CALOCUS-CASII©

CHILD & ADOLESCENT LEVEL OF CARE/ SERVICE INTENSITY UTILIZATION SYSTEM©

FOR CHILDREN AND ADOLESCENTS AGES 6-18

USER MANUAL

2020

Edition 1.2

American Academy of Child & Adolescent Psychiatry
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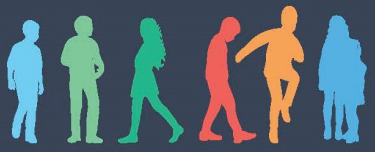
American Association for Community Psychiatry



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AMERICAN ASSOCIATION
FOR COMMUNITY PSYCHIATRY (AACP)
&
AMERICAN ACADEMY OF CHILD AND
ADOLESCENT PSYCHIATRY (AACAP)

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American Association for Community Psychiatry (AACP)

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INTRODUCTION

CALOCUS-CASII was first developed in 2001 in a collaboration between the American Association for Community Psychiatry (AACP) and the American Academy of Child and Adolescent Psychiatry (AACAP). CALOCUS-CASII closely mirrors the structure of its parent, the adult Level of Care Utilization System (LOCUS), developed by AACP, including its emphasis on simplicity and accessibility.

CALOCUS-CASII extends the LOCUS to reflect a developmental perspective, a System of Care approach, and the inclusion of a comprehensive array of supports and services in systems that serve children and adolescents, especially those with complex needs and co-occurring conditions. Integrating mental health, physical health, substance use and developmental concerns, it provides a common language and set of standards with which to make sound judgments regarding care planning and to monitor progress. This new version of the CALOCUS again is a collaboration between AACP and AACAP. It merges the previous version of the CALOCUS with language taken from the Child and Adolescent Service Intensity Instrument (CASII) developed by AACAP, which maintained the integrity of LOCUS framework while extending the text around the instrument guiding its use. This new version makes very minimal changes to the instrument from the initial CALOCUS collaboration.

The CALOCUS-CASII provides a tool for clinicians and managers of healthcare resources that is easy to understand and use, but also meaningful and sufficiently sensitive to distinguish appropriate needs and services. It provides clear, reliable and consistent measures that are relevant for making decisions related to quality of care and resource allocation. Moreover, the lack of reliance on a diagnosis to guide treatment supports its use within systems outside of healthcare, such as Child Welfare, Juvenile Justice, and Education.

In most cases, the CALOCUS-CASII may be applied to children ages 6 through 18 years. Because the service needs of infants and toddlers are fundamentally different than those of older children, they are excluded from CALOCUS-CASII evaluations. Instead, the service intensity needs of children under the age of 6 years should be determined by use of the Early Childhood Service Intensity Instrument (ECSII), developed by AACAP in 2009.

The CALOCUS-CASII draws from clinical experience and a number of values, principles, and resources, including:

- System of Care (SOC): This approach has been the primary value base of the federal Substance Abuse and Mental Health Services Administration SAMHSA and State Departments of Health and Human Services for over 35 years. System of Care values and principles call for care that is family-driven and youth-guided, culturally competent, strength-based, coordinated, community-based and least restrictive, emphasizing early intervention and prevention, transition to adulthood, and outcomes-based. (Stroul, Blau, and Friedman,

System of Care Values and Principles Updated; Stroul and Blau, *Handbook of System of Care; Winters, Pumariega, et al, 2007*). In recent years, the System of Care approach has also incorporated wellness, prevention, and early intervention as part of its overall commitment. For further information on the SOC approach please see the AACAP Clinical Update on Community Systems of Care (to be reviewed 2021).

- Developmental theory (Harris, 1995; Gilmore and Meersand, 2014), which describes the trajectory of normative physical, emotional, cognitive, and social changes of childhood and adolescents, to be addressed in both assessment and treatment.

- Cultural Sensitivity (Cross et al., 1998; Pumariega, et al, 2013), which embodies respect for people of all ethnic backgrounds, accommodation of their needs and priorities (e.g. culturally appropriate assessment and treatment, linguistic support) and whenever possible, provision of services by culturally competent professionals and staff members whose ethnic diversity mirrors that of the populations served. Cultural factors often impact the assessment of comorbidity, level of functioning, environmental support, and treatment and engagement, thus potentially biasing diagnosis, treatment planning, and level of care placements.

- Co-occurring (Complexity) Capability (Minkoff and Cline, 2004, 2005, ASAM, 2013) is a conceptual framework for best practice service design that is derived from the high prevalence of co-occurring mental health, physical health, substance use, and developmental disability challenges, as well as other complex health and human service needs, among all populations (including children and families/caregivers) receiving services. In short, complexity is an expectation, not an exception. For this reason, in this framework, all services are designed to provide appropriately matched integrated interventions for individuals and families with co-occurring mental health and substance use challenges, as well as other types of complexity. That is, all services are designed to be co-occurring capable or complexity capable. In describing recommended service packages, the CALOCUS-CASII recommends that co-occurring capability is a routine feature of service provision.

- Clinical Knowledge: The CALOCUS-CASII provides an objective appraisal of the service needs of children and adolescents with mental health disorders and/or emotional/behavioral challenges,, incorporating consideration of co-occurring substance use, developmental disorders, physical health diagnoses, family and community contexts, and the child/adolescent's and the family's response to treatment efforts.

- Wraparound concepts, which entail the family-driven, team-based integration of a comprehensive network of professional and natural community-based supports for the child or adolescent and family as well as multi-system

structures capable of providing blended and flexible funding to provide services and supports (VanDenBerg and Grealish, 1996). This model supports the use of a strength-based, Individualized Service Plan (ISP) for each child and adolescent. Furthermore, Wraparound concepts including other Intensive Home and Community-based Services have been recognized by the federal Centers for Medicare and Medicaid Services (CMS) as reimbursable services through Medicaid, when included in the State's plan. Wraparound now has an established an evidence-base and accepted role within child and adolescent psychiatric care (McGinty, et al, 2013; Coldiron et al, 2017).

- Clinical expertise of psychiatrists serving children and adolescents, and young adults with a variety of psychiatric, substance use, and developmental disorders.

CALOCUS-CASII has four main objectives. The first is to provide a system for assessment of service needs for children and adolescents, based on six evaluation dimensions that can be a common language within and across systems. The second is to describe a continuum of service intensities that are characterized by the amount and scope of resources available at each "level" of care, or service intensity. The third is to create a methodology for quantifying the assessment of service needs to permit reliable determinations of placement, or service intensity, need. The fourth is to facilitate service planning and clinical services and documentation, and to monitor progress. Additional training on use of the instrument to create a service plan and to communicate and monitor progress is available through the CALOCUS-CASII asynchronous online training. For information contact AACAP's Clinical Practice Department (clinical@aacap.org).

The LOCUS family of instruments, including the CALOCUS-CASII, have evolved over the years. Since its inception, CALOCUS-CASII has included content related to resiliency, social and family circumstances, and choice. The instrument's simple style and structure has invited use in over 30 states and 3 foreign countries not only by a variety of clinicians with various levels of training, but by those who use services themselves, both children and their parents, allowing assessment to become a more collaborative process. Engagement in this collaboration is central to family-driven, youth-guided care planning. We continue to encourage collaboration in the assessment process between the clinician and the child or parent when using the CALOCUS-CASII whenever this is possible. Language has been made accessible to support that process. As systems develop services and processes to improve the quality of care they provide, these additions will allow CALOCUS-CASII to be an even more powerful tool to assist these transformations.

One of the most important changes in the current edition of CALOCUS-CASII is an expanded elaboration of "integration" in light of the progress that has been made in designing and delivering integrated services in the last decade. This edition of CALOCUS-CASII further develops the range of integrated practice and programming for individuals and families with complex and co-occurring needs. All levels of service

intensity descriptions include a statement that indicates the need to include integrated and holistic approaches to care in the design of programs. CALOCUS-CASII encourages the vision that all services should encourage autonomy and change, and be "complexity capable" as well as "family-driven and youth guided."

The instrument continues to demonstrate multiple potential uses:

At the individual client level:

- To assess immediate service needs (e.g., for children or adolescents in crisis)
- To monitor the course of recovery and service needs over time
- To provide valid, value-driven guidance to payers for "medical necessity criteria", the application of which will better meet the needs of clients in real world systems
- To inform the treatment planning processes

At the system or population level:

- To plan system level resource needs for complex populations over time and help identify deficits in the service array
- To assist in the development of bundled payments or case rates for episodes of care for specific clinical conditions and severity levels
- To provide a framework for a comprehensive system of clinical management and documentation
- To facilitate communication within and between child serving systems regarding service intensity needs

CALOCUS-CASII is divided into two sections. The first section defines six evaluation parameters or Dimensions: I Risk of Harm; II Functional Status; III Co-Occurence of Conditions: Developmental, Medical, Substance Use and Psychiatric; IV Recovery Environment; V Resiliency and Treatment History; and VI Engagement in Services. A five-point scale indicating level of intensity is constructed for each dimension and the criteria, or anchor points, are identified for assigning a given rating or score in that dimension. In Dimension IV, Recovery Environment, two subscales are defined, Environmental Stress and Environmental Support. For all other dimensions only one scale is used. Dimension VI contains two options (parent or adolescent), though only the one with the highest score will be applied.

The second section of the document defines six "levels of service intensity" in the service continuum in terms of four variables: 1) Care Environment (where care is received), 2) Clinical Services, 3) Support Services, and 4) Crisis Resolution and Prevention Services. The term "level" is used for simplicity, but it is not intended to imply that the service arrays are static or linear or can be defined solely by a particular program or location. Rather, each level describes a flexible or variable combination of specific service types and might more accurately be said to describe levels of resource intensity. The particulars of program development are left to providers to determine

based on local circumstances and outcome evaluations. Each level of service intensity encompasses a multidimensional array of service elements, combining crisis, supportive, clinical, and environmental interventions, which vary independently.

This edition includes language referencing the capability of each service intensity level to provide matched services for individuals with co-occurring mental health and/or substance use and/or health conditions. Services and supports/medical necessity criteria are then elaborated for each service intensity level. Separate admission, continuing stay, and discharge criteria are not needed for use of this instrument, as changes in level of service intensity will follow from changes in ratings in any of the six dimensions over the course of time. Each level of service intensity description provides guidance for payers by establishing usual time frames for review and revision of scores and authorizations. The final section describes the scoring methodology that facilitates the translation of assessment results into a service plan based on service intensity level recommendations.

Conclusions

We hope that this version of CALOCUS-CASII will continue to stimulate discussion, and additional testing for reliability and validity in varying circumstances. It is recognized that a document of this type must be dynamic and that adjustments or addendums may be required either to accommodate local needs or to address unanticipated or unrecognized circumstances or deficiencies. It does not claim to replace clinical judgment, and is meant to serve only as an operationalized guide to resource utilization that must be applied in conjunction with sound clinical thinking. It is offered as an instrument that should have considerable utility in its present form, but growth and improvement should be realized with time and further testing.

AACP and AACAP welcome any comments or suggestions and encourage them to be sent directly to AACP (projectcoordinator@communitypsychiatry.org) and/or AACAP (clinical@aacap.org).

INSTRUCTIONS FOR USE

The first step in scoring the CALOCUS-CASII assessment is to complete a rating in each evaluation Dimension along a severity level scale of one to five. Each rating in the scale is defined by one or more or anchor points, which are designated by separate letters. Only one of the anchor points in a severity level needs to be met for a score to be assigned for that dimension. The evaluator should select the highest score or rating in which at least one of the anchor points is met. In some cases, more than one of the anchor point for each rating will be met, and in that case, they can both be recorded. This will assist in treatment planning once the service intensity level has been determined.

There will, on occasion, be instances where there will be some ambiguity about whether a subject has met an anchor point for a score on the scale within one of the Dimensions. This may be due to inadequate information, conflicting information, or simply due to difficulty in making a judgment about whether the available information is consistent with any of the criteria for that score. In these cases the rating or criterion that provides the closest approximation to the actual circumstance should be selected. However, if it remains unclear which rating fits best, the highest score in which it is more likely than not that at least one anchor point has been met should be assigned. The result is that any inexact rating will be made on the side of caution.

A composite score is generated that often determines the level of service intensity recommendation, but there are some factors that are independent criteria that override the composite score. For example, high scores in the first three Dimensions will override some composite scores for determination of the level of care/service intensity recommendation. Independent criteria that impact the composite Service Intensity Level score are detailed in Appendix II.

Since CALOCUS-CASII is designed as a dynamic instrument, scores should be expected to change over time, sometimes (i.e. young people in crisis) in a matter of hours. Scores are assigned on a here and now basis, representing the clinical picture at the time of evaluation. In some of the Dimensions, historical information is taken into account, but it should not be considered unless it is a clear part of the defined criteria. In certain crisis situations, the score may change rapidly as interventions are implemented. In other situations, where a subject may be living under very stable circumstances, scores may not change for extended periods of time. Clinical judgment should prevail in the determination of how frequently scores should be reassessed. As a general rule, they will be reassessed more frequently at higher levels of acuity and higher levels of service intensity. At the lowest levels of care, they may show little change from visit to visit, and clinicians need only verify that previous ratings are accurate during periodic visits. Rescoring is also recommended when the child's situation has changed, such as after return home from a residential setting or foster care.

Once scores have been assigned in all six Dimensions and computed manually or entered into the CALOCUS-CASII automated scoring system, a recommended level of care is generated based on a weighted algorithm.

Although the use of CALOCUS-CASII is fairly intuitive, there may be situations in which raters encounter uncertainty in how to apply the criteria as intended. For this reason, an approved training is strongly recommended for potential users. This may be obtained in a three ways: On site live training, online live training, and online streamed training, all with accompanying written training materials. For further information, contact AACP (projectcoordinator@communitypsychiatry.org) or AACAP (clinical@aacap.org).

Each region or service system using CALOCUS-CASII will want to create a list of existing programs or service sites that would provide some or all of the needed service elements for each defined level of service intensity, as outlined in the second part of CALOCUS-CASII. Once the level of care/service intensity recommendation has been obtained, providers, in conjunction with the family (and wraparound team when indicated), can consult this catalogue of services, or service array, to find the best fit of supports and services to address the child and family's service intensity needs, including guidance derived from diagnosis or other formal assessments.

In assigning the level of service intensity, there will be some systems that do not have comprehensive services for all populations at every level of the service intensity continuum. When this is the case, the level of care/service intensity recommended by CALOCUS-CASII may not be available and a choice will need to be made as to whether more intensive services or less intensive services should be provided. The higher level of care should be selected, unless there is a clear and compelling rationale to do otherwise. As an example, if a patient initially being served at Service Intensity Level 6 (locked hospital care or other secure facility) has a reduction in his score that allows a transition to Level 5, but no Level 5 placement is currently available, that patient should continue to be served at Level 6 until there is further improvement enabling placement at Level 4, or until Level 5 placement becomes available. This requires providers and payers to err on the side of caution and safety rather than risk and instability.

MEDICAL NECESSITY AND RESOURCE MANAGEMENT

CALOCUS-CASII is an objective tool developed by expert consensus and further validated by initial psychometric testing, available for review in Appendix VII, as well as the longstanding satisfaction of many of its users over the past 20 years. As exposure and experience with CALOCUS and CASII has grown, so has the realization that it provides a superior medical necessity instrument for managing care. This revision provides more detailed guidance on the use of CALOCUS-CASII by both payers and providers for determining the "medical necessity" of treatment throughout the continuum of care. CALOCUS-CASII includes guidance for the appropriate duration of an authorization and the maximum time to reassessment of need for each defined level of service intensity. In some instances, recommendations regarding the workforce most appropriate for various levels of service intensity or types of intervention are also provided.

In addition to providing support to providers and families in Individualized Service Planning, CALOCUS-CASII has increasingly demonstrated value as a systematic tool for managed care organizations, as well as for the public and private insurers that may contract with them. Using CALOCUS-CASII in an organized fashion guides users to the most effective and economic measures for ensuring good outcomes for both individuals and populations. CALOCUS-CASII assists payers to manage resources wisely while maintaining a high standard of quality for services delivered by network providers. Many payers have discovered that CALOCUS-CASII, due to its emphasis on the balance of quality and economy, allows them to reduce overhead costs by eliminating the need for "micro-management" of care decisions made by providers, thus allowing more resources to be dedicated to the provision of care. Periodic audits to insure the appropriate use of the instrument by providers are sufficient in systems that have matured in their previous use of CALOCUS and CASII. Appropriate use of CALOCUS-CASII can assist both providers and payers in avoiding inappropriate and expensive over-utilization of higher levels of care, and inappropriate as well as dangerous under-utilization of those levels of service intensity.

CALOCUS-CASII offers several strengths as a tool to assess for level of service intensity and focus for intervention:

- CALOCUS-CASII provides medical necessity/ placement criteria that are comprehensive, and are applicable to the entire continuum of care. Alternatives generally focus on only a single level of care, usually inpatient hospitalization.
- CALOCUS-CASII provides a method of "value" management. It meets the needs of both payers and providers for a system to ensure that resources are being applied efficiently and effectively.
- CALOCUS-CASII criteria take into account the interpersonal and social determinants of functional impairment, as well as prior responses to treatment, which alternative tools do not.
- In addition, CALOCUS-CASII provides a framework for clinical management and documentation extending from the initial assessment, through the treatment planning

and progress recording processes, to the transition to less restrictive and intensive levels of care. This clinical framework facilitates monitoring and maintenance of accountability to those entities who bear financial risk and ultimate responsibility for health care outcomes.

In this period of transformation in health care systems, CALOCUS-CASII has been ahead of the curve in its facilitation of family-driven, youth-guided care. It has likewise been a progressive method for thinking about service needs and the judicious use of resources. We hope that the revisions in this version of CALOCUS-CASII will further advance these aims.

CALOCUS-CASII DIMENSIONS AND ANCHOR POINTS FOR LEVEL OF CARE/SERVICE INTENSITY SCORING

Dimension I: Risk of Harm

This dimension considers a child or adolescent's potential to be harmed by others or cause significant harm to self or others. Each category contains items that assess a child or adolescent's risk of harming themselves and of harming others. While the Risk of Harm dimension is most frequently manifested by suicidal or homicidal behavior, it also may embody unintentional harm from misinterpretation of reality, inability to adequately care for oneself, impulsive behavior, poor judgment, and/or gross mishandling of alcohol or other drugs.

Children of any age who have experienced severe and/or repeated abuse in a hostile environment may be unable to perceive threat or take adequate measures to increase their safety.

In addition to direct evidence of potentially dangerous behavior or vulnerability from interview and observation, other factors may be considered in determining the likelihood of such behavior, such as past history of dangerous behavior, abuse and neglect, inability to contract for safety, and inability to use available supports. It also is important to be alert to racial or ethnic biases that may lead clinicians to misinterpret behaviors as threatening or dangerous.

1 - Low Risk of Harm

a- No indication of current suicidal or homicidal thoughts or impulses, with no significant distress, and no history of suicidal or homicidal ideation.
b- No indication or report of physically or sexually aggressive impulses.
c- Developmentally appropriate ability to maintain physical safety and/or use environment for safety.
d- Low risk for victimization, abuse, or neglect.

2 - Some Risk of Harm

a- Past history of fleeting suicidal or homicidal thoughts with no current ideation, plan, or intention and no significant distress.
b- Mild suicidal ideation with no intent or conscious plan and with no past history.
c- Indication or report of occasional impulsivity, and/or some physically or sexually aggressive impulses with minimal consequences for self or others.
d- Substance use without significant endangerment of self or others.
e- Infrequent, brief lapses in the ability to care for self and/or use environment for safety.
f- Some risk for victimization, abuse, or neglect.

3 - Significant Risk of Harm

a- Significant current suicidal or homicidal ideation with some intent and plan, with an ability for the child or adolescent and his/her family to carry out a safety plan. Child or adolescent expresses some reason not act on their suicidal ideation.
b- No active suicidal or homicidal ideation, but extreme distress and/or a history of suicidal/homicidal behavior.
c- Indication or report of incidents of acting without thinking, or physically or sexually aggressive actions that endanger self or others, breaking laws, self-mutilation; running away, fire setting, violence toward animals.
d- Binge or excessive use of alcohol and other drugs resulting in potentially harmful behaviors.
e- Periods of inability to care for self and/or maintain physical safety in developmentally appropriate ways.
f- Significant risk for victimization, abuse, or neglect.

4 - Serious Risk of Harm

a- Current suicidal or homicidal ideation with either clear, expressed intentions and/or past history of carrying out such behavior. Child or adolescent has expressed ambivalence about carrying out the safety plan and/or his/her family's ability to carry out the safety plan is compromised.
b- Indication or report of significant impulsivity and/or physical or sexual aggression, with poor judgment and insight, and that is/are significantly endangering to self or others (property destruction; repetitive fire setting or violence toward animals).
c- Signs of consistent deficits in ability to care for self and/or use environment for safety.
d- Recent pattern of excessive substance use resulting in clearly harmful behaviors with no demonstrated ability of child/adolescent or family to restrict use.
e- Clear and persistent inability, given developmental stage, to maintain physical safety and/or use environment for safety.
f- Imminent risk of severe victimization, abuse, or neglect.

5 - Extreme Risk of Harm

a- Current suicidal or homicidal behavior or such intentions with a plan and available means to carry out this behavior.
    - without expressed ambivalence or significant barriers to doing so, or
    - with a history of serious past attempts that are not of a chronic, impulsive, or consistent nature, or
    - in presence of command hallucinations or delusions that threaten to override usual impulse control.
b- Indication or report of repeated behavior, including physical or sexual aggression, that is clearly injurious to self or others (e.g., fire setting with intent of serious property destruction or harm to others or self, planned violence and/or group violence with other perpetrators) with history, plan, or intent, and no insight and judgment (forcible and violent, repetitive sexual acts against others).
c- Relentlessly engaging in acutely self-endangering behaviors.

d- A pattern of nearly constant and uncontrolled use of alcohol or other drugs, resulting in behavior that is clearly endangering.

Dimension II: Functional Status

This dimension measures changes in the degree to which a child or adolescent is able to fulfill responsibilities for a given developmental level. This may include interactions with others in school, at home and in social situations with peers as well as changes in self-care. For the purposes of this dimension, only sources of impairment directly related to developmental, psychiatric, and/or substance use problems should be considered. While other types of disabilities may play a role in determining the support services required, they generally will not be considered in determining level of care placement in the behavioral treatment continuum. Functional deficits that are ongoing and may place a child or adolescent at risk of harm are rated on dimension I. Physical function refers to sleep/wake cycles, patterns of eating, exercise, and sexual interest.

1 - Minimal Functional Impairment

a- Consistent functioning appropriate to age and developmental level in school behavior and/or academic achievement, relationships with peers, adults, and family, and self-care, hygiene, and control of bodily functions.
b- No more than temporary impairment in functioning following exposure to an identifiable stressor with consistent and normal physical function.

2 - Mild Functional Impairment

a- Some evidence of minor failures of function in any of several areas of living; school, family, peers. These periodic or momentary failures are time limited.
b- Occasional episodes in which some aspects of self-care/hygiene or physical function are disrupted.
c- Demonstrates significant improvement in function following a period of deterioration.

3 - Moderate Functional Impairment

a- Conflicted, withdrawn, or otherwise troubled in relationships with peers, adults, and/or family, but without episodes of physical aggression.
b- Self-care/hygiene deteriorates below usual or expected standards on a frequent basis.
c- Significant disturbances in physical function that do not pose a serious threat to health.
d- School behavior has deteriorated to the point of the child/adolescent has faced some school disciplinary action and is at risk for placement in an alternative school program or repeating their grade. Absenteeism may be sporadic.
e- Chronic and/or variably severe deficits in interpersonal relationships, but with ability to engage in socially constructive activities, and ability to maintain responsibilities.
f- Recent gains and/or stabilization in functioning have been achieved while participating in treatment in a structured, protected, and/or enriched service.

4 - Serious Functional Impairment

a- Serious deterioration of interpersonal interactions with consistent conflict or otherwise disrupted interactions with others, which may include impulsive or abusive behaviors.
b- Significant withdrawal and avoidance of almost all social interaction.
c- Consistent failure to achieve self-care/hygiene at levels appropriate to age and/or developmental level.
d- Serious disturbances in physical function.
e- Inability to perform adequately even in a specialized school setting due to disruptive behavior, inattentiveness or frequent unexcused absence from school. The child or adolescent has multiple academic failures.

5 - Severe Functional Impairment

a- Extreme deterioration in interactions with peers, adults, and/or family that may include chaotic communication or assaultive behaviors with little or no provocation, or minimal control over impulses that may result in abusive behaviors.
b- Complete withdrawal from all social interactions.
c- Complete neglect of and inability to attend to self-care/hygiene/control of biological functions with associated impairment in physical status.
d- Extreme disruption in physical function causing serious compromise of health and well-being.
e- Inability to attend school or to maintain acceptable school behavior and/or academic achievement given age and developmental level.

Dimension III: Co-Occurrence Of Conditions: Developmental, Medical. Substance Use and Psychiatric

This dimension measures the coexistence of disorders across four domains (psychiatric, substance use, medical and developmental): but does not consider co-occurring disturbances within each domain. If a child or adolescent has more than one disorder in the same domain (e.g., two psychiatric, substance use, medical, or developmental disorders), the second does not count as a "co-occurrence" for purposes of scoring on CALOCUS-CASII. For example, two medical disorders, such as diabetes and asthma or two psychiatric disorders, such as attention deficit hyperactivity disorder and major depressive disorder, are not counted as additional co-occurrences. Coexisting disorders across domains may prolong the course of illness, or necessitate the use of more intensive or restrictive services. Physiologic withdrawal states related to substance use should be considered medical co-occurrence for scoring purposes. Clinicians must be alert to the under-recognition of co-occurring conditions in children, and in particular children from lower socioeconomic backgrounds and culturally distinct backgrounds.

It is crucial to include a broad range of developmental problems into the domain of developmental disabilities. This category includes not only formally defined intellectual

disability but functionally significant low intelligence. It also includes subtle brain damage syndromes such as Traumatic Brain Injury and Fetal Alcohol Spectrum Disorder, as well as Autistic Spectrum Disorders. Specific Learning Disorders, significant enough to impair a child's development, are also included. As with the psychiatric and medical conditions more than one developmentally disruptive condition is not considered a co-occurrence, but rather should be considered together for their effect on other co-occurring conditions

For the purposes of this document, the first issue to be identified in the clinical encounter will be referred to as the "presenting condition". This term does not imply anything about the relative importance of the condition, but merely provides a starting point for considering interactions between co-occurring conditions.

1 - No Co-Occurrence

a- No evidence of medical illness, substance abuse, developmental disability, or psychiatric disturbances apart from the presenting condition.
b- Past medical, substance use, developmental, or psychiatric conditions are stable and pose no threat to the child or adolescent's current functioning or presenting condition.

2 - Minor Co-Occurrence

a- Minimal developmental delay, disorder or brain dysfunction is present and has no impact on the presenting condition for which the child or adolescent has achieved satisfactory adaptation and/or compensation.
b- Self-limited medical conditions are present that are not immediately threatening or debilitating and that have no impact on the presenting condition and are not affected by it.
c- Occasional, self-limited episodes of substance use are present that show no pattern of escalation, with no indication of adverse effect on functioning or the presenting condition.
d- Transient, occasional, stress-related psychiatric symptoms are present that has no discernable impact on the presenting condition.

3 - Significant Co-Occurrence

a- Developmental disability is present that may adversely affect the presenting condition, and/or may require significant augmentation or alteration of treatment for the presenting condition or co-morbid condition, or adversely affects the presenting condition.
b- Medical conditions are present requiring significant medical monitoring (e.g., diabetes or asthma).
c- Medical conditions are present that may adversely affect, or be adversely affected by, the presenting condition.
d- Substance abuse is present, with significant adverse effect on functioning and the presenting condition.

e- Recent substance use that has significant impact on the presenting condition has been arrested due to use of a highly structured or protected setting or through other external means.
f- Psychiatric signs and symptoms are present that persist in the absence of stress, are moderately debilitating, and adversely affect the presenting condition.

4 - Major Co-Occurrence

a- Medical conditions are present or have a high likelihood of developing that may require intensive, although not constant, medical monitoring (e.g., insulin-dependent diabetes, hemophilia).
b- Medical conditions are present that will adversely affect, or be affected by, the presenting condition.
c- Uncontrolled substance use is present that poses a serious threat to health if unabated and impedes recovery from the presenting condition.
d- Developmental delay or disorder is present that significantly reduces functional capacity and ability to participate meaningfully in a psychiatric or substance abuse services.
e- Psychiatric symptoms are present that clearly impair functioning, persist in the absence of stressors, and seriously impair recovery from the presenting condition.

5 - Severe Co-Occurrence

a- Significant medical condition is present that is poorly controlled and/or potentially life threatening in the absence of close medical management (e.g., severe alcohol withdrawal, uncontrolled diabetes mellitus, complicated pregnancy, severe liver disease, debilitating cardiovascular disease).
b- Medical condition acutely or chronically worsens or is worsened by the presenting condition.
c- Substance dependence is present, with inability to control use, intense withdrawal symptoms and extreme negative impact on the presenting condition.
d- Developmental disorder is present that seriously complicates, or is seriously compromised by, the presenting condition.
e- Acute or severe psychiatric symptoms are present that seriously impair functioning, and/or prevent voluntary participation in treatment for the presenting condition, or otherwise prevent recovery from the presenting condition.

Dimension IV: Recovery Environment

This dimension considers factors in the environment that may contribute to the onset or maintenance of illness or disability, and factors that may support a child or adolescent's efforts to achieve or maintain recovery. Supportive elements in the environment include, first and foremost, the presence of stable, supportive, and ongoing relationships with family (biological or adoptive) members. Other important supportive factors include the availability of adequate housing and material resources, stable and supportive relationships with friends, employers or teachers, clergy, professionals, and other community members. Clinicians must be alert to underestimation of family, cultural, and community strengths, especially when such strengths/resources may not be evident or may not be readily mobilized. Stressful circumstances may include interpersonal conflict, neglect and/or trauma, life transitions, losses, worries relating to health and safety, and difficulty in maintaining role responsibilities.

Because children and adolescents are more dependent on, and exert less control over, their environment than adults, in the CALOCUS-CASII, the recovery environment encompasses the family milieu, as well as the school, medical, social services, juvenile justice, and other components in which the child or adolescent may receive services or be involved on an ongoing basis. Two sub-scales are used to measure this dimension: Environmental Stress and Environmental Support. These two sub-scales are designed to balance the relative contributions of these factors.

It should be noted that intensive home and community-based supports and services, including wraparound service planning and/or or intensive professional services accessible to the child and family may allow care to be delivered at the same service intensity level in a less restrictive environment than an out of home placement.

Environmental Stress Sub-Scale

1 - Minimally Stressful Environment

a- Absence of significant or enduring difficulties in environment and life circumstances are stable.
b- Absence of recent transitions or losses of consequence (e.g., no change in school, residence, or marital status of parents, or no birth/death of family member).
c- Material needs are met without significant cause for concern that they may diminish in the near future, with no significant threats to safety or health.
d- Living environment is conducive to normative growth, development, and recovery.
e- Role expectations are consistent with child or adolescent's age, capacities and/or developmental level.

2 - Mildly Stressful Environment

a- Significant transition requiring adjustment, such as change in household members, or new school or teacher.
b- Minor interpersonal loss or conflict, such as peer relationship ending due to change in residence or school, or illness or death of distant extended family member that has moderate effect on child and family.
c- Transient but significant illness or injury (e.g., pneumonia, broken bone).
d- Somewhat inadequate material resources or threat of loss of resources due to parental underemployment, separation, or other factor.
e- Expectations for performance at home or school that create discomfort.
f- Potential for exposure to substance use exists.

3 - Moderately Stressful Environment

a- Disruption of family/social milieu (e.g., move to significantly different living situation, absence or addition of parent or other primary caretaker, serious legal or school difficulties, serious drop in capacity of parent or usual primary caretaker due to physical, psychiatric, substance abuse, or other problem with expectation of return to previous functioning).
b- Interpersonal or material loss that has significant impact on child and family.
c- Serious illness or injury for prolonged period, constant pain, or other disabling condition.
d- Danger or threat in neighborhood or community, or ongoing harassment by peers or others.
e- Exposure to substance abuse and its effects.
f- Role expectations that exceed child or adolescent's capacity given age, status, and developmental level.

4 - Highly Stressful Environment

a- Serious disruption of family or social milieu due to illness, death, divorce or separation of parent and child or adolescent; severe conflict, torment and/or physical/sexual abuse or maltreatment.
b- Threat of severe disruption in life circumstances, including threat of imminent incarceration of caregiver or self, lack of permanent residence, or immersion in alien and hostile culture.
c- Inability to meet needs for physical and/or material well-being.
d- Exposure to endangering, criminal activities in family and/or neighborhood.
e- Difficulty avoiding exposure to substance use and its effects.

5 - Extremely Stressful Environment

a- Highly traumatic and/or enduring and disturbing circumstances, such as daily exposure to violence, sexual abuse or illegal activity in the home or community, the child or adolescent is witness to or a victim of a natural disaster, the sudden or unexpected death of a loved one, or an unexpected or unwanted pregnancy.
b- Political or racial persecution, immigration, social isolation, language barriers, and/or illegal alien status.

c- Youth faces incarceration, foster home placement or re-placement, inadequate residence, and/or extreme poverty or constant threat of such.
d- Severe pain, injury, or disability, or imminent threat of death due to severe illness or injury.

Environmental Support Sub-Scale

1 - Highly Supportive Environment
a- Family and ordinary community resources are adequate to address child's developmental and material needs.
b- Continuity of active, engaged primary caretakers, with a warm, caring relationship with at least one primary caretaker.
c- Effective involvement in a Wraparound Process, or use of other highly supportive resources.
(presence of this anchor point may pre-empt higher ratings)

2 - Supportive Environment
a- Continuity of family or primary caretakers is only occasionally disrupted, and/or relationships with family or primary caretakers are only occasionally inconsistent.
b- Family/primary caretakers are willing and able to participate in treatment if requested to do so and have capacity to effect needed changes.
c- Special needs are addressed through successful involvement in systems of care (e.g., low level special education, tutoring, speech therapy).
d- Community resources are sufficient to address child or adolescent's developmental and material needs.

3 - Limited Support in Environment
a- Family has limited ability to respond appropriately to child's developmental needs and/or problems, or is ambivalent toward meeting these needs or addressing these problems.
b- Community resources only partially compensate for unmet material and emotional needs and/or child or adolescent has limited or inconsistent access to network.
c- Family or primary caretakers demonstrate only partial ability to make necessary changes during treatment.

4 - Minimally Supportive Environment
a- Family or primary caretaker is seriously limited in ability to provide for the child's developmental, material, and emotional needs.
b- Few community supports and/or serious limitations in access to sources of support so that material, health, and/or emotional needs are mostly unmet.
c- Family and other primary caretakers display limited ability to participate in treatment and/or service plan (e.g. unwilling, inaccessible, cultural discomfort).

5 - No Support in Environment
a- Family and/or other primary caretakers are completely unable to meet the child's developmental, material, and/or emotional needs.

b- Community has deteriorated so that it is unsafe and/or hostile to the needs of children and adolescents for education, recreation, constructive peer relations, and mentoring from unrelated adults.
c- Lack of liaison and cooperation between child-servicing agencies
d- Inability of family or other primary caretakers to make changes or participate in treatment.
e- Lack of even minimal attachment to benevolent other, or multiple attachments to abusive, violent, and/or threatening others.

Dimension V: Resiliency and Response to Services

Children and adolescents demonstrate widely varying levels of the capacity for resilience in the face of stress. Resilience can be enhanced through support for stable, caring connections with others such as in a treatment relationship and/or the provision of supports as in a wraparound process and/or informal supports such as faith-based organizations or other community resources. This section aims to measure how well a child or adolescent copes with all types of adversity and uses treatment and/or natural and formal community supports. Natural responses to stressors and life changes with no professional involvement or other specific supports should be considered as well, especially if the child or adolescent has not had previous services.

Most recent responses to community supports, treatment or specialized care should take precedence over more remote responses in determining the score.

1 - Full Resiliency and/or Response to Services
a- Child has no previous experience with services.
b- Child has demonstrated significant and consistent capacity to maintain normal development in the face of normal challenges, or to readily resume normal development following extraordinary challenges.
c- Prior experience indicates that efforts in most types of treatment or other formal supports have been helpful in controlling the presenting condition in a relatively short period of time.
d- There has been successful management of extended recovery with few and limited periods of relapse even in unstructured environments or without frequent treatment.
e- Able to transition successfully and accept changes in routine without support; optimal flexibility.

2 - Significant Resiliency and/or Response to Services
a- Child demonstrated average ability to deal with stressors and maintain developmental progress.
b- Previous experience with services has been successful in controlling symptoms but more lengthy intervention is required.
c- Significant ability to manage recovery has been demonstrated for extended periods, but has required formal supports or ongoing care in alternative supportive relationships.

d- Recovery has been managed for short periods of time with limited support or structure.
e- Able to transition successfully and accept changes in routine with minimal support.

3 - Moderate or Equivocal Resiliency and/or Response to Services

a- Child/youth has demonstrated an inconsistent or equivocal capacity to deal with stressors and maintain normal development.
b- Previous experience in treatment at low level of intensity has not been successful in relief of symptoms or optimal control of symptoms.
c- Recovery has been maintained for moderate periods of time, but only with strong professional or peer supports or in structured settings.
d- Has demonstrated limited ability to follow through with treatment recommendations.
e- Developmental pressures and life changes have caused some deterioration in function.
f- Able to transition successfully and accept change in routine most of the time with moderate intensity support.

4 - Poor Resiliency and/or Response to Services

a- Child has demonstrated frequent evidence of innate vulnerability under stress and difficulty resuming progress toward expected developmental level.
b- Previous treatment has not achieved complete remission of symptoms or optimal control of symptoms even with intensive and/or repeated exposure to interventions.
c- Attempts to maintain whatever gains that were attained in intensive treatment have limited success, even for limited time periods or in structured settings.
d- Developmental pressures and life changes have created episodes of turmoil or sustained distress.
e- Transitions with changes in routine are difficult even with a high degree of support.

5 - Negligible Resiliency and/or Response to Services

a- Child has demonstrated significant and consistent evidence of innate vulnerability under stress, with lack of any resumption of progress toward expected developmental level.
b- Past response to treatment has been quite minimal, even when treated at high levels of care for extended periods of time.
c- Symptoms are persistent and functional ability shows no significant improvement despite receiving intensive services.
d- Developmental pressures and life changes have created sustained turmoil and/or developmental regression.
e- Unable to transition or accept changes in routine successfully despite intensive support.

Dimension VI: Engagement in Services

This dimension measures the child or adolescent's, as well as the parents and/or primary caretakers', recognition and acceptance of their condition and their engagement in services. For the purpose of this document, services includes an array of formal and informal therapeutic interventions to address the child's, adolescent's, and parent's and/or primary caretaker's needs. The sub-scales reflect the importance of the child/youth's willingness to be involved in intake, care planning, implementation and maintenance phases of care, as well as the parent and/or primary caretakers' willingness and ability to participate pro-actively in the same elements of a treatment/care plan. It also is critical to note that a youth and their parent or primary caretakers' cultural background influences understanding and acceptance of a problem, as well as choice of care options for addressing it. Attention should be given to note barriers to proper assessment and treatment based on cultural differences between the youth and parent and/or primary caretaker and the clinician or other involved professionals. Structural barriers (e.g. location of services; accessability) should also be considered and addressed.

Only the highest of the two sub-scale scores (child or adolescent vs. parent and/or primary caretaker) is added into the composite score. If a child or adolescent is emancipated, the parent and/or primary caretaker sub-scale is not scored.

Child or Adolescent Engagement Sub-Scale

The child or adolescent sub-scale measures the ability of the child or adolescent, within developmental constraints, to form a positive, trusting relationships with people in components of the system providing care, to define the issues of concern, to accept his or her role in the development and perpetuation of their distress of disability, and to participate actively in the care planning process.

1 - Optimal

a- Quickly forms a trusting and respectful positive therapeutic relationship with clinicians and other care providers.
b- As developmentally appropriate, able to define problem(s) and understands consequences and how others may see them differently.
c- Accepts age-appropriate responsibility for behavior that causes and/or exacerbates primary problem.
d- Actively participates in treatment planning and cooperates in services.

2 – Adequate

a- Able to develop a trusting, positive relationship with clinicians and other care providers.
b- Unable to define the problem, but can understand and accept how others define the problem and its consequences.
c- Accepts limited age-appropriate responsibility for behavior.
d- Passively cooperates in treatment planning and services

3 – Limited

a- Ambivalent, avoidant, or distrustful relationship with clinicians and other care providers.
b- Acknowledges existence of problem, but resists accepting even limited age-appropriate responsibility for development, perpetuation, or consequences of the problem.
c- Minimizes or rationalizes distressing behaviors and consequences.
d- Unable to accept others' definition of the problem and its consequences.
e- Frequently misses or is late for treatment appointments and/or does not follow the service plan.

4 – Minimal

a- A difficult and unproductive relationship with clinicians and other care providers
b- Accepts no age-appropriate responsibility role in development, perpetuation, or consequences of the problem.
c- Actively, frequently disrupts assessment and services.

5 – Absent

a- Unable to form therapeutic working relationship with clinicians or other care providers, severe withdrawal, psychosis, or other profound disturbance in relatedness.

b- Unaware of problem or its consequences and does not understand or accept explanations.
c- Unable to communicate with clinician due to severe cognitive delay or speech/language impairment.

Parental and/or Primary Caretaker Engagement Sub-Scale

The parent and/or primary caretaker sub-scale measures the ability of the parents or other primary caretaker to form positive collaborative relationships, to engage with the clinician and care planning team in defining the presenting condition, to explore their role as it impacts the child or adolescent, and to take an active role in the care planning and implementation process.

1 - Optimal

a- Quickly and actively engages in a trusting and positive relationship with clinician and other service providers.
b- Sensitive and aware of the child or adolescent's needs and strengths as they pertain to the presenting condition.
c- Sensitive and aware of the child or adolescent's problems and how they can contribute to their child's recovery.
d- Active and enthusiastic in participating in assessment and services

2 – Adequate

a- Develops a positive therapeutic relationship with clinicians and other primary caretakers.
b- Explores the problem and accepts others' definition of the problem.
c- Works collaboratively with clinicians and other primary caretakers in development of treatment plan.
d- Collaborates with service plan, with behavior change and good follow-through on interventions, including supervision of medications and homework assignments.

3 – Limited

a- Inconsistent and/or avoidant relationship with clinicians and other care providers.
b- Defines problem, but has difficulty creating a shared definition of development, perpetuation, or consequences of the problem.
c- Unable to collaborate in development of service plan.
d- Unable to participate consistently in treatment, with inconsistent follow-through.

4 – Minimal

a- A difficult and unproductive relationship with clinician and other care providers.
b- Unable to reach shared definition of the development, perpetuation, or consequences of problem.
c- Able to accept child or adolescent's need to change, but unable or unwilling to consider the need for any changes in other family members.
d- Engages in behaviors that are inconsistent with the service plan.

5 – Absent

a- No awareness of problem.
b- Not physically available.
c- Refuses to accept child or adolescent, or other family members' need to change.
d- Avoidant and/or unable to form relationship with clinician or other care provider, due to significant cognitive difficulties, psychosis, intoxication, or major mental illness or impairment.

CALOCUS-CASII LEVEL OF CARE/SERVICE INTENSITY DEFINITIONS AND UTILIZATION CRITERIA

The levels of care, or service intensity described in CALOCUS-CASII represent a graded continuum of treatment and other service options corresponding to the CALOCUS-CASII dimensional assessment and composite score. At each level of service intensity, a broad range of programming options is described, allowing for variations in practice patterns and resources among communities. The continuum encompasses traditional services, as well emphasizing nontraditional forms of care, such as those in programs based on a System of Care approach.

As stated in the introduction of this instrument, the term "level of care" is used for simplicity, but it is not the intention of this section to imply that the service arrays are static or linear. Rather, each level describes a flexible or variable combination of specific service types and might more accurately be said to describe **levels of service intensity**. The particulars of program development are left to providers to determine based on local circumstances and outcome evaluations. Each level encompasses a multidimensional array of service elements, combining crisis, supportive, clinical, and environmental interventions, which vary independently depending on identified needs.

This edition includes specifications for the capacity of each level of care to provide matched services for individuals with co-occurring mental health,substance use, developmental, and/or health conditions. Service design should assume that users have complex needs and all services should be co-occurring capable or complexity capable. With that in mind, each section's definition includes a reminder that services should reflect this expectation. In addition, suggested durations for authorizations and reviews of clinical status are provided to facilitate oversight processes and reduce unnecessary administrative expenditures. Intensity of services should be consistent with Center for Medicare and Medicaid Services (CMS) certification and accreditation organizations' standards.

The CALOCUS-CASII levels of care description also provide rough estimates of the staff time involved in providing services at different levels. The actual service times required by each child or adolescent and family are highly variable. However, in the aggregate, service time estimates may be of value to programs.

There may be instances in which clinicians may feel that a different level of care or service intensity than that recommended through the CALOCUS-CASII assessment is necessary. While parent-child desires and clinician judgment must be a priority, a clear and compelling rationale for deviation from the level of care recommended by the instrument should be documented in the case record by the clinician.

One additional aspect of the role of the CALOCUS-CASII in treatment planning needs to be recognized. It is not just the overall CALOCUS-CASII score but also the scores for specific Dimensions that are important to track. A high score in a given Dimension directs particular attention to services that are needed to address those

specific aspects of overall service intensity need. Serial administrations of the CALOCUS-CASII will help to track changes in critical Dimensions (i.e, Dimensions that have been scored highly) over time. For example, Risk of Harm—a high Risk of Harm score reflects that the child's safety is compromised, requiring ongoing monitoring.

Workforce Characteristics

This document supports the view that many types of agencies and professionals, when providing services within their scope of practice, are integral to the successful treatment of children and adolescents. Programs should be licensed to offer the requisite services for the levels of care provided and should have the staff and program capabilities necessary to provide those services. In addition, while this document does not specify requirements for the levels of clinician training, clinicians should be well trained, with applicable licensure and/or certification (e.g., child and adolescent psychiatrists, pediatricians, family doctors, child and adolescent psychologists, marriage and family therapists, clinical social workers, professional counselors, psychosocial nurses, independent nurse practitioners, substance abuse clinicians, and/or pastoral counselors), and with training specifically in child, adolescent, and family treatment. Clinicians should provide only care that is within their scope of practice. Non-licensed staff, paraprofessionals and peer support specialists providing therapeutic services as part of the treatment, or care plan should receive supervision by licensed practitioners with training and expertise in child, adolescent, and family treatment. In addition, family members and/or members of the child or adolescent's community provide an array of critically important non-clinical supports and should be included in providing direction and oversight to the program at the management level as well as the service level.

This document does not preclude a child and adolescent psychiatrist from being the primary clinician for both psychotherapeutic and medication services, but providers must determine when this arrangement is advantageous in the treatment planning process. At all levels of care beyond Basic Services, including crisis intervention, access to child and adolescent psychiatrists and child psychiatric Nurse Practitioners is an essential element of the service system. In addition, medical care from either a pediatrician, family medicine physician, or a nurse practitioner must be available in the community for all Service Intensity Levels.

The levels of care are described along a continuum of restrictiveness and intensity. No recommendations in this document supersede Federal, State, or local licensing or operating requirements for agencies, programs, or facilities.

Definitions

Level 0: BASIC SERVICES: Prevention and Health Maintenance

Basic Services are designed to prevent the onset of illness and/or to limit the magnitude of morbidity associated with individual family or social risk factors, developmental delays, and existing emotional disorders in various stages of improvement or remission. Services may be developed for individual or community application and are generally offered in a variety of community settings. Prevention and community support involve education and referral services and may be provided through traditional means, as well as through print and broadcast media (e.g., public service announcements and/or targeted mailings). The expectation that individuals utilizing these services may have complex needs requires that these services should be designed to be welcoming to all individuals and provide preventive, holistic, co-occurring/complexity capable care.

This level of care should be available to everyone in the community without obtaining a prior authorization from insurers. Professionals providing services should be appropriately licensed and in good standing. Many support services may be provided by appropriately trained and/or certified paraprofessionals, including certified peer and family specialists.

1. **Clinical Services** - It is imperative that Basic Services in all settings provide screening for mental health and developmental disorders. Comprehensive, multidisciplinary assessments for children and adolescents who, after initial screening, emerge with multi-faceted problems should be readily available. Early Periodic Screening, Detection and Treatment (EPSDT) guidelines should be followed and evaluations should be completed on a regular basis. Linkage with appropriately matched co-occurring capable mental health and/or substance use disorder services (e.g., scheduling intakes) should be provided to families identified in screening assessments. Consultative services by mental health clinicians should be effectively integrated into all prevention and support functions. Medical care from either a pediatrician or family physician should be available in the community.
2. **Support Services** - Basic Services should be available to children, adolescents, and families through active collaboration with religious and culturally distinct community groups, and in a variety of community settings, including schools and adult education centers, day care and recreational/social facilities, vocational and social services agencies, family resource centers and medical facilities. Community volunteers and agency staff should be trained to provide prevention services. Parent psychoeducation related to effective child behavioral management and early awareness and detection of developmental difficulties should be available.
3. **Crisis Stabilization and Prevention Services** - 24-hour crisis services should be publicized, accessible, and fully integrated into Basic Services in all community settings. Crisis services should include emergency evaluation, brief intervention, and disposition. Child and adolescent psychiatrists and/or psychosocial nurses

should be available for direct contact and consultation on a 24-hour basis. Additional crisis intervention and stabilization efforts should include outreach to vulnerable populations, such as homeless families, as well as intervention with victims of trauma and disaster.

4. **Care Environment** - Prevention and community support activities may occur in many settings including a child or adolescent's home, to Head Start programs, primary care offices, schools, churches, medical and recreational facilities, or traditional mental health settings. Facilities should address ease of access (e.g., proximity to public transportation, schools, social services agencies); adequate design (e.g., accommodation for families with disabled or special needs members, play areas for children); cultural competence (e.g., ambiance that is welcoming to families of multiple ethnic and socio-economic groups) and specific service needs (e.g., supervised day care so that parents can participate, staff or consultants for non-English speaking and/or hearing-impaired attendees).

Level 0 Placement Criteria

All children, adolescents, and families should have access to Basic Services.

LEVEL ONE: Recovery Maintenance and Health Management

Level One services are designed to provide initial steps to limit the magnitude of morbidity associated with individual family and/or community risk and protective factors. .Level One services typically provide follow-up care to reinforce family strengths and family connections with natural supports. Those appropriate for Level One services may either be substantially recovered from an emotional disorder or other problem, or their problems are sufficiently manageable within their families, such that the problems are no longer threatening to expected growth and development. This is a "step down" level of care, or service intensity, designed to prevent or mitigate future episodes of illness or deterioration of function. Treatment and service needs do not require supervision or frequent contact when community support plans are in place. Although this is a low intensity service level, there should be an expectation that individuals utilizing these services may have complex needs. As such, these services should be designed to be welcoming to individuals (and caregivers) who have multiple conditions, and to provide co-occurring/complexity capable services.

This low intensity level of care should not require prior authorization from insurers, and should be available as long as it is needed in much the same way as periodic visits to primary care providers are provided. Professionals providing services should be appropriately licensed or certified. Many support services may be provided by appropriately trained and/or certified paraprofessionals, including certified family and peer specialists. Community resources as faith-based organizations, Boys and Girls Clubs, etc. also provide important support for prevention and maintenance of recovery.

1. **Clinical Services** - Treatment programming (i.e. individual, family and/or group therapy) will be available up to one hour per month, and usually not less than one hour every three months. Psychiatric or physician review and/or contact should take place about once every three to six months. While clinical services at Level One

may be non-intensive and/or episodic, they should be readily accessible so that families may use services to avert the need for higher levels of care. Clinical consultation and assessment should be culturally competent and should consider the extent to which families can mobilize natural supports in the community. Time-limited professional interventions, opportunities for check-ins for "graduates" who value continuity of a treatment relationship, as well as ongoing case management and follow-up medication services may be provided as part of Level One clinical services. Medical care from either a pediatrician or family physician should be available in the community and should be supported by consultation from a mental health professional as part of an integrated health program such as a Medical Home.

2. **Support Services** - Level One support services consist mainly of natural supports in the community, including extended family, friends, and neighbors; parent sponsored support groups, church and recreational programs; 12-step and other self-help programs; school-sponsored programs; and employment. Families appropriate to this level of care have the capacity to access these community resources as needed without professional intervention. Family and youth group psychoeducation should be provided through primary mental health care. Provision of these services should not require more than 1-2 hours per month on the average, though there may be occasional life crises, which would require additional support for short periods of time.

3. **Crisis Stabilization and Prevention Services** - 24-hour crisis services should be available to children, adolescents, and families at this level of service intensity. Crisis intervention staff should consult with primary clinicians. Crisis services should include emergency evaluation, brief intervention, and outreach services. Direct services and/or consultation from child and adolescent psychiatrists and/or psychosocial nurses should be available in each community on a 24-hour basis.

4. **Care Environment** - Recovery maintenance and health management services may be provided in a traditional mental health setting (e.g., office or clinic), in integrated primary care settings or in facilities of other components in the system of care. Facilities should address ease of access (e.g., proximity to public transportation, schools, social services agencies, etc.); adequate design (e.g., accommodation for families with disabled or special needs members, play areas for children); and specific service needs (e.g., supervised day care so that parents can participate, resources for non-English speaking and/or hearing-impaired attendees, etc.). For adolescents, facilities should facilitate a mix of adult supervision with privacy for peer group activities. The facilities should be safe and comfortable for children and adolescents at all developmental levels, as well as their families.

Level 1 Placement Criteria

Children and adolescents with composite scores in the range of 10-13 generally may be stepped down to or receive Level One services. Placement at Level One usually indicates that the child or adolescent has successfully completed treatment at a more intensive level of care and primarily needs assistance in maintaining gains realized in the past, or does not need services that are more intensive or restrictive than those offered at Level One. Placement determinations should be made by culturally competent staff or with consultation by culturally competent clinical specialists.

LEVEL TWO: Low Intensity Community-Based Services

This level of care includes mental health services for children, adolescents, and families living in the community. Level Two services frequently are provided in mental health and/or substance use disorder clinics or clinicians' offices that most resemble traditional "outpatient" services. However, services also may be provided within a Medical Home as part of an integrated behavioral health program, juvenile justice facility, school, social service agency, or other community settings. Children and adolescents appropriate for Level Two services generally do not require the extensive systems coordination and case management of the higher levels of sevice intensity, since their families are able to use community supports with minimal assistance. The degree of individualization of services at Level Two also may not be as extensive as at higher levels of service intensity but continuity of care will still be important. There should be an expectation that individuals utilizing these services will often have complex needs, that these services should be welcoming to individuals (and caregivers) who have multiple conditions, and designed to provide co-occurring/complexity capable services..

Some payers may require that these services be authorized, but close oversight should not be needed, as it would likely incur more expense than savings. Reviews should not be required more often than every four months. Professionals providing services should be appropriately licensed and certified. Many support services may be provided by appropriately trained and/or certified paraprofessionals, including certified family and peer specialists.

1. **Clinical Services** - Clinical services for outpatient care consist primarily of individual, group, and family therapies with active family participation in treatment planning and implementation. Treatment intensity ranges from one hour every four weeks, to up to two hours per week. Psychiatric and cultural competency consultation to the treatment team should be available. Child Psychiatric evaluation and medication management may be needed at this level of service intensity. Family and youth group psycho-education around illness management and relapse prevention may also be provided. Child and adolescent psychiatrists and advance practice psychiatric nurses or primary care physicians should be part of an integrated primary health care network for medication services and 24-hour backup. Other interventions (e.g., occupational, recreational, vocational, and/or expressive therapies) should be made available as indicated.
2. **Support Services** - Support services for children, adolescents, and families are most often natural supports within the community, including extended family, friends, and neighbors; church and recreational programs; 12 step and other self-help groups; parent organization support groups; youth empowerment programs; school sponsored programs; and employment. These families should have the capacity to access other elements of the system of care without substantial professional help, but may need referral and minimal care coordination . Families also may need support for financial, housing, or child-care problems, or for accessing vocational and education services. These should be included as part of the child or adolescent's

individualized service plan. Provision of professional support services should not average more than 2-3 hours per month at this level.

3. **Crisis Stabilization and Prevention Services** - 24-hour crisis services should be accessible to children, adolescents, and families at this level of care. Furthermore, crisis services should be provided in collaboration with the family's other service providers. Crisis services should include emergency evaluation, brief intervention, and outreach services. Direct services and/or consultation from child and adolescent psychiatrists and psychosocial nurses should be available on a 24-hour basis.
4. **Care Environment** - Outpatient services may be provided in a traditional mental health setting (e.g., office or clinic), in facilities of other components of the service system, or in other community settings, including as part of an integrated behavioral health program within a primary care, or Medical Home setting. Facilities used for treatment should address ease of access (e.g., proximity to public transportation, schools, social services agencies, etc.); adequate design (e.g., accommodation for families with disabled or special needs members, play areas for children); and specific service needs (e.g., supervised day care so that parents can participate, resources for non-English speaking and/or hearing-impaired attendees, etc.). For adolescents, facilities should facilitate a mix of adult supervision with privacy for peer group activities. The facilities should be safe and comfortable for children and adolescents at all developmental levels, as well as their families.

Level 2 Placement Criteria

Children and adolescents with a composite score in the range of 14-16 generally may begin treatment at, or be stepped down to, Level Two services. Placement at Level Two indicates that the child or adolescent either does not need services that are more intensive or restrictive than those offered at Level Two, or has successfully completed treatment at a more intensive level of care and primarily needs assistance in maintaining gains realized in the past. Placement determinations should be made by culturally competent staff or with consultation by culturally competent specialists.

LEVEL THREE: High Intensity Community-Based Services

This level of care generally is appropriate for children and adolescents who need more intensive outpatient treatment and who are living either with their families or in alternative families or group facilities in the community. The family's strengths and available community resources should allow many, but not all, of the child's needs to be met through natural supports. Treatment may be needed several times per week, with daily supervision of the child or adolescent provided by the family or facility staff. There should be an expectation that individuals utilizing these services will commonly have complex needs, so these services should be welcoming to individuals (and caregivers) who have multiple conditions, and be designed to provide co-occurring/complexity capable services. Targeted or limited care coordination may also be needed at this level of service intensity, services may be provided in a mental health clinic or a clinician's office, but often are provided in other components of the system of care with mental health consultation, including a primary care, or Medical Home setting.

Minimal utilization review should be required for this level of service and reviews should not be required more often than every two weeks for persons with acute conditions and every two months for those with more slowly evolving conditions. Professionals providing services should be appropriately licensed and certified. Many support services may be provided by trained and/or certified paraprofessionals, including certified family and peer specialists.

1. **Clinical Services** - Level Three services include more than one type of therapy service, or contact with a therapist or Child Psychiatrist or Nurse Practitioner may occur at more frequent intervals.. Level Three services may involve the use of wraparound teams as service coordination becomes more complex. Service delivery occurs two or more days a week for Psychiatric consultation to the treatment or wraparound team should occur regularly. Medication management may be an essential part of treatment. Child and adolescent psychiatrists and psychosocial nurses are part of the treatment team, providing medication services and 24-hour backup. Selected adjunct interventions (e.g., educational support, speech, occupational, physical, and/or expressive therapies) must be available when indicated. In addition, referrals for clinical services for other family members may be needed. Transition planning for a lower level of care should be part of the services plan. Close collaboration for medical care with either a pediatrician or family physician should be in place and co-located if possible.
2. **Support Services** – Care coordination by a culturally competent primary care provider or care coordinator may be included. Family partners and youth peer mentors may be essential to support parent and youth voice in the care planning process and in supporting skill acquisition by the parents and/or youth. Support services for these children, adolescents, and families should emphasize natural and culturally congruent supports within the community, such as extended family, neighborhood, church groups, parents organization sponsored support groups, youth empowerment programs, self-help groups and community employers. Families may have difficulty accessing elements of the system of care without professional help due to the complexity of their child or adolescent's problems. In addition, families may need support for financial, housing, child-care, vocational, or education services. These should be included as part of the child or adolescent's individualized service plan. Although the need for professional support services is variable at this level, an average of two hours per week is commonly required.
3. **Crisis Stabilization and Prevention Services** - 24-hour crisis services, including child and adolescent psychiatric and nursing consultation and/or direct contact, should be available at this level of care. Crisis services should be accessible and, when provided, crisis team personnel should contact the family's primary service providers. Crisis services should include emergency evaluation, brief intervention, and outreach. An individual crisis, or safety plan, may be indicated, depending on the risk of harm to the youth..
4. **Care Environment** - Intensive outpatient services may be provided in a traditional mental health and/or substance use disorder treatment setting (e.g., office or clinic), in facilities of other components of the service system, or in other community

settings, such as the family's home. The site should have the capacity for short-term management of aggressive or other endangering behavior. Facilities should address ease of access (e.g., proximity to public transportation, schools, social services agencies, etc.); adequate design (e.g., accommodation for families with disabled or special needs members, play areas for children); and specific service needs (e.g., supervised day care so that parents can participate, resources for non-English speaking and/or hearing-impaired attendees, etc.). For adolescents, facilities should facilitate a mix of adult supervision with privacy for peer group activities. The facilities should be safe and comfortable for children and adolescents at all developmental levels, as well as their families.

Level 3 Placement Criteria

Children and adolescents with scores in the range of 17-19 generally may begin treatment at, or be stepped down to, Level Three services. Placement at Level Three generally is excluded by a score of 4 or higher on any Dimension. Placement at Level Three indicates that the child or adolescent either does not need more intensive or restrictive services, or has successfully completed treatment at a higher level of care and needs assistance in maintaining gains. Consideration for this level of care should include the age, size, and manageability of the child or adolescent, and the family and community resources available. Placement determinations should be made by culturally competent staff or in consultation with cultural competency specialists.

LEVEL FOUR: Medically Monitored Community Based Services: Intensive Integrated Services Without 24-hour Psychiatric Monitoring/

This level of care refers to services provided to children and adolescents capable of living in the community with support, either in their family, or in placements such as group homes, foster care, homeless or domestic violence shelters, or transitional housing. To be eligible for Level Four services, a child or adolescent's service needs will require the involvement of multiple service elements or interventions within the system of care (i.e. medical, behavioral health, education, substance use, developmental disabilities, and/or probation), both for the child/adolescent as well as for their families/caregivers. These children and adolescents, therefore, need intensive, clinically informed and integrated care coordination for multi-system and multidisciplinary interventions. Because co-occurring MH, SUD, medical and developmental conditions are an expectation, all services should be designed to be co-occurring/complexity capable. Optimally, an individualized service plan is developed by a wraparound or other team-based planning process that includes a dedicated care coordinator, and when desired by the parents or youth, a family partner and/or youth peer mentor. Services in this level of care include partial hospitalization, intensive day treatment, treatment foster care, and home-based care. In addition, Level Four services also may be provided in schools, substance use disorder treatment programs, juvenile justice facilities, or child welfare congregate care facilities. A detailed Crisis, or Safety Plan and transition planning for discharge to a lower level of service intensity should be part of the plan of care.

Payer oversight may be required for this level of service, but reviews should not be required more often than every four weeks.

1. **Clinical Services** - Clinical services at Level Four should be available at times that meet the needs of the family, including non-traditional periods (e.g., evenings and weekends). The frequency of direct contact and/or consultation by child and adolescent psychiatrists and psychosocial nurses should be determined in consultation with the primary clinician and the wraparound team. Close collaboration with primary medical care should be in place as an integrated part of the comprehensive array of services and should be co-located if possible. Interventions may include individual, group, and family therapy, and may be organized into protocols such as occur in day treatment, or offered as part of a comprehensive wraparound, or Individualized Service Plan. Services may be offered within any of the components of the system of care. Services should be designed for flexibility as part of a comprehensive service plan that includes the mental health individualized treatment plan, and places emphasis on building on the strengths of the child or adolescent and family. Services should be accessible on a daily basis and contact would occur as required by initial and ongoing assessment. Psychiatric services would also be available by in person contact or telehealth on a 24-hour basis. Medication will be carefully monitored, but can be administered by parents when the youth is still living at home. Non-psychiatric clinical services generally average 5-16 hours weekly.

2. **Support Services** – Care coordination services are provided for the multi-faceted service needs of the children and adolescents and their families at this level of care. Recreational activities, after-school employment, church programs, and other community activities may be integrated into the comprehensive service plan to form an integrated continuum of natural, clinical, and culturally congruent services and supports, that includes natural supports from family, advocacy programs, and youth empowerment programs when available. Families are likely to need support for financial, housing, childcare, vocational, and/or education services. These should be included as part of the child or adolescent's comprehensive service plan. Services should be family-driven and youth-guided, with the goal of either maintaining or reintegrating the child or adolescent into the home and community. The need for supportive services will vary, but will usually require an average 5 to 10 hours per week including indirect service time.

3. **Crisis Stabilization and Prevention Services** - At Level Four, children, adolescents, and families must have access to 24-hour emergency evaluation and brief intervention services that include direct contact and/or consultation by a child and adolescent psychiatrist or psychosocial nurse. Mobile crisis services are essential at this level of service intensity to support stabilization in the community. Crisis services may include a number of components in the system of care in addition to licensed mental health clinicians, including outreach by family organization members and/or youth peer support specialists. Care should be taken to avoid service duplication. The goal of crisis services is to foster family strengths and prevent the need for admission to higher levels of care.

   At Level Four, respite care may be offered to families to provide relief from the demands of caring for the child or adolescent and as a "cooling off" mechanism during crises and while treatment plans are implemented.

An inability to manage risk of harm may be reflected in a higher score on the Risk of Harm dimension, and may justify transfer to a more restrictive setting, or intensification of the wraparound plan in other ways, including active medical monitoring or management.

4. **Care Environment** - Level Four services may be provided wherever they are needed to maintain the child or adolescent in the home or community setting such as in an outpatient clinic or hospital (e.g., partial or intensive day treatment), any component in the service system (e.g. public or private day school, juvenile detention center, group home), or in the home (e.g., home-based services). The facility must have the capacity for short-term management of aggressive or other endangering behavior. Transportation needs should be accommodated, both for staff to serve children and adolescents in community settings and to help children, adolescents, and families access services. When home-based treatment is provided, staff transportation needs should be addressed as well as flexible hours to assure continuity of supports for as many hours of the day as is deemed necessary. To optimize family participation, Level Four facilities should be located as near as possible to the child or adolescent's home. Facilities should incorporate ease of access (e.g., proximity to public transportation, schools, social services agencies); adequate design (e.g., accommodation for families with disabled or special needs members, play areas for children); and specific service needs (e.g., supervised day care so that parents can participate, interpretive services for non-English speaking and/or hearing impaired people). For adolescents, facilities should allow for a mix of adult supervision and privacy for peer group activities. The facilities should be safe and comfortable for children and adolescents at all developmental levels, as well as their families.

Level 4 Placement Criteria

Children and adolescents with scores in the range of 20-22 generally may begin treatment at, or be stepped down to, Level Four services. Consideration of the location for this level of care should include ability to maintain the safety of the child or adolescent in their home or other community setting. Placement determinations should be made by culturally competent staff or with consultation by culturally competent specialists.

LEVEL FIVE: Medically Monitored Intensive Integrated Services: Non-Secure, 24 hour Service with Psychiatric Monitoring

This level of service intensity refers to treatment in which the essential element is the maintenance of a milieu in which the therapeutic needs of the child or adolescent and family can be addressed intensively. This level of care traditionally has been provided in non-hospital settings such as residential treatment facilities or therapeutic foster homes. Equivalent services have been provided in juvenile justice facilities and specialized community based residential schools, hospitals with designated step down program units and could be provided in homeless and/or domestic violence shelters or other community settings. The involvement of a wraparound team is essential and may allow this level of care to be provided in the family's home if adequate resources are available. If so, the Crisis, or Safety Plan must be quite detailed and access to needed "back-up" services

must be immediate. Because co-occurring MH, SUD, developmental and/or medical conditions are an expectation, all services should be designed to be co-occurring/complexity capable. Ideally, the transition plan will provide continuity of care for both the child and the family, and integrate the child or adolescent's treatment experiences into their return to less restrictive settings.

Ideally, the step-down plan represents a modification of the Level 5 service plan, providing continuity of care and sustaining the gains made. This is facilitated by the same service team following the child/youth across different levels of service intensity. This means that the child or adolescent's community-based wraparound team should remain involved if the child or adolescent requires out of home placement. If no community-based wraparound team exists, a primary goal of the out of home placement should be to support the family to help create such a team to support subsequent transition to a lower level of services intensity, as explicated by the SAMHSA Building Bridges Initiative.

Payer authorization is often required for this level of service, but reviews should not be more often than every week for sub-acute intensive care settings such as respite or step down facilities, and no more than every three months for extended care services such as residential treatment facilities. Professionals providing services should be appropriately licensed and certified and should include a full array of disciplines including rehabilitation, addiction, and medical specialists. Many support services may be provided by appropriately trained and/or certified paraprofessionals, including family and peer specialists.

1. **Clinical Services** - Programs for children or adolescents in residential settings are frequently utilized at this level of care. However, the same intensity of clinical programming must be provided whether children or adolescents are in residential settings or in community settings, including the home. The primary clinician should review the child or adolescent's progress daily and debrief back-up staff as needed. Child and adolescent psychiatrists are integral members of the treatment team and serve an important consultative or supervisory function, maintaining daily contact with the team and providing 24-hour psychiatric consultation. Psychiatric care should be available on site at least weekly, but client contact may be required as often as daily. Facilities serving the most acute populations will require 0.5 - 1.0 hours of psychiatric time per client per week. Treatment modalities may include individual, group, and family therapy, with integrated attention to address co-occurring mental health and substance use disorders, as indicated. Primary medical care should be an accessible, integrated part of the comprehensive array of services. Close collaboration with either a pediatrician or family physician should be in place. Non-credentialed child-care staff are an important part of the clinical team, and so will participate in treatment planning, and will be actively supervised and trained. Similarly, parent and youth peer support specialists should be supervised actively and integrated into the service plan when parents or youth request these additional supports. Non-psychiatric clinical services generally average 8-20 hours per client weekly. Staff and programs should be culturally competent, with access to cultural

competency consultation as needed. Treatment should be family-driven and youth-guided. The goal of treatment for children or adolescents in out-of-home placements should be a timely return to the family and community. Thus, transition planning should be considered in daily clinical review.

2. **Support Services** - Care coordination is integral to care at this level regardless of which component of the system of care is the lead service provider. Children and adolescents in Level Five programs should receive adequate supervision for activities of daily living. Supervised off-campus passes or excursions into the community from a home-based wraparound program should be provided. Facility or program staff, supportive family members, and/or family friends identified by the "child and family" team may provide basic support services, including recreational, social, or educational activities, and, as needed, escort to substance abuse or self-help groups. Families may need help for problems with their own mental health and substance use challenges, as well as with housing, child-care, finances, and job or school problems. These services should be integrated into the child or adolescent's individual service plan.

3. **Crisis Stabilization and Prevention Services** - Children and adolescents at Level Five may require higher levels of care for brief periods to manage crises. All staff must be trained in de-escalation and safety maintenance techniques should they be required until a secure placement can be obtained. These interventions must be used in accordance with the legal requirements of the jurisdiction and ethical professional practices.

   More restrictive care may be needed temporarily because the team cannot safely manage acute exacerbations in the child or adolescent's risk of harm status or sudden deteriorations in functioning. Reevaluation using the dimension scales of CALOCUS-CASII may yield a composite score supporting admission to Level Six. When more restrictive or intensive services are provided outside of the residential unit or wraparound plan, the staff of all involved service components should collaborate with the family to plan a timely return to lower levels of care. In addition, the service plan should be reviewed for adequacy in meeting the child or adolescent's fluctuating needs.

4. **Care Environment** - When care at Level Five is provided institutionally, living space must be provided that offers reasonable protection and safely given the developmental status of the child or adolescent. Physical barriers preventing easy egress from or entry to the facility may be used, but doors at Level Five facilities or other care settings are not locked. Staffing and engagement are the primary methods of providing security both in facilities and in home-based plans. Staffing patterns should be adequate to accommodate episodes of aggressive and/or endangering behavior of moderate duration (e.g., sufficient staff should be available to both monitor a safe room for unlocked seclusion and maintain supervision of the other children or adolescents). Capacity for transporting residents off-campus for educational or recreational activities is a critical element of Level Five services when such services are not available within the Level Five service delivery setting.

Level Five facilities should be located as near as possible to the child or adolescent's home. In addition, facilities for Level Five activities should incorporate ease of access (e.g., proximity to public transportation, schools, social services agencies, etc.); adequate design (e.g., accommodation for families with disabled or special needs members, play areas for children); and specific service needs (e.g., supervised day care so that parents can participate, resources for non-English speaking and/or hearing-impaired people, etc.). Facilities should be safe and comfortable for children and adolescents at all developmental levels, as well as for their families.

Level 5 Placement Criteria

Children and adolescents with scores in the range of 23-27 generally may begin treatment at, or may be transitioned into, Level Five services. Placement at Level Five indicates that the child or adolescent either does not need more intensive services, or has successfully completed treatment at a more intensive level and primarily needs assistance in maintaining gains. Consideration for Level Five services should include the age, size, and manageability of the child or adolescent, and the family and community resources available. Placement determinations should be made by culturally competent staff or in consultation with culturally competent specialists.

LEVEL SIX: Medically Managed Secure, Integrated Intensive Services: Secure, 24 Hour Services with Psychiatric Management

Level Six services are the most restrictive and the most intensive in the level of care continuum. Traditionally, Level Six services have been provided in a secure facility such as a hospital or locked residential program. This level of service intensity also may be provided through intensive application of mental health and medical services in a juvenile detention and/or educational facility, or even in the child's home provided that these settings are able to adhere to medical and psychiatric care standards needed at Level Six. Although high levels of restrictiveness are typically required for effective intervention at Level Six, every effort to reduce, as feasible, the duration and pervasiveness of restrictiveness is desirable to minimize its negative effects. Collaborative transition planning that maintains connections with wraparound planning services should be in place to promote a rapid and safe return to community based services. It is essential that the community-based Wraparound team remain active when a child is in a residential treatment center or hospital setting. With the expectation that individuals (and their caregivers) utilizing these services will almost always have complex needs, these services should be welcoming to individuals and caregivers who have multiple conditions, and should be designed so that all services are co-occurring/complexity capable.

Payer authorization is usually required for this level of service. Reviews of revised CALOCUS-CASII assessments should not be more often than every three days for acute intensive care settings such as inpatient psychiatric hospitals, and no more than every month for long term secure care services such state hospitals or community based locked facilities. Professionals providing services should be appropriately licensed and certified and should include a full array of disciplines including rehabilitation, addiction, and

medical specialists. Support services may also be provided by paraprofessionals, including family and peer specialists, who have been trained and/or certified.

1. **Clinical Services** - Clinical services must be comprehensive and relevant to safety and other emergent issues that may arise. Children and adolescents at Level Six require monitoring and observation on a 24-hour basis. Treatment modalities may include individual, group, and intensive family therapy as well as medication management, and are aimed at managing the crisis, restoring previous levels of functioning, and decreasing risk of harm. Co-occurring substance use should be treated in an integrated manner and treatment may include medical detoxification. The treatment plan must be family-driven and youth-guided and must address management of aggressive and/or suicidal or self-endangering behavior. Access to pediatric or family medicine physician should be available within the hospital community as consultants as needed for management of medical issues.

   Active child psychiatric care is required at this level of service intensity and daily contact with the child or adolescent is necessary. The child and adolescent psychiatrist supporting or directing this level of intensity should consult regularly with the family and the child or adolescent and the family and the wraparound/intensive care coordination team when the latter is involved to support integration of Level Six services with the care to be provided at a lower levels of care/service intensity level. Uncomplicated or specialized transition plans may be necessary, depending on the child or adolescent's or family's needs during step-down. All children and adolescents leaving Level Six services must have a well-defined crisis plan that anticipates and accommodates complications during transition to lower levels of care. Treatment for co-occurring medical conditions must be integrated into all treatment plans.

2. **Support Services** - All necessities of living and well-being must be provided for children and adolescents treated at Level Six. Children's legal, educational, recreational, vocational, and spiritual needs should be assessed according to individual needs and culture. Social and cultural factors must be considered in discharge planning. A wraparound team should be created, if not already in place, mobilizing the strengths of the child or adolescent and family to provide support during the crisis and in aftercare. When capable, children and adolescents should be encouraged to participate in treatment planning, both with the hospital team and with the wraparound process. Families are likely to need support for financial, housing, child-care, vocational, and/or educational services. Case management for coordination of services provided after transition to lower care levels should begin while the child or adolescent receives Level Six services. Transition planning should include integration of the child or adolescent into the home and community, and linkage with social services, education, juvenile justice, and recreational resources as needed and in coordination with the hospital transition planner. All support services should be described in the comprehensive service plan.

3. **Crisis Stabilization and Prevention Services** - At Level Six, crisis services involve rapid response to fluctuations in psychiatric and/or medical status. It is imperative to avoid the trauma of seclusion and restraint whenever possible, so de-escalation and

safety techniques must be employed. Emergency medical services should be available on-site or in close proximity and all staff must have training in emergency protocols.

4. **Care Environment** - In most cases, Level Six care is provided in a closed and locked facility. Alternative settings must have an equivalent capacity for providing a secure environment. Facilities should have space that is quiet and free of potentially harmful items, with adequate staffing to monitor child or adolescent using such a space. Facilities and staff also must provide protection from potential abuse from others. Level Six facilities should be capable of providing involuntary care. Adequate temporary accommodations for family members must be available if needed for the family to be available to participate in the child or adolescent's treatment.

   Level Six facilities, or their alternatives, should be located as near as possible to the child or adolescent's home. In addition, these facilities should incorporate ease of access (e.g., proximity to public transportation; adequate design (e.g., accommodation for families with disabled or special needs members and specific service needs (e.g., supervised day care so that parents can visit, resources for non-English speaking and/or hearing-impaired people, etc.). The facilities should be safe and comfortable for all children and adolescents admitted to the facility at all developmental levels, as well as for their families.

Level 6 Placement Criteria

Children and adolescents with scores of 28 or higher are appropriate for treatment at Level Six. Consideration for this level of care should include the age, size, and manageability of the child or adolescent, and the family and community resources available. Placement determinations should be made that are culturally sensitive and/or with consultation by cultural competency specialists.

APPENDIX I
CALOCUS-CASII ANCHOR POINT QUICK REFERENCE SHEET

Dimension I - Risk of Harm

1. Low Risk of Harm	2. Some Risk of Harm	3. Significant Risk of Harm	4. Serious Risk of Harm (Requires Care at Level 5)	5. Extreme Risk of Harm (Requires Care at Level 6)
A. No indication of current suicidal or homicidal thoughts or impulses, with no significant distress, and no history of suicidal or homicidal ideation B. No indication or report of physically or sexually aggressive impulses C. Developmentally appropriate ability to maintain physical safety and/or use environment for safety D. Low risk for victimization, abuse, or neglect	A. Past history of fleeting suicidal or homicidal thoughts with no current ideation, plan, or intention, and no significant distress B. Mild suicidal ideation with no intent or conscious plan and with no past history C. Indication or report of occasional impulsivity, and/or some physically or sexually aggressive impulses with minimal consequences for self or others D. Substance use without significant endangerment of self or others E. Infrequent, brief lapses in the ability to care for self and/or use environment for safety F. Some risk for victimization, abuse, or neglect	A. Significant current suicidal or homicidal ideation with some intent and plan, with the ability of the child and family to contract for safety and carry out a safety plan. Child expresses some aversion to carrying out such behavior. B. No active suicidal/homicidal ideation, but extreme distress and/or history of suicidal/ homicidal behavior C. Indication or report of episodic impulsivity, or physically or sexually aggressive impulses that are moderately endangering to self or others (ie status offenses, impulsive acts while intoxicated, self-mutilation, running away with voluntary return, fire-setting, violence toward animals, affiliation with dangerous peer group) D. Binge or excessive use of alcohol and other drugs resulting in potentially harmful behaviors E. Episodic inability to care for self and/or maintain physical safety in developmentally appropriate ways F. Serious or extreme risk for victimization, abuse, or neglect	A. Current suicidal or homicidal ideation with either clear, expressed intentions and/or past history of carrying out such behavior. Child has expressed ambivalence about carrying out the safety plan and/or family's ability to carry out the safety plan is compromised. B. Indication or report of significant impulsivity and/or physical or sexual aggression, with poor judgment and insight, and that is/are significantly endangering to self or others (property destruction, repetitive fire-setting or violence toward animals) C. Indication of consistent deficits in ability to care for self and/or use environment for safety D. Recent pattern of excessive substance use resulting in clearly harmful behaviors with no demonstrated ability of child or family to restrict use E. Clear and persistent inability, given developmental abilities, to maintain physical safety and/or use environment for safety	A. Current suicidal or homicidal behavior or such intentions with a plan and available means to carry out this behavior: 1) without expressed ambivalence or significant barriers to not doing so, or 2) with a history of serious past attempts that are not of a chronic, impulsive or consistent nature, or in presence of command hallucinations or delusions that threaten to override usual impulse control B. Indication or report of repeated behavior, including physical or sexual aggression, that is clearly injurious to self or others (eg fire setting with intent of serious property destruction or harm to others or self, planned and/or group violence) with history, plan, or intent, and no insight and judgment (forceful and violent repetitive sexual acts against others. C. Relentlessly engaging in acutely self-endangering behaviors D. A pattern of nearly constant and uncontrolled use of alcohol or other drugs, resulting in behavior that is clearly endangering.

APPENDIX I
CALOCUS-CASII ANCHOR POINT QUICK REFERENCE SHEET

Dimension II - Functional Status

1. Minimal Functional Impairment	2. Mild Functional Impairment	3. Moderate Functional Impairment	4. Serious Functional Impairment (Requires Care at Level 5)	5. Severe Functional Impairment (Requires Care at Level 6)
A. Consistent functioning appropriate to age and developmental level in school behavior and/or academic achievement, relationships with peers, adults, and family, and self-care/ hygiene/ control of bodily functions. B. No more than transient impairment in functioning following exposure to an identifiable stressor with consistent and normative sleep, eating, energy, and self-care.	A. Evidence of minor deterioration, or episodic failure to achieve expected levels of functioning, in relationship with peers, adults, and/or family (eg defiance, provocative behavior, lying/cheating/not sharing, or avoidance/lack of follow through); school behavior and/or academic achievement (difficulty turning in homework, occasional attendance problems) or biologic functions (feeding or elimination problems) but with adequate functioning in at least some areas and/or ability to respond to redirection/intervention. B. Sporadic episodes during which some aspects of sleep, eating, energy, and self-care are compromised. C. Demonstrates significant improvement in function following a period of deterioration	A. Conflicted, withdrawn, or otherwise troubled in relationships with peers, adults, and/or family, but without episodes of physical aggression. B. Self-care/hygiene deteriorates below usual or expected standards on a frequent basis. C. Consistent failure to achieve self-care/hygiene at levels appropriate to age and/or developmental level. D. School behavior has deteriorated to the point that in-school suspension has occurred and the child or youth is at risk for placement in an alternative school or expulsion due to their disruptive behavior. E. Chronic and/or variably severe deficits in interpersonal relationships, ability to engage in constructive activities, and ability to maintain responsibilities. F. Recent gains and/or stabilization in functioning have been achieved while participating in services in a structured, protected, and or/ enriched setting.	A. Serious deterioration of interpersonal interactions with consistently conflictual or otherwise disrupted relations with others, which may include impulsive or abusive behaviors. B. Significant withdrawal and avoidance of almost all social interaction. C. Consistent failure to achieve self-care/hygiene at levels appropriate to age and/or developmental level. D. Serious disturbances in vegetative status, such as weight change, disrupted sleep or fatigue, and feeding or elimination, which threaten physical functioning. E. Inability to perform adequately even in a specialized school setting due to disrupted or aggressive behaviors. School attendance may be sporadic. The child has multiple academic failures.	A. Extreme deterioration in interactions with peers, adults and/or family that may include chaotic communication or assaultive behaviors with little or no provocation, minimal control over impulses that may result in abusive behaviors. B. Complete withdrawal from all social interactions. C. Complete neglect of and inability to attend to self-care/hygiene/ control of biological functions with associated impairment in physical status. D. Extreme disruption in physical functions causing serious comprise of health and well-being. E. Nearly complete inability to maintain any appropriate school behavior and/or academic achievement given age and developmental level.

APPENDIX I
CALOCUS-CASII ANCHOR POINT QUICK REFERENCE SHEET

Dimension III - Co-Occurrence of Conditions: Medical, Substance Use, Developmental, and Psychiatric

1. No Co-Occurrence	2. Minor Co-Occurrence	3. Significant Co-Occurrence	4. Major Co-Occurrence (Requires Care at Level 5)	5. Severe Co-Occurrence (Requires Care at Level 6)
A. No medical, substance abuse, developmental disability, or psychiatric disturbances apart from presenting problem. B. Past medical, substance use, developmental, or psychiatric conditions stable and pose no threat to child's or adolescent's current functioning or presenting problem.	A. Minimal developmental delay or disorder is present that has no impact on the presenting problem and for which the child or adolescent has achieved satisfactory adaptation and or compensation. B. Self-limited medical problems are present that are not immediately threatening or debilitating and have no impact on the presenting problem and are not affected by it. C. Occasional, self-limited episodes of substance use are present that show no escalation, no indication of adverse effect on function or presenting problem. D. Transient, occasional, stress-related psychiatric symptoms are present that have no impact on presenting problem.	A. Developmental disability is present that may/does adversely affect the presenting problem, or require significant alteration of services for the presenting problem or co-occurring condition. B. Medical conditions are present requiring significant medical monitoring C. Medical conditions are present that may adversely affect, or be adversely affected by, the presenting problem. D. Substance abuse is present, with significant adverse effect on functioning and the presenting problem. E. Recent substance use that has a significant impact on presenting problem and that has been arrested stopped due to use of a highly structured/protected setting or through external means. F. Psychiatric signs and symptoms are present and persist in the absence of stress, are moderately debilitating, and adversely affect the presenting problem.	A. Medical conditions present or have a high likelihood of developing that may require intensive, although not constant, medical monitoring. B. Medical conditions are present that will adversely affect, or be affected by, the presenting disorder. C. Uncontrolled substance use that poses a serious threat to health if unabated and impedes recovery from presenting problem. D. Developmental delay or disorder is present that will adversely affect the course, treatment, or outcome of the presenting disorder. E. Psychiatric symptoms are present that clearly impair functioning, persist in the absence of stressors, and seriously impair recovery from the presenting problem.	A. Significant medical condition poorly controlled and/or potentially life threatening in absence of close medical management B. Medical condition acutely or chronically worsens or is worsened by the presenting problem. C. Substance dependence present, with inability to control use, intense withdrawal symptoms, & extreme negative impact on the presenting disorder. D. Developmental disorder that seriously complicates, or is seriously compromised by, the presenting disorder. E. Acute or severe psychiatric symptoms that seriously impair functioning, and/or prevent voluntary participation in treatment for presenting problem, or prevent recovery.

APPENDIX I
CALOCUS-CASII ANCHOR POINT QUICK REFERENCE SHEET

Dimension IV (A) - Environmental Stress

1. Miminally Stressful Environment	2. Mild Environmental Stress	3. Moderate Environmental Stress	4. Highly Stressful Environment	5. Extremely Stressful Environment
A. Absence of significant or enduring difficulties in environment and life circumstances are stable. B. Absence of recent transitions or losses of consequence C. Material needs met without significant cause for concern that they may diminish in the near future with no threats to safety or health. D. Living environment is conducive to normative growth, development, and recovery. E. Role expectations normative and congruent with child's age, capacities and/or developmental level.	A. Significant normative transition requiring adjustment, such as change in household members, or new school or teacher. B. Minor interpersonal loss or conflict, such as peer relationship ending due to change in residence or school, illness or death of distant extended family member that has a mild effect on child and family. C. Transient but significant illness or injury (pneumonia, broken bone). D. Somewhat inadequate material resources or threat of loss of resources due to parental underemployment, separation, etc. E. Expectations for performance at home or school create discomfort. F. Potential for exposure to substance use exists.	A. Disruption of family/social milieu B. Interpersonal or material loss that has significant impact child and family. C. Serious prolonged illness or injury, unremitting pain, other disabling condition. D. Danger or threat in neighborhood or community, or sustained harassment by peers or others. E. Exposure to substance abuse and its effects. F. Role expectations that exceed child's or adolescent's capacity, given his/her age, status and developmental level.	A. Serious disruption of family or social milieu due to illness, death, divorce, or separation of parent and child or adolescent; severe conflict; torment and/or physical/sexual abuse or maltreatment. B. Threat of severe disruption in life circumstances, including threat of imminent incarceration, lack of permanent residence or immersion in alien and hostile culture. C. Inability to meet needs for physical and/or material well-being. D. Exposure to endangering criminal activities in family/community. E. Difficulty avoiding substance use and its effects.	A. Traumatic or enduring and highly disturbing circumstances, such as: 1) Violence, sexual abuse or illegal activity in the home or community 2) The child or adolescent is witness to or a victim of natural disaster 3) The sudden or unexpected death of a loved one 4) Unexpected or unwanted pregnancy B. Political or racial persecution, immigration, social isolation, language barriers, and/or illegal status. C. Incarceration, foster home placement or re-placement, inadequate residence, and/or extreme poverty or constant threat of such. D. Severe pain, injury or disability or imminent threat of death due to severe illness or injury.

APPENDIX I
CALOCUS-CASII ANCHOR POINT QUICK REFERENCE SHEET

Dimension IV (B) - Environmental Support

1. Highly Suppportive Environment	2. Supportive Environment	3. Limited Environmental Support	4. Minimal Environmental Support	5. No Environmental Support
A. Family and ordinary community resources are adequate to address child's developmental and material needs. B. Continuity of active, engaged care takers, with a warm, caring relationship with at least one care taker.	A. Continuity of family members/care takers is only occasionally disrupted, and/or relationships with family members/care takers are only occasionally inconsistent. B. Family/care takers willing and able to participate in treatment if requested and have capacity to effect needed changes. C. Special needs addressed through successful involvement in systems of care D. Community resources are sufficient to address child=s developmental and material needs.	A. Family has limited ability to respond appropriately to child or adolescent's developmental needs and/or problems, or is ambivalent toward meeting these needs or addressing these problems. B. Community resources only partially compensate for unmet material and emotional needs and/or child or adolescent has limited or inconsistent access to network. C. Family or primary care takers demonstrate only partial ability to make necessary changes during treatment.	A. Family or primary care taker is seriously limited in ability to provide for the child or adolescent's developmental, material, and emotional needs. B. Few community supports and/or serious limitations in access to sources of support so that material, health, and/or emotional needs are mostly unmet. C. Family and other care takers display limited ability to participate in treatment and/or service plan	A. Family and/or other care takers are completely unable to meet the child or adolescent's developmental, material, and/or emotional needs. B. Community has deteriorated so that it is unsafe and/or hostile to the needs of children and adolescents for education, recreation, constructive peer relations and mentoring from unrelated adults. C. Lack of liaison and cooperation between child/youth-serving agencies. D. Inability of family or other primary care takers to make changes or participate in services E. Lack of even minimal attachment to benevolent other, or multiple attachments to abusive, violent and/or threatening others.

APPENDIX I
CALOCUS-CASII ANCHOR POINT QUICK REFERENCE SHEET

Dimension V - Resilience and/or Response to Services

1. Full Resiliency	2. Significant Resiliency	3. Moderate/Equivocal Resiliency	4. Poor Resiliency	5. Negligible Resiliency
A. Child has no previous experience with services. B. Child/youth has demonstrated significant and consistent capacity to maintain development in the face of normal challenges. C. Prior experience indicates that efforts in most types of services have been helpful in controlling the presenting problem in a relatively short period of time. D. There has been successful management of extended recovery with few and limited periods of relapse even in unstructured environments or without frequent services. E. Able to transition successfully and accept changes in routine without support; optimal flexibility	A. Child/youth have demonstrated average ability to deal with stressors and maintain developmental progress. B. Previous experience with services has been successful in controlling symptoms but more lengthy intervention is required. C. Significant ability to manage recovery demonstrated for extended periods, but has required structured setting or ongoing care and/or peer support. D. Recovery has been managed for short periods of time with limited support or structure. E. Able to transition successfully and accept changes in routine with minimal support	A. Child/youth has demonstrated an inconsistent or equivocal capacity to deal with stressors and maintain normal development. B. Previous experiences with services at low level of intensity has not been successful in relief of symptoms or optimal control of symptoms. C. Recovery has been maintained for moderate periods, but only with strong professional/peer support or in structured settings. D. Developmental pressures and life changes have created temporary stress. E. Able to transition successfully and accept change in routine most of the time with a moderate intensity of support.	A. Child/youth has demonstrated frequent evidence of innate vulnerability under stress and difficulty resuming progress toward expected developmental level. B. Previous services have not achieved complete remission of symptoms or optimal control of symptoms even with intensive and/or repeated interventions. C. Attempts to maintain whatever gains that can be attained with intensive services have limited success, even for limited time periods or in structured settings. D. Developmental pressures and life changes have created episodes of turmoil or sustained distress. E. Transitions with changes in routine are difficult even with a high degree of support.	A. Child/youth has demonstrated significant and consistent evidence of innate vulnerability under stress, with lack of any resumption of progress toward expected developmental level. B. Past response to services has been quite minimal, even when treated at high levels of service intensity for extended periods of time. C. Symptoms are persistent and functional ability shows no significant improvement despite receiving services. D. Developmental pressures and life changes have created sustained turmoil and/or developmental regression. E. Unable to transition or accept changes in routine successfully despite intensive support.

APPENDIX I
CALOCUS-CASII ANCHOR POINT QUICK REFERENCE SHEET

Dimension VI (A) - Child or Adolescent Engagement in Services

1. Optimal Involvement in Services	2. Adequate Involvement in Services	3. Limited Involvement in Services	4. Minimal Involvement in Services	5. Absent Involvement in Services
A. Quickly forms a trusting and respectful positive therapeutic relationship with clinicians and other care providers. B. Able to define problem(s) as developmentally appropriate and accepts others' definition of the problem(s), and consequences. C. Accepts age-appropriate responsibility for behavior that causes and/or exacerbates primary problem. D. Cooperates and actively participates in services.	A. Able to develop a trusting, positive relationship with clinicians and other care providers. B. Unable to define the problem as developmentally appropriate, but accepts others definition of the problem and its consequences. C. Accepts limited age-appropriate responsibility for behavior. D. Passively cooperates in services.	A. Ambivalent, avoidant, or distrustful relationship with clinicians and other care providers. B. Acknowledges existence of problem, but has trouble accepting limited age-appropriate responsibility for development, perpetuation, or consequences of the problem. C. Minimizes or rationalizes problem behaviors and consequences. D. Unable to accept others definition of the problem and its consequences. E. Frequently misses or is late for appointments and/or does not follow the service plan.	A. A difficult and unproductive relationship with clinician and other care providers. B. Accepts no age-appropriate responsibility role in development, perpetuation, or consequences of the problem. C. Frequently disrupts assessment and services.	A. Unable to form therapeutic working relationship with clinicians or other care providers due to severe withdrawal, psychosis, or other profound disturbance in relatedness. B. Unaware of problem or its consequences. C. Unable to communicate with clinician due to severe cognitive delay or speech/language impairment.

APPENDIX I
CALOCUS-CASII ANCHOR POINT QUICK REFERENCE SHEET

Dimension VI (B) - Parent/Primary Care Engagement in Services

1. Optimal Involvement in Services	2. Adequate Involvement in Services	3. Limited Involvement in Services	4. Minimal Involvement in Services	5. Absent Involvement in Services
A. Quickly and actively engages in a trusting and positive relationship with clinician and other service providers. B. Sensitive and aware of the child or adolescent's needs and strengths as they pertain to the presenting problem. C. Sensitive and aware of their child or adolescent's problems and how they can contribute to their child's recovery. D. Active and enthusiastic participation in services assessment and services.	A. Develops positive therapeutic relationship with clinicians and other primary care takers. B. Explores the problem and accept others definition of the problem. C. Works collaboratively with clinicians and other care takers in development of service plan. D. Cooperates with service plan, with behavior change and good follow-through on interventions.	A. Inconsistent and/or avoidant relationship with clinicians and other care providers. B. Defines problem, but has difficulty creating a shared definition of development, perpetuation, or consequences of the problem. C. Unable to collaborate in development of service plan. D. Unable to participate consistently in service plan, with inconsistent follow-through.	A. A difficult and unproductive relationship with clinician and other care providers. B. Unable to reach shared definition of the development, perpetuation, or consequences of problem. C. Able to accept child or adolescent's need to change, but unable or unwilling to consider the need for any change in other family members. D. Engages in behaviors that are inconsistent with the service plan.	A. No awareness of problem. B. Not physically available. C. Refuses to accept child or adolescents, or other family members' need to change. D. Unable to form relationship with clinician or other care provider due to significant cognitive difficulties, psychosis, intoxication, or major mental illness or impairment.

APPENDIX II
CALOCUS-CASII SERVICE INTENSITY LEVEL DETERMINATION GRID

Dimension	Recovery Maintenance Health Management **Level 1**	Low Intensity Community-Based Services **Level 2**	High Intensity Community-Based Services **Level 3**	Medically Monitored Community-Based Services **Level 4**	Medically Monitored Intensive Integrated Services **Level 5**	Medically Managed Secure, Integrated Services **Level 6**
I Risk of Harm Score	2 or less	2 or less	3 or less	3 or less	3 (4)	4 (5)
II Functional Status Score	2 or less	2 or less	3 or less	3 or less	3 (4)*	4 (5)*
III Co-Occurrence of Conditions Score	2 or less	2 or less	3 or less	3 or less	3 (4)*	4 (5)
IVA Recovery Environment - Stress Score	Sum of IVA + IVB is 4 or less	Sum of IVA + IVB is 5 or less	Sum of IVA + IVB is 5 or less	3 or 4	4 or more	4 or more
IVB Recovery Environment - Support Score				3 or less	4 or more	4 or more
V Resiliency and/or Response to Services Score	2 or less	2 or less	3 or less	3 or 4	3 or more	4 or more
VIA Engagement in Services - Child or Adolescent Score**	2 or less	2 or less	3 or less	3 or 4	3 or more	4 or more
VIB Engagement in Services - Parent/Primary Caregiver Score**	2 or less	2 or less	3 or less	3 or 4	3 or more	4 or more
Composite Score	**10 to 13**	**14 to 16**	**17 to 19**	**20 to 22**	**23 to 27**	**28 or more**

(◯) Indicates that independent criteria require admission to this service intensity level regardless of composite score. *Independent criteria may be waived if the sum of the Recovery Environment sub-scale (IVA and IVB) scores = 2.

**In the composite score, include only the higher of the two Engagement in Services sub-scale scores: either VIA or VIB.

APPENDIX III
CALOCUS-CASII LEVEL OF SERVICE INTENSITY COMPOSITE SCORE TABLE

LEVEL	SERVICE INTENSITY DESCRIPTION	SCORE
Zero	Basic Services for Prevention and Maintenance	7-9
One	Recovery Maintenance and Health Management	10-13
Two	Low Intensity Community-Based Services	14-16
Three	High Intensity Community-Based Services	17-19
Four	Medically Monitored Community-Based Services: Intensive Integrated Services without 24-hour Psychiatric Monitoring	20-22
Five	Medically Monitored Intensive Integrated Services: Non-secure, 24-hour Services with Psychiatric Monitoring	23-27
Six	Medically Managed Intensive Integrated Services: Secure, 24-hour Services with Psychiatric Management	28+

APPENDIX IV
CALOCUS-CASII SCORE SHEET

Child: _____ Date:_____

Scorer: _____ Date of last Scoring: _____

Dimension	Score (1-5)	Descriptors (a, c, etc.)	Client Specific Examples
I - Risk of Harm*			
II - Functional Status*			
III - Co-occurrence*			
IVA - Environmental Stress			
IVB - Environmental Support			
V - Resiliency/Response to Services			
VIA - Child/Adolescent Engagement in Services			
	OR		
VIB - Parent/Caretaker Engagement in Services			
TOTAL SCORE:		**LEVEL:**	* Score of 4 automatically = level 5, Score of 5 = level 6 (unless 4A+4B=2)

Level 0: 7-9 Level 1: 10-13 Level 2: 14-16 Level 3: 17-19 Level 4: 20-22 Level 5: 23-27 Level 6: 28+

APPENDIX V
FREQUENTLY ASKED QUESTIONS & ANSWERS

Introduction

1. Q: For what age range is CALOCUS-CASII designed?

   A: In most cases, the CALOCUS-CASII may be applied to children ages 6 through 18 years.

2. Q: For what disorders can the CALOCUS-CASII be used to determine the service needs of children and adolescents?

   A: Though the CALOCUS-CASII was developed to determine the service needs of children and adolescents with Serious Emotional Disturbance, the instrument applies equally well to children and adolescents with a broader range of presenting problems, including mental illness, substance use disorder, developmental disorder, and medical comorbidities.

3. Q: Name the six evaluation dimensions of the CALOCUS-CASII.

   A: 1) Risk of Harm
   2) Functional Status
   3) Co-Occurrence of Conditions: Developmental, Medical, Substance Use, and Psychiatric
   4) Recovery Environment
      a. Scale A = Environmental stress
      b. Scale B = Environmental support
   5) Resiliency and/or Response to Services History
   6) Involvement in Services
      a. Scale A = child/adolescent
      b. Scale B = parent/primary caretaker

4. Q: Describe the concept of levels of service intensity.

   A: Level of service intensity is a programmatic concept recognizing the need for changes in service environment beyond just bricks and mortar considerations, based on a System of Care approach to service planning and service delivery. The levels of service intensity have been defined to reflect two interrelated but independent aspects of service: restrictiveness and intensity.

Instructions

5. Q: If you are not sure which score to assign to a CALOCUS-CASII dimension, what score do you choose?

   A: Should there be ambiguity about which score to assign on a dimension, clinical judgment and experience should be applied to make the best determination of a

score. When significant doubt remains, the higher score in the dimension should be assigned.

6. Q: As a general rule, how often should the CALOCUS-CASII be administered?

   A: The CALOCUS-CASII should be administered at the beginning of services, at points of significant change, at service plan reviews and at termination of service.

7. Q: When specific services described in a CALOCUS-CASII level of service intensity are not available in your community, what services should be assigned? Why?

   A: The combination of services closest to the recommended level of intensity and/or restrictiveness that is available in the community should be assigned, unless there is a clear and compelling rationale to do otherwise. This practice reflects the value of treating children and adolescents within their communities, instead of seeking service remotely, which increases barriers for family and community integration both during and after services.

8. Q: How do you resolve the differences between the recommended level of service intensity obtained from CALOCUS-CASII and that determined on the basis of clinical judgment?

   A: If there is a difference between clinical judgment and the CALOCUS-CASII level of service intensity, clinical judgment supported by a clearly articulated rationale will take precedence.

<u>Dimension I: Risk of Harm</u>

9. Q: What are the components of Dimension I: Risk of Harm?

   A: This dimension of the assessment considers a child or adolescent's potential to be harmed by others or cause significant harm to self or others.

10. Q: How would you score "binge or excessive use of alcohol and other drugs resulting in potentially harmful behaviors" on Dimension I: Risk of Harm?

    A: Score of 3: Significant Risk of Harm

11. Q: True or False: The presence of a developmental disability in the parent may increase The Risk of Harm to the child.

    A: True

12. Q: A child has a parent with schizophrenia, who has also recently developed a substance abuse problem? Which of the following answers are correct?
    a. The substance abuse is not as important as the schizophrenia.
    b. The substance abuse is more important than the schizophrenia.
    c. The parent's illness has no effect on the Risk of Harm to the child.

d. The development of substance abuse in a parent who has schizophrenia has a negative impact on the recovery environment and so increases the Risk of Harm to the child.

A: d: The development of substance abuse in a parent who has schizophrenia has a negative impact on the recovery environment and so increases the Risk of Harm to the child.

13. Q: True or False: The potential Risk of Harm increased for a child from South America who has just moved to the United States with parents who are unable to speak English and who are unemployed.

A: True

14. Q: An adolescent with impulse control disorder (e.g. Fetal Alcohol Syndrome) lives with an unemployed single father. Which of the following statements are true about Dimension I: Risk of Harm?

a. The Fetal Alcohol Syndrome increases the Risk of Harm because the patient is unpredictable.
b. The age of the adolescent is the most important factor.
c. The father's unemployment increases the Risk of Harm only if he is emotionally upset by the loss of his job.
d. The adolescent is securely attached to the father and so the Risk of Harm is negligible.

A: a: The Fetal Alcohol Syndrome increases the Risk of Harm because the patient is unpredictable.

c: The father's unemployment increases the Risk of Harm only if he is emotionally upset by the loss of his job.

<u>Dimension II: Functional Status</u>

15. Q: What are the components of Dimension II: Functional Status?

A: This dimension measures changes in the degree to which a child or adolescent is able to fulfill responsibilities and to interact with others, deterioration in eating and sleeping habits, and capacity for self-care.

16. Q: How would you score "sporadic episodes during which some aspects of self-care and hygiene are compromised" on Dimension II: Functional Status?

A: Score of 2: Mild functional impairment.

17. Q: How would you score "nearly complete inability to maintain any appropriate school behavior given age and developmental level" on Dimension II: Functional Status?

A: Score of 5: Severe functional impairment.

18. Q: A child/adolescent with chronic and severe problems in peer and adult relationships has recently developed a friendship with someone who positively guides and gently controls the child/adolescent:
    a. True or False: The impact on Functional Status is through an improvement of the Recovery Environment determined by a re-administration of the CALOCUS-CASII.
    b. True or False: The impact on Functional Status is through an improvement in Involvement in Services determined by a re-administration of the CALOCUS-CASII.

A: a. True
b. True

19. Q: True or False: The impact of a ten pound weight loss in a 6 year old child should be assessed on both Dimensions II: Functional Status and Dimension III: Co-Occurrence of Conditions.

A: True

20. Q: A child/adolescent with a psychiatric problem deteriorates in services due to side effects from medication. The following answer(s) is/are true:
    a. The number of medications the patient is taking is the only important factor.
    b. The only medication to worry about is an anticonvulsant.
    c. The gender of the patient is the most important issue.
    d. The presence of side effects will have a negative impact on Functional Status.

A: d: The presence of side effects will have a negative impact on Functional Status.

<u>Dimension III: Co-Occurrence of Conditions</u>

21. Q: What are the four domains of Dimension III: Co-Occurrence of Conditions?

A: The four domains are:
1-developmental
2-medical
3-substance use
4-psychiatric

22. Q: How would you score "medical conditions that are present requiring significant medical monitoring such as diabetes or asthma" on Dimension III: Co-Occurrence of Conditions?

A: Score of 3: Significant co-occurrence

23. Q: How would you score a "developmental disorder which seriously compromises the presenting psychiatric disorder" on Dimension III: Co-Occurrence of Conditions?

    A: Score of 5: Severe co-occurrence

24. Q: True or False: The impact of the co-occurrence of a medical illness such as diabetes or epilepsy on a child or adolescent will decrease if the condition responds to medical services.

    A: True

25. Q: Of the following statement(s) which is/are true in an adolescent whose substance abuse has changed from use of cocaine and alcohol to alcohol alone?
    a. The impact of alcohol alone is less than that of alcohol and cocaine.
    b. The decrease in co-occurrence will improve the adolescent's functional status.
    c. Other co-occurrence issues such as co-existing medical or psychiatric conditions are not relevant.
    d. The alcohol abuse can still have a negative impact on Involvement in Services, Acceptance and Engagement

    A: b: The decrease in co-occurrence will improve the adolescent's functional status
    d: The alcohol abuse can still have a negative impact on Involvement in Services.

Dimension IV: Recovery Environment

26. Q: What are the components of Dimension IV: Recovery Environment?

    A: This dimension has two components:
    - Environmental stress: stressful circumstances may include interpersonal conflict or trauma, life transitions, losses, worries relating to health and safety, and difficulty in maintaining role responsibilities.
    - Environmental support: supportive elements in the environment include, first and foremost, the presence of stable, supportive, and ongoing relationships with family (biological or adoptive) members and then, factors such as the availability of adequate housing and material resources; stable, supportive, and ongoing relationships with friends, employers or teachers, clergy, professionals, and other community members.

27. Q: How are CALOCUS-CASII ratings on Dimension IV: Recovery Environment to be made on children or adolescents in residential treatment environments?

    A: For children living in residential or otherwise protected or enriched environments, ratings should be based on conditions that will be encountered on transition to a new environment or back to their pre-service environment.

28. Q: How would you score an environment that has "somewhat inadequate material resources or a threat of loss of resources due to parental unemployment or separation" on Dimension IV: Recovery Environment?

    A: Score of 2: Mild stressful environment

29. Q: How would you score an environment in which a child or adolescent has witnessed physical or sexual abuse on Dimension IV: Recovery Environment?

    A: Score of 5: Severe stressful environment

30. Q: How would you score an environment where "family and ordinary community resources are adequate to address the child's developmental and material needs" on Dimension IV: Recovery Environment?

    A: Score of 1: Optimal supportive environment

31. Q: How would you score an environment that fails to provide education, recreation, peer relationships on Dimension IV: Recovery Environment?

    A: Score of 5: No supportive environment

32. Q: A child or adolescent has a step parent they do not like who leaves the home. Which of the following is/are true:
    a. This has no effect on the Recovery Environment.
    b. This affects the Environmental Stress only.
    c. It affects the child more than the adolescent.
    d. It affects both Environmental Stress and Environmental Support.

    A: d: It affects both Environmental Stress and Environmental Support

33. Q: A single parent has become involved with a new partner who does not like or want children.
    a. True or False: The Environmental Support increases.
    b. True or False: The Environmental Stress increases.

    A: a: False
    b: True

<u>Dimension V: Resiliency and/or Response to Services</u>

34. Q: What are the components of Dimension V: Resiliency and/or Response to Services?

    A: This dimension recognizes that a child or adolescent's natural history of response to developmental challenges and stressors (resiliency) may indicate how that child or adolescent may respond to services. This dimension also assesses the family unit's ability to respond constructively to stressors and services.

35. Q: True or False: The service response of a child or adolescent is always related to the level of intensity of the service.

    A: False. Service response in some cases may not be related to the level of intensity, but rather to the unique characteristic of the service provider such as his/her level of cultural competency.

36. Q: True or False: A child or adolescent's most recent experience in services takes precedence over past service experience in determining the CALOCUS-CASII score.

    A: True

37. Q: How can you determine Resiliency in a young child who has not been involved in services?

    A: Responses to developmental challenges without professional involvement may be as indicative of resiliency as response to services.

38. Q: True or False: Response to services is improved in a child or adolescent who did not connect with two previous female therapists but is now responding to a new male therapist.

    A: True

Dimension VI: Engagement in Services

39. Q: What are the two subscales of Dimension VI: Involvement in Services?

    A: The Involvement in Services dimension measures both the child or adolescent's and the parent and/or primary caretaker's acceptance of and engagement in services.

40. Q: Cultural factors affect all of the dimensions of the CALOCUS-CASII. Specifically, how do cultural factors affect Dimension VI: Involvement in Services?

    A: A parent and/or primary caretaker's cultural background influences understanding and acceptance of a problem, as well as choice of care options for solving it. Thus, care should be taken to note barriers to proper assessment and services based on cultural differences between the child or adolescent and parent and/or primary caretaker and the clinician.

41. Q: What are the rules for use of the two sub-scale scores (parent/primary caretaker and child/adolescent) of Dimension VI: Involvement in Services?

    A: Only the highest of the two sub-scale scores is added into the composite score. In

addition, if a child or adolescent is emancipated, the parent/primary caretaker sub-scale is not scored.

42. Q: What does the child or adolescent's Involvement in Services sub-scale on Dimension VI measure?

A: This sub-scale measures the ability of the child or adolescent, within developmental constraints, to: form a positive therapeutic relationship with people in components of the system providing services; define the presenting problems; accept his or her role in the development and perpetuation of the primary problem; accept his or her role in the service planning and service process; and to actively cooperate in services.

43. Q: How would you score an adolescent who had an "actively hostile relationship with clinicians and other care providers" on Dimension VI: Involvement in Services?

A: Score of 4: Adversarial

44. Q: What does the parent/primary caretaker sub-scale of Dimension VI measure?

A: This sub-scale measures the ability of the parents or other care givers to: form a positive therapeutic relationship; engage with the clinician in defining the presenting problem; explore their role as it impacts on the primary problem; and take an active role in the service planning and process.

45. Q: How would you score a family with "no awareness of the problem" on Dimension VI: Involvement in Services?

A: Score of 5: Inaccessible

46. Q: Which of the following will occur in an adolescent who has a drug-induced Psychosis during his course of services?

a. There will be little effect on Involvement in Services.
b. There will be a negative effect on Involvement in Services.
c. The Risk of Harm will be decreased.
d. The involvement of the parent/primary caretaker is important.

A: b: There will be a negative effect on Involvement in Services
d: The involvement of the parent/primary caretaker is important.

<u>Level of Service Criteria</u>

47. Q: What are the seven levels of service intensity identified in the CALOCUS-CASII?

47. A: Level 0: Basic services for prevention and maintenance
Level 1: Recovery maintenance and health management
Level 2: Low Intensity Community-Based services
Level 3: High Intensity Community-Based services

Level 4: Medically Monitored Community Based Services: Intensive Integrated Services without 24-hour Psychiatric Monitoring
Level 5: Medically Monitored Intensive Integrated Services: Non-secure, 24-hour services with psychiatric monitoring:
Level 6: Medically Managed Intensive Integrated Services: Secure, 24-hour services with psychiatric management

48. Q: True or False: In children and adolescents' services, the highest level of service intensity is always in patient hospitalization.

A: False. The highest level of service intensity may not be inpatient hospitalization, but rather, intensive home-based services, such as those described in the Wraparound principles concept. Likewise, the most restrictive level of service is not inpatient service, but rather, may be services at different levels of intensity occurring within juvenile justice settings.

49. Q: Describe the use of Wraparound principles in the various levels of service intensity of the CALOCUS-CASII.

A: As the intensity of service increases, so does the need for individualization of the service plan in order to meet the child or adolescent's multiple needs in a community-based setting. The principles of Wraparound, including strength-based planning, use of natural and professional supports and use of parent-directed child/youth and family teams to develop and implement the service plan allow for high intensity services (CALOCUS-CASII Levels of Care Four, Five and Six) to be provided in community settings.

50. Q: At which level(s) of service intensity does a child or adolescent's service needs "require the involvement of multiple components within the system of care"?

A: Levels 4, 5, and 6.

APPENDIX VI
SYSTEMS OF CARE GUIDING VALUES AND PRINCIPLES UPDATED

Updated System of Care Concept and Philosophy (Stroul et al, 2008)

DEFINITION

A system of care is:

> A spectrum of effective, community-based services and supports for children and youth with or at risk for mental health or other challenges and their families, which is organized into a coordinated network, builds meaningful partnerships with families and youth, and addresses their cultural and linguistic needs, in order to help the child or youth to function better at home, in school, in the community, and throughout life.

CORE VALUES

Systems of care are:

1. Family driven and youth guided, with the strengths and needs of the child and family determining the types and
1. mix of services and supports provided.
2. Community based, with the locus of services as well as system management resting within a supportive, adaptive
3. infrastructure of structures, processes, and relationships at the community level.
4. Culturally and linguistically competent, with agencies, programs, and services that reflect the cultural, racial,
5. ethnic, and linguistic differences of the populations they serve to facilitate access to and utilization of appropriate
6. services and supports and to eliminate disparities in care.

GUIDING PRINCIPLES

Systems of care are designed to:

1. Ensure availability and access to a broad, flexible array of effective, community-based services and supports for children and their families that address their emotional, social, educational, and physical needs, including traditional and nontraditional services as well as natural and informal supports.
2. Provide individualized services in accordance with the unique potentials and needs of each child and family, guided by a strengths-based, wraparound service planning process and an individualized service plan developed in true partnership with the child and family.
3. Ensure that services and supports include evidence-informed and promising practices, as well as interventions supported by practice-based evidence, to ensure the effectiveness of services and improve outcomes for children and their families.
4. Deliver services and supports within the least restrictive, most normative environments that are clinically appropriate.
5. Ensure that families, other caregivers, and youth are full partners in all aspects of the planning and delivery of their own services and in the policies and procedures that govern care for all children and youth in their community, state, territory, tribe, and nation.
6. Ensure that services are integrated at the system level, with linkages between child-serving agencies and programs across administrative and funding boundaries and mechanisms for system-level management, coordination, and integrated care management.
7. Provide care management or similar mechanisms at the practice level to ensure that multiple services are delivered in a coordinated and therapeutic manner and that children

and their families can move through the system of services in accordance with their changing needs.

8. Provide developmentally appropriate mental health services and supports that promote optimal social-emotional outcomes for young children and their families in their homes and community settings.
9. Provide developmentally appropriate services and supports to facilitate the transition of youth to adulthood and to the adult service system as needed.
10. Incorporate or link with mental health promotion, prevention, and early identification and intervention in order to improve long-term outcomes, including mechanisms to identify problems at an earlier stage and mental health promotion and prevention activities directed at all children and adolescents.
11. Incorporate continuous accountability and quality improvement mechanisms to track, monitor, and manage the achievement of system of care goals; fidelity to the system of care philosophy; and quality, effectiveness, and outcomes at the system level, practice level, and child and family level.
12. Protect the rights of children and families and promote effective advocacy efforts.
13. Provide services and supports without regard to race, religion, national origin, gender, gender expression, sexual orientation, physical disability, socio-economic status, geography, language, immigration status, or other characteristics, and ensure that services are sensitive and responsive to these differences.

APPENDIX VII
PSYCHOMETRIC TESTING AND EVIDENCE

In order to determine the scale's ability to perform, validity and reliability were tested in a national field study funded by the Center for Mental Health Services through the American Institute for Research. Four study sites were recruited:

- An academically sponsored community based program in Philadelphia;
- A network of day treatment providers in Portland, Oregon;
- The public child mental health service agency for the state of Hawaii and;
- The public mental health agency for the state of North Carolina focusing on community mental health centers in the central and western regions of the state.

The study was reviewed and approved by the East Tennessee University Institutional Review Board Clinicians were trained and data was collected between September 1999 and June 2000.

Psychometric testing of the CASII in this national field trial has indicated that this instrument can be used reliably by a broad range of clinicians, even with relatively brief training (6 hours). The general trend is that subscale scores for the child psychiatrist were more consistent, but the composite score balances out the inconsistencies for the non-psychiatrists providing an extremely reliable summary score even for clinicians with less extensive training and experience. Another finding was that psychiatrists tended to rate slightly lower (less severe) than non-psychiatrists. This is ideal as it would be preferable to have less experienced clinicians be more cautious, particularly with regard to safety issues.

Validity testing indicates that there is moderate correlation between conventionally used scales (CGAS and CAFAS) and the CASII, although there seems to be higher correlation between the CASII and the CAFAS - particularly the composite scores. This study trained clinicians in the use of the CASII but not in the use of the CAFAS or the CGAS. Both of these scales were being used routinely at the test sites. Clinicians were not tested on their proficiency of the CAFAS or the CGAS. It is also encouraging to see that those CASII sub-scales that measure the child alone correlate more highly with the CAFAS and CGAS scores, while those sub-scales that measure environment or engagement have much lower correlation - as would be expected - further supporting the validity of the CASII.

It is curious that co-occurrence of conditions correlated poorly with the CGAS. Although it would be expected that CGAS might take co-occurrence of conditions into account, it appears that it does not. It is also curious that environmental stress is highly correlated with CGAS. Although environmental stress is related to the child's clinical state, this correlation might be expected to be lower than say resiliency and/or response to services.

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Reliability

Method

Seven clinical vignettes were constructed, each oriented to a particular level of service intensity. These vignettes were given to 16 child and adolescent psychiatrists and 78 non-psychiatrists (mostly case managers). The 16 child and adolescent psychiatrists had assisted in the construction of the CASII and thus were very familiar with the instrument. Each of these psychiatrists rated the 7 vignettes for a total of 105 ratings (the psychiatrist who constructed the vignette did not rate that vignette).

The 78 non-psychiatrists were trained on the CASII in a 6 hour workshop. These non-psychiatrists were mostly Master-level social workers with an average of 5 years of experience (see Table 4 below). At the end of their training, these clinicians used the CASII to rate at least 2 of the 7 vignettes chosen at random for a total of 157 ratings. Intraclass correlation coefficients (ICC 2,2) as described by Shrout and Fleiss (1979) were calculated for the child and adolescent psychiatrists and non-psychiatrists separately.

The study demonstrated that the CASII has a high degree of inter-rater reliability when used by a broad range of clinicians, and in fact greater inter-rater reliability in clinicians with lower levels of training.

Non-Psychiatrist Raters

Training	Number	Average years of experience post training
BA training	12	1.5 years
Master training	64	5.2 years
PhD training	2	18.5 years

Results

As seen in the Table below, intraclass correlation coefficients for the sub-scales for physicians ranged between 0.73 and 0.93 while the composite score was 0.89. For the non-physicians, the subscale scores ranged from 0.57 to 0.95 while the composite score coefficient was 0.93. For all of the vignettes, non-psychiatrist rated cases an average of 1.9 points higher than psychiatrists on the total CASII score amounting to less than a full level of service intensity difference on ratings.

Intraclass Correlation Coefficients Comparing Raters on CASII Scores (ICC2,2)

	Child Psychiatrist Ratings	Non-Psychiatrist Ratings
Risk of Harm	.87	.95
Functional Status	.77	.71
Co-Occurrence of Conditions	.86	.81
Environmental Stress	.78	.57
Environmental Support	.93	.89
Resiliency and/or Response	.82	.85
Parent Involvement	.81	.79
Child Involvement	.73	.58
Composite Score	.89	.93
Resiliency and/or Response	.82	.85

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Validity

Methods

After training on the CASII, the non-psychiatrists (as described above) completed routine clinical evaluations and then rated these patients with the CASII and either the Child Global Assessment Scale (CGAS) as described by Shaffer et al. (1983) or the Child and Adolescent Functional Assessment Scale (CAFAS) as described by Hodges and Wong (1996). CAFAS scores were computed using the 8 CAFAS sub-scales. Patients, ages 6 to 18 years old, came from inpatient, outpatient, intensive community and residential settings. Modalities for outpatient treatment included individual, family, group psychotherapies, case management, and wraparound services. Pearson correlation coefficients compared the CASII ratings with the CGAS and CAFAS scores.

Results:

CGAS scores in this population of patients (n=182) varied from 23 to 81 with a mean of 40. CASII composite scores varied from 8 to 34 with a mean of 20.

Correlation of the CGAS with the sub-scale scores of the CASII varied 0.41 to 0 (See table below). Those sub-scale correlations related to the child's clinical presentation that would be expected to correlate with CGAS (functional status, risk of harm and resiliency and/or response to services) were 0.41 to 0.26 while those sub-scales having to do with environment and not related to the child directly (environmental support, parent involvement) were close to 0. The CASII Co-Occurrence of Conditions subscale was also close to 0.

It also demonstrated good external validity when compared with the Child and Adolescent Functional Assessment Scale (CAFAS) (Hodges, 1998), and the Child Global Assessment Scale (CGAS) (Schaffer, 1983), particularly on dimensions that relate to functionality.

Correlation of CASII Scores With CGAS Scores (n=182)

	Correlation with CGAS
Risk of Harm	-.37
Functional Status	-.41
Co-Occurrence of Conditions	-.05
Environmental Stress	-.28
Environmental Support	-.05
Resiliency and/or Response	-.26
Parent Involvement	-.02
Child Involvement	-.24
Composite Score	-.33

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All patients who had CGAS ratings also had CAFAS ratings. In addition, there were 432 patients who had only CAFAS ratings (total n =614 for CAFAS/CASII rating combinations). Mean CASII composite score on these 614 patients was 20 with a range of 8-34 while CAFAS composite score mean was 96 with a range of 0 to 200.

The table below shows the Pearson Correlation Coefficients between the CASII scores and the CAFAS composite score. As with the CASII/CGAS correlations, those CASII scales that reflect attributes about the child were moderately correlated with the CAFAS composite score: Risk of Harm, Functional Status and Resiliency and/or Response to Services. With the CAFAS scores, the Co-Occurrence of Conditions scale was more highly correlated than with the CGAS. Also, just as with the CGAS comparison, the CASII sub-scales having to do with environment and not related to the child directly (environmental support, parent involvement) was lower (.11 - .22). For comparison, for those patients who had both CAFAS and CGAS scores (n=182), this correlation was computed to be 0.50.

Correlation of CASII Subscale and Composite Scores With CAFAS Composite Score (n=614)

	Pearson Correlations with CAFAS composite score
Risk of Harm	.51
Functional Status	.52
Co-Occurrence of Conditions	.41
Environmental Stress	.35
Environmental Support	.22
Resiliency and/or Response	.50
Parent Involvement	.11
Child Involvement	.31
Composite CASII Score	.62
CGAS (n=182)	.50

Subsequent Studies

Subsequent studies have further established the CASII as a reliable and valid instrument in child welfare populations and juvenile justice populations as well as other child mental health settings. The CASII was evaluated in child welfare and juvenile justice populations in the context of the annual survey of children in state custody by the state of Tennessee's Children's Placement Outcome Review Team (C-PORT) program (Pumariega, et al, 2006; Pumariega, et al, In Press). The studies demonstrated strong external validity correlations between the CASII Total Score and Recommended Level of Care not only to the CAFAS (Hodges and Wong, 1996) Total Score but also the Child Behavior Checklist, Youth Self Report, and Teacher Report Total and T scores (Achenbach, 1991). In both the child welfare and juvenile justice populations the CASII demonstrated a stronger correlation to the Child and Family Indicators outcomes measure of C-PORT than the actual level of care the youth was placed in. It also demonstrated the potential to step down a number of youth from unnecessarily high levels of care they were placed in, while demonstrating that some youth needed more intensive community-based services than they were receiving.

The Hawaii Child and Adolescent Mental Health Division began using the CASII in 2001, being the first state that received system-wide training for their child welfare population. Daleiden (2004) reported on the results of the first two years' use of the CASII, including longitudinal rating of 3,305 children and youth over 10 fiscal quarters (July 2000 to June 2003), He found that the CASII had a strong concurrent validity versus the CAFAS as well as prospective validity demonstrated by continued correlations between CASII and CAFAS scores out to ten quarters, but also was significantly predictive validity for services restrictiveness and services cost. Daleiden et al (2006) also used the CASII as an outcomes evaluation instrument to measure population outcomes for the Hawaii statewide system of care and found that it demonstrated overall acceleration of improvement in the population as did the CAFAS over a four year period. Tolman et al (2008) also demonstrated that CASII total and level of care scores correlated to therapist assessment of improvement from Multisystemic Therapy in Hawaii's system of care, and that youth who improved had a mean reduction of 1 level of care (from 3.5 to 2.5).

The state of Minnesota also conducted its own pilot evaluation of the CASII in its child and adolescent mental health system (Children's Mental Health Division, Minnesota Department of Human Services, 2008). In its evaluation they rated 4239 children and youth for initial evaluation, 1679 at 6 months' evaluation, and 435 at 12 month follow-up. They found that CASII Scores ranged across all seven levels of care and decreased significantly from initial administration to 6-month follow-up and from 6-month follow-up to 12-month follow-up, suggesting that it discriminates between services needs and assesses changes in service needs and functioning over time. On average, children/adolescents that were identified by the CASII as having higher services need were recommended more hours of services and more hours of services by providers. CASII test-retest validity was similar to previous studies and comparable instruments. The CASII also was significantly correlated to all versions of the Strengths and Difficulties Questionnaire (Goodman, 1997), including the Parent SDQ, Teacher SDQ, and Self SDQ. CASII scores related significantly to all types of providers' service recommendations.

Subsequently,, multiple peer reviewed published studies in multiple service settings with diverse populations over the past 20 years have added to the evidence base that the CALOCUS-CASII is a reliable and valid instrument that is useful in supporting cost effective care and is easy to use.

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