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DOMAIN 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.

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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

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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

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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

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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

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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.

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DOMAIN II - DEGREE OF SAFETY

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

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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

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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.

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DOMAIN 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.

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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

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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

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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

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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

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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

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DOMAIN 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.

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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

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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

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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

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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.

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DOMAIN 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

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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

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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

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DOMAIN 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.**

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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.)

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A. INVOLVEMENT IN SERVICES

CAREGIVER(S) RATING:

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

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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

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CHILD'S INVOLVEMENT IN SERVICES RATING: (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

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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

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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

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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

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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

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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

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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