SECTION III

PART VI

CASII INSTRUMENT

Evaluation Parameters for Assessment of Service Needs

Definitions

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 him/herself and of harming others. While Risk of Harm most frequently is manifested by suicidal or homicidal behavior, it also may embody unintentional harm from misinterpretations of reality; inability to adequately care for oneself or temper impulses with judgment; or intoxication. Furthermore, Risk of Harm may be manifested by a child or adolescent's inability to perceive threats to safety and to take appropriate action to be safe. In this regard, younger children and children with developmental or other disabilities, unless protected, are more vulnerable. It also is true that 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 should be considered in determining the likelihood of such behavior, such as past history of dangerous behavior and/or abuse and/or neglect, ability to contract for safety, and ability 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.
e. Other: ______________________________

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.

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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.
g. Other: ________________________________

3. SIGNIFICANT RISK OF HARM

a. Significant current suicidal or homicidal ideation with some intent and plan, with the ability of the child or adolescent and his/her family to contract for safety and carry out a safety plan. Child or adolescent expresses some aversion to carrying out such behavior.
b. No active suicidal/homicidal ideation, but extreme distress and/or a 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 (e.g. status offenses, impulsive acts while intoxicated; self-mutilation; running away from home or facility 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.
g. Other: ________________________________

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. 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/adolescent or family to restrict use.
e. Clear and persistent inability, given developmental abilities, to maintain physical safety and/or use environment for safety.
f. Other: ________________________________

Note: A rating of serious risk of harm requires care at level 5 (non-secure, 24-hour services with psychiatric monitoring), independent of other dimensions.

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;
    i. Without expressed ambivalence or significant barriers to doing so, or
    ii. 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.

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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.
e. Other: ____________________________________

Note: A rating of extreme risk of harm requires care at level 6 (secure, 24-hour services with psychiatric management), independent of other dimensions.

DIMENSION II. FUNCTIONAL STATUS

This dimension measures changes in the degree to which a child or adolescent is able to fulfill responsibilities and to interact with others, changes in sleeping, eating habits, activity level, or sexual interest, and capacity for self-care. Functioning may be compared against what would be expected for a child or adolescent at a given developmental level, or may be compared to a baseline functional level for that individual. 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 are not considered in determining level of service need in the behavioral service continuum. Functional deficits that are ongoing and may place a child or adolescent at risk of harm are rated on Dimension I, such as the failure of a child with autism to understand the risk of safety when crossing a busy intersection. Clinicians also need to be aware that psychosocial functioning may be under-estimated in the context of low socioeconomic status or different expectations about functioning for children and adolescents of culturally distinct backgrounds.

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/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.
c. Other: ____________________________________

2. MILD FUNCTIONAL IMPAIRMENT

a. Evidence of minor deterioration, or episodic failure to achieve expected levels of functioning, in relationships with peers, adults, and/or family (e.g., 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

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compromised.

c. Demonstrates significant improvement in function following a period of deterioration.
d. Other: ______________________________

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 physical disturbances in sleeping, eating habits, or activity level that do not pose a serious threat to health.
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. (Absenteeism may be frequent. The child or youth is at risk for repeating their grade.)
e. Chronic and/or variably severe deficits in interpersonal relationships, 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 services in a structured, protected, and/or enriched setting.
g. Other: ______________________________

4. SERIOUS FUNCTIONAL IMPAIRMENT

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 physical disturbances such as weight change, disrupted sleep or fatigue, and feeding or elimination, which threaten health and functioning.
e. Inability to perform adequately even in a specialized school setting due to disruptive or aggressive behavior. School attendance may be sporadic. The child or adolescent has multiple academic failures.
f. Other: ______________________________

Note: A rating of serious functional impairment requires care at level 5 (non-secure, 24-hour services with psychiatric monitoring), independent of other dimensions. The only exception to this is if the sum of IVA & IVB = 2, indicating both a minimally stressful and a highly supportive recovering environment.

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, 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 compromise of health and well

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being.

e. Nearly complete inability to maintain any appropriate school behavior and/or academic achievement given age and developmental level.
f. Other: ______________________________

Note: A rating of severe functional impairment requires care at level 6 (secure, 24-hour services with psychiatric management), independent of other dimensions. The only exception to this is if the sum of IVA & IVB = 2, indicating both a minimally stressful and a highly supportive recovering environment.

DIMENSION III. CO-OCCURRENCE OF CONDITIONS: DEVELOPMENTAL, MEDICAL, SUBSTANCE USE, AND PSYCHIATRIC

This dimension measures the coexistence of conditions across four domains (developmental, medical, substance use, and psychiatric), but does not consider co-occurring conditions within each domain. Coexisting conditions across domains may prolong the course of illness, or necessitate the use of more intensive or restrictive, or additional, services. Physiologic withdrawal states related to substance use should be considered medical conditions for scoring purposes. Users of the CASII must be alert to the under-recognition of co-occurring conditions in children from lower socioeconomic backgrounds and culturally distinct backgrounds that are underserved.

NOTE: If a child or adolescent has more than one condition in the same domain (e.g., two medical, developmental, substance use, or psychiatric disorders), the second does not count as a co-occurring condition for purposes of scoring. For example, two medical conditions, such as diabetes and asthma or two psychiatric conditions, such as attention-deficit/hyperactivity disorder and major depressive disorder, are not counted as co-occurring conditions for the purposes of scoring the CASII.

1. NO CO-OCCURRENCE

a. No evidence of medical illness, substance abuse, developmental disability, or psychiatric disturbances apart from the presenting problem.
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 problem.
c. Other: ______________________________

2. MINOR CO-OCCURRENCE

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 that 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 pattern of escalation, with no indication of adverse effect on functioning or the presenting problem.
d. Transient, occasional, stress-related psychiatric symptoms are present that have no discernable impact on the presenting problem.

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e. Other: ________________________________

3. SIGNIFICANT CO-OCCURRENCE

a. Developmental disability is present that may adversely affect the presenting problem, and/or may require significant augmentation or alteration of services for the presenting problem or co-occurring condition, or adversely affects the presenting problem.
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 problem.
d. Substance abuse is present, with significant adverse effect on functioning and the presenting problem.
e. Recent substance use that has significant impact on the presenting problem and that 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 and persist in the absence of stress, are moderately debilitating, and adversely affect the presenting problem.
g. Other: ________________________________

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 disorder.
c. Uncontrolled substance use is present that poses a serious threat to health if unabated and impedes recovery from the presenting problem.
d. Developmental delay or condition is present that will adversely affect the course, treatment, or outcome of the presenting condition.
e. Psychiatric symptoms are present that clearly impair functioning, persist in the absence of stressors, and seriously impair recovery from the presenting problem.
f. Other: ________________________________

Note: A rating of major co-occurrence requires care at a level of 5 (non-secure, 24-hour services with psychiatric monitoring), independent of other dimensions. The only exception to this is if the sum of IVA & IVB = 2, indicating both a minimally stressful and a highly supportive recovering environment.

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 problem.
c. Substance dependence is present, with inability to control use, intense withdrawal symptoms and extreme negative impact on the presenting disorder.

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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 services for the presenting problem, or otherwise prevent recovery from the presenting problem.
f. Other: ______________________________

Note: A rating of severe co-occurrence requires care at level 6 (secure, 24-hour services with psychiatric management), independent of other dimensions.

DIMENSION IV. RECOVERY ENVIRONMENT

This dimension considers environmental factors that have the potential to impact a youth's efforts to achieve or maintain recovery. Scoring this domain requires balancing those factors that promote resiliency and ongoing success in attaining life's goals with factors in the environment that may have contributed to the onset or maintenance of the primary disorder. The influence of and dependence on the environment can not be underestimated, even as children and adolescents mature to progressively more autonomous individuals. The recovery environment should not be considered narrowly, but should instead include family, natural supports, school, medical services, juvenile justice and other community supports.

Supportive elements in the environment include, first and foremost, the presence of consistent, supportive, and ongoing relationships with family members. It is important to remember that family can be defined in many different ways, and can have different cultural meanings. Other important supportive factors include the availability of adequate housing and material resources, consistent and supportive relationships with relatives, friends, employers, teachers, clergy, professionals, and other community members. Clinicians must be alert to underestimation of family, cultural, and community strengths. The breadth of family, cultural, and community strengths are often not evident in the midst of stressful life circumstances, or acute crisis, but may become apparent after the engagement of ongoing services. The recognition and mobilization of community supports/strengths is a vital component of the recovery process.

The rating of this dimension is inherently dependent on the child or youth's context, and may change rapidly with a change in level or intensity of services. This dimension may be helpful when considering service needs and/or recruitment of supportive services, especially when considering a change in intensity. Consider a child or youth in a secure environment being provided with constant monitoring (Level 6) who is doing well, whose home environment is unsafe due to a lack of adult supervision at certain times throughout the day. This child may have difficulty maintaining gains if moved to a lower service intensity without appropriate supportive services being brought to bear. This example reveals the complex interaction of environment and service delivery/intensity, and the importance of considering how these elements might change with change in context. When the discharge environment results in a higher score in this domain, it may be necessary to mobilize additional services to sufficiently support stabilization and recovery and increase the potential for success. Thus, it maybe helpful for service planning purposes to rate both the environment the child is leaving (hospital, residential treatment, foster care, etc.) and the environment that will be receiving the child.

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Stressful life elements have the potential to negatively impact a youth or family's level of distress or functioning. They include, but are not limited to, interpersonal conflict or trauma, life transitions, losses, worries relating to health and safety, and difficulty in maintaining role responsibilities. It is important to remember that even eagerly anticipated family events have the potential to be stressful life elements for a child/youth and/or family. Stressful life events do not include events that the youth has created, such as being expelled from school, but rather include those events that come to the child such as a loss of a parent or a family move.

Environmental Stress

1. ABSENT

a. Absence of significant or enduring difficulties in environment and life circumstances not expected to change significantly.
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 normative and congruent with child or adolescent's age, capacities and/or developmental level.
f. Other: ______________________________

2. MILD

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, 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.
g. Other: ______________________________

3. MODERATE

a. Disruption of family/social milieu (e.g., move to significantly different living situation, absence or addition of parent or other primary care taker, serious legal or school difficulties, serious drop in capacity of parent or usual primary care taker 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, unremitting pain, or other disabling condition.
d. Danger or threat in neighborhood or community, or sustained harassment by peers or others.

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e. Exposure to substance abuse and its effects.
f. Role expectations that exceed child or adolescent's capacity, given his/her age, status, and developmental level.
g. Other: ________________________________

4. SERIOUS

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 and/or neighborhood.
e. Difficulty avoiding substance use and its effects.
f. Other: ________________________

5. SEVERE

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 a 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 alien 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.

e. Other: ________________________________

Environmental Support

1. OPTIMAL

a. Family and ordinary community resources address child or adolescent's developmental and material needs without outside intervention.
b. Continuity of active, engaged primary care takers, with a warm, caring relationship with at least one primary care taker.
c. Other: ________________________________

2. ADEQUATE

a. Continuity of family or primary care takers is only occasionally disrupted, and/or relationships with family or primary care takers are only occasionally inconsistent.
b. Family/primary care takers are willing and able to participate in services 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

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material needs.
e. Other: ____

3. LIMITED

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 the course of treatment.
d. Other: ____

4. MINIMAL

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 primary care takers display limited ability to participate in services and/or the service plan (e.g., not involved).
d. Other: ____

5. NONE

a. Family and/or other primary 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-servicing 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.
f. Other: ____

DIMENSION V. RESILIENCY AND/OR RESPONSE TO SERVICES

This dimension records a child or adolescent's ability to self-correct when there are disruptions in the environment. This includes the ability to use the environment as well as the child/adolescent's own internal resources. This judgment can be made by considering how well the child or adolescent has responded to the services in the past, but consideration should also be given to responses to stressor and life changes.

For children/adolescents who have faced major life changes and respond adaptively, the score will be low. For children/adolescents who are sensitive to minor changes such as schedule disruptions, the score will be higher. Most children/youth in the autistic spectrum struggle with particular sensitivities that leave them much less flexible to manage the minor bumps of life.

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Children/youth may respond well to some services and poorly to others. The response to services in some cases may not be related to level of intensity, but rather to the characteristics, acceptability, and/or cultural competency of the service provided. Because children and adolescents rarely have long histories of receiving services, their responses to stressors and life changes in the absence of professional intervention should be considered as well.

Most recent experiences with services should take precedence over more remote experiences in determining the score. For younger children who may not have involvement in any services, responses to developmental challenges without professional involvement may be as indicative of resiliency as service history.

Recovery for children and adolescents is defined not only as a period of stability and control of problems, but also as a continuation or resumption of progress toward an expected developmental level for a given child or adolescent.

1. FULL RESILIENCY AND/OR RESPONSE TO SERVICES

a. Child/youth has demonstrated significant and consistent capacity to maintain development in the face of normal challenges, or to readily resume normal development following extraordinary challenges.
b. 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.
c. There has been successful management of extended recovery with few and limited periods of relapse even in unstructured environments or without frequent services.
d. Able to transition successfully and accept changes in routing without support; optimal flexibility.
e. Other: ______________________________

2. SIGNIFICANT RESILIENCY AND/OR RESPONSE TO SERVICES

a. Child/youth demonstrated average ability to deal with stressors and maintain developmental progress.
b. Previous experience with services has been effective in controlling symptoms but more lengthy intervention is required.
c. Significant ability to manage recovery has been demonstrated for extended periods, but has required structured settings 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.
f. Other: ______________________________

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 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 of time, but only with strong professional or peer support or in structured settings..

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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.
f. Other: ______________________________

4. POOR RESILIENCY AND/OR RESPONSE TO SERVICES

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.
f. Other: ______________________________

5. NEGLIGIBLE RESILIENCY AND/OR RESPONSE TO SERVICES

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 have 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.
f. Other: ______________________________

DIMENSION VI. INVOLVEMENT IN SERVICES

This dimension is designed to reflect the quantity and quality of the child/youth and primary care taker's involvement in services. For the purpose of the CASII, services include an array of therapeutic interventions to address the child/youth and primary care taker's needs. The sub-scales reflect the importance of the parent and/or primary care taker's participation in the intake, planning, implementation, and maintenance phases of services.

There are many factors which can impact client involvement in service planning and delivery, including experiences with services that are not effective, culturally competent, or collaborative. The rating of this dimension does not evaluate the cause of limited involvement, but instead rates only the quantity and quality of involvement in services.

A high rating in this dimension should trigger a collaborative and thoughtful consideration of past and current services in order to identify services and supports that promote participation and are most appropriate to the level of need of the child/youth and/or family. This dimension can serve as

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serve as an early indicator of the need to modify services or strengthen service relationships so that there is likelihood of positive outcomes.

The *cause* of a high score in this domain may need to be evaluated and addressed in order to successfully implement specific, collaborative, client-centered goals for treatment and recovery. For example, a care provider who is not aware of cultural differences between care providers, child/youth and/or family may inadvertently increase barriers to proper assessment and service delivery, because cultural values can influence service understanding and acceptance. Consultation with or addition of cultural specialists may eliminate cultural barriers to effective service.

Only the higher of the two sub-scale scores (child or adolescent vs. parent and/or primary care taker) is added into the composite score. In addition, if a child or adolescent is legally emancipated and living independently, the parent and/or primary care taker sub-scale is not scored.

Child or adolescent involvement in services

The child/youth sub-scale measures the quality of the child or adolescent's therapeutic relationships as well as the quality and quantity of involvement in service planning and delivery. When rating this dimension one may need to consider engagement in previous service relationships, although the ultimate score should stress current participation. The rater should also consider what level of engagement is developmentally appropriate for the child or youth. A higher score reflects consistent inability to follow through on essential components of services (i.e. not attending sessions), lack of engagement in therapeutic relationships with current providers, and/or inability to reach consensus regarding service planning.

1. OPTIMAL

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.
e. Other: ______________________________

2. ADEQUATE

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.
e. Other: ______________________________

3. LIMITED

a. Ambivalent, avoidant, or distrustful relationship with clinicians and other care providers.

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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.
f. Other: ______________________________

4. MINIMAL

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.
d. Other: ______________________________

5. ABSENT

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.
d. Other: ______________________________

Parent and/or primary care taker involvement in services

The parent sub-scale measures the quality of the child or adolescent's therapeutic relationships as well as the quality and quantity of involvement in service planning and service. When rating this dimension one may need to consider engagement in previous service relationships, although the ultimate score should stress current participation. A higher score reflects consistent inability to follow through on essential components of services (i.e. not attending sessions or not bringing child to session), lack of engagement in therapeutic relationships with current providers, and/or inability to reach consensus regarding service planning.

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 problem.
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 participation in services.
e. Other: ______________________________

2. ADEQUATE

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 primary care takers in development of service plan.

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d. Cooperates with service plan, with behavior change and good follow-through on interventions.
e. Other: ________________________________

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 service plan, with inconsistent follow-through.
e. Other: ________________________________

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 change in other family members.
d. Engages in behaviors that are inconsistent with the service plan.
e. Other: ________________________________

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. Unable to form relationship with clinician or other care provider due to significant cognitive difficulties, psychosis, intoxication, or major mental illness or impairment.
e. Other: ________________________________

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PART VII

CASII LEVELS OF SERVICE INTENSITY CRITERIA

The levels of service intensity described in the CASII represent a graded continuum of services designed for use with the CASII dimensional assessments and composite score. At each level of service, a broad range of programming options, allowing for variations in practice patterns and resources among communities, is described. The continuum encompasses traditional services, as well as newer forms of care, such as those in plans inspired by CASSP Principles. Each level of service intensity subsumes the services at every level below it. (See Appendix A.)

The system of care described in this document includes, but is not limited to, services provided by mental health, social services, juvenile justice, health, education, substance abuse, vocational, developmental disability, and recreational agencies, as well as other programs with unique funding streams and overlapping functions.

Children and adolescents with multiple complex problems usually require the services of multiple components within the system of care. In these cases, integrating care is essential. This document advocates for the use of child/youth and family teams, composed of family members, supportive members of the family's community, and service providers from a spectrum of components in the system of care. These teams give families a role in directing care by bringing together with the family all those with the potential to assist the child or adolescent. These teams may be given various names in different localities, but should include representatives from as many components as necessary from the local system of care. Optimally, Wraparound service principles form the basis for sharing resources and blending services in an individualized service plan for a child or adolescent and family (VanDenBerg and Grealish, 1996).

The CASII levels of service intensity also provide rough estimates of the staff time involved in providing services at different levels. The actual service time required by each child or adolescent and family is highly variable. However, in the aggregate, service time estimates may be of value to program planners.

Level of Service Intensity Transitions

The needs of a child or adolescent and family in services are likely to change as services progress. For example, the needed level of service intensity may drop below the provided level of service intensity, and/or the child/youth's status may indicate that care may be better provided in either traditional or Wraparound configurations. Level of service intensity transitions need not occur sequentially. It may be desirable for a child or adolescent to remain at a higher level of service intensity to preclude relapse and unnecessary disruption of care, and to promote lasting stability.

A child or adolescent may make the transition to another level of service intensity when, after an adequate period of stabilization and based on the family's and service team's clinical judgment, the child or adolescent meets the criteria for the other level of service intensity. Re-administration of the CASII can help clinicians determine a child or adolescent's readiness for another level of service intensity, and can help identify the foci of subsequent services. A flexible Individualized

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flexible Individualized Service (Wraparound) Plan can facilitate seamless transitions, with the same clinicians and staff providing care at multiple service levels whenever possible.

Multidisciplinary Service Teams
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 care of children and adolescents. Programs should be licensed to offer the requisite services for the levels of service intensity 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 highly 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, nurses, independent nurse practitioners, substance abuse clinicians, and/or pastoral counselors), and with training specifically to work with children, youth, and their families. Clinicians should provide care that is within their scope of practice. Non-credentialed staff or paraprofessionals providing therapeutic services as part of the service plan should receive supervision by licensed practitioners with training and expertise to work with children, youth, and their families. In addition, family members and/or members of the child or adolescent's community may provide an array of non-clinical supports.

Nothing in this document precludes a child and adolescent psychiatrist from being the primary clinician for both psychotherapeutic and medication services. In addition, at all levels of service intensity including crisis intervention, access to child and adolescent psychiatrists is an essential element of the service system.

The levels of service 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.

Even with conscientious assessment and scoring of the CASII, critical differences among children and adolescents and their families may demand an Individualized Service Plan (ISP) encompassing services at more than one level of service intensity. Measured and informed clinical judgment and service planning with the family take precedence. Reasons for deviation from the level of service intensity recommended by the instrument should be documented by the clinician in the case record.

LEVEL 0. BASIC SERVICES FOR PREVENTION AND 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 may be provided through traditional means, as well as through print and broadcast media (e.g., public service announcements and/or targeted mailings).

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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. Expert evaluations should be readily available. Linkage with mental health and substance abuse services (e.g., scheduling intakes) should be provided to families identified in screening assessment. 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 sites, including schools and adult education centers, day care and recreational/social settings, vocational and social services agencies, and medical settings. Community volunteers and agency staff should be trained to provide prevention services.

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 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 at many sites, from a child or adolescent's home, to schools, churches, medical, recreational, or traditional mental health settings. Services 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).

Placement Criteria

All children, adolescents, and families should receive Basic Services.

LEVEL ONE. RECOVERY MAINTENANCE AND HEALTH MANAGEMENT

Level One services typically provide follow-up care to mobilize family strengths and reinforce linkages to natural supports. Those children and adolescents appropriate for Level One services either may 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.

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1. **CLINICAL SERVICES**. 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 intensity. 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, 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.

2. **SUPPORT SERVICES**. Level One support services consist mainly of natural supports in the community, including extended family, family friends, and neighbors; church and recreational programs; 12-step and other self-help programs; school-sponsored programs; and employment. Families appropriate to this level of service intensity have the capacity to access these community resources as needed without professional intervention.

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 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), or in other components in the system of care. Services 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 deaf or hard-of-hearing attendees, etc.). For adolescents, services should facilitate a mix of adult supervision with privacy for peer group activities. The environment should be safe and comfortable for children and adolescents at all developmental levels, as well as their families.

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 services at a more intensive level 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.

COMPOSITE SCORE (Level 1) **10 - 13**

<u>LEVEL TWO. OUTPATIENT SERVICES</u>

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