child's medical, developmental, or emotional/behavioral problem.	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.	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.
Financial impact	**e.**	No financial stress on family related to the child's medical, developmental, or emotional/behavioral problem.	Costs related to the child's medical, developmental, or emotional/behavioral problem can be met by family resources and/or health insurance.	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).	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.	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.
Other	**f.**	Other	Other	Other	Other	Other

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VI. Service Profile – Caregiver(s) Involvement in Services

		1	2	3	4	5
Criteria		**Optimal**	**Adequate**	**Limited**	**Minimal**	**None**
Engagement	**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.	One caregiver is fully engaged with all needed services and providers and communicates effectively with all other caregivers.	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.	Caregiver(s) engages with essential services and interacts with providers only during crises.	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.
Communication	**b.**	Caregiver(s) routinely meets and or communicates with providers regarding the child and family's needs.	Caregiver(s) communicates often enough with providers to maintain the service plan.	Caregiver(s) communicates with selected providers only.	Caregiver(s) communicates with selected providers only when contacted by providers.	Caregiver(s) and providers fail to meet and or communicate.
Agreement	**c.**	Caregiver(s) and providers have complete agreement about the child and family's strengths and needs regarding the child's service plan.	Caregiver(s) and providers generally agree about the child and family's strengths and needs regarding the child's service plan.	Caregiver(s) and providers are in disagreement about some aspect of the service plan.	Caregiver(s) and providers are in disagreement about many aspects of the service plan.	Caregiver(s) and providers have complete disagreement about the child and family's strengths and needs regarding the child's service plan.
Other	**d.**	Other	Other	Other	Other	Other

VI. Service Profile – Child's Involvement in Services

		1	2	3	4	5
Criteria		**Optimal**	**Adequate**	**Limited**	**Minimal**	**None**
Engagement	**a.**	Child is fully engaged during all interactions with provider(s) in an age appropriate manner.	Child is engaged with provider(s) during most interactions.	Child is intermittently engaged with provider(s) during interactions.	Child is rarely engaged with provider(s) during interactions.	Child is not engaged during any interactions with provider(s).
Communication	**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).	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.	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).	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).	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).
Cooperation	**c.**	Child is fully cooperative with provider(s)' interventions.	Child is cooperative with provider(s)' interventions most of the time.	Child is intermittently cooperative with provider(s)' interventions.	Child is rarely cooperative with provider(s)' interventions.	Child is routinely not cooperative with provider(s)' interventions.
Other	**d.**	Other	Other	Other	Other	Other

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VI. Service Profile – Service Fit

		1	2	3	4	5
Criteria		**Optimal**	**Adequate**	**Limited**	**Minimal**	**None**
Agreement	**a.**	Caregiver(s) and provider(s) agree that all services and supports offered are appropriate for the needs of the child and family.	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.	Caregiver(s) and provider(s) disagree about the services and supports offered (e.g., caregiver(s) requests sensory integration therapy but only traditional occupational therapy is offered).	Caregiver(s) and providers have minimal agreement about the services and supports offered.	Total mismatch of services with caregiver(s) perception of child and family's problems and needs.
Appropriateness to the problem(s)	**b.**	Services optimally address the child's developmental, social/emotional, or medical needs.	Services address the majority, but not all of the child's developmental, social/emotional, or medical needs.	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).	Services address the child's developmental, emotional, or medical needs poorly, (e.g., play therapy as a single modality for a child with autism).	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).
Climate in which services are provided	**c.**	Services are provided in a respectful and supportive manner, promoting active participation.	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).	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).	The climate in which services are provided promotes minimal participation (e.g., child and/or family feel blamed for lack of progress).	The climate in which services are offered is experienced as totally disrespectful and unsupportive, preventing any meaningful participation.
Access to Needed Services	**d.**	There is full access to needed services, including appropriate flexible services (e.g., respite, in-home services, parent-to-parent support, mentoring).	There is access to most, but not all, needed services (including flexible services).	There is lack of access to or delay in availability of some needed services (e.g., overly long waiting time for needed services).	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).	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).
Cultural Competency	**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).	Most services are culturally competent. (e.g., a language interpreter is available most times but not for all services on a consistent basis).	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).	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).	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).
Collaboration and Coordination	**f.**	There is active collaboration among providers, involved agencies, and the family; services are well coordinated.	Collaboration and coordination of services occurs most of the time.	Collaboration and coordination of services occurs less often than needed (e.g., meetings held only when crises occur).	Services are in place (some of which may be appropriate), but they are not coordinated with each other and may be duplicative.	Services are totally uncoordinated or duplicative.
	g.				Providers/agencies do not communicate.	
Other	**h.**	Other	Other	Other	Other	Other

Note: In ECSII Manual "Other" is labeled anchor-point "g." at every level except "Minimal". Here it is listed as "h." for continuity across levels.

Early Childhood Service Intensity Instrument (ECSII) - Table of Criteria for Domains I.-VI.

VI. Service Profile – Effectiveness of Services

		1	2	3	4	5
Criteria		**Optimal**	**Adequate**	**Limited**	**Minimal**	**Not Effective**
Resolution of child's symptoms	**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).	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).	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).	Caregiver(s), child (if relevant) or provider(s) believe that services are having a marginal impact toward improving the child's symptoms.	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).
Child's development back on track	**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.	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.	Caregiver(s) or provider(s) see child's growth and development as partially on track; if applicable, rehabilitation goals have been partially met.	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.	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.
Resolution of family concerns	**c.**	Caregiver(s) and provider(s) believe that family difficulties or concerns have resolved or reached the desired outcome(s).	Caregiver(s) and provider(s) believe that family difficulties or concerns have largely resolved or largely reached the desired outcome(s).	Caregiver(s) or provider(s) believe that family difficulties or concerns have only partially resolved or partially reached the desired outcome(s).	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.	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).
Preparation for child and family's future needs	**d.**	Caregiver(s) and provider(s) feel the child and family's future needs have been well prepared for.	Caregiver(s) and provider(s) feel the child and family's future needs have been mostly prepared for.	Caregiver(s) or provider(s) feel the child and family's future needs have been partially prepared for.	Caregiver(s) or provider(s) feel the child and family's future needs have been marginally prepared for.	Caregiver(s) and provider(s) feel there has been no planning for the child and family's future needs.
Other	**e.**	Other	Other	Other	Other	Other