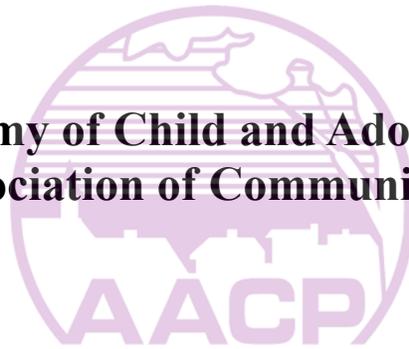


CALOCUS

Version 1.5

Child and Adolescent Level of Care Utilization System

**American Academy of Child and Adolescent Psychiatry
American Association of Community Psychiatrists**



Edited by:

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PART I

HISTORICAL PERSPECTIVE

The need for the Child and Adolescent Level Of Care Utilization System (CALOCUS) stems from the progressive development since the mid-1980's of Systems of Care for children and adolescents with serious emotional disturbances. These systems have been further impacted by the development of managed care principles during the 1990's. These two threads in children's mental health have resulted in the majority of children and adolescents being treated in community settings with limited access to inpatient and residential services. CALOCUS provides a framework for defining the appropriate character and intensity of both services and resources to meet the needs of these children and adolescents.

Jane Knitter's 1982 book, Unclaimed Children: The Failure of Public Responsibility to Children and Adolescents In Need of Mental Health Services, was the first to identify significant services gaps for those children most in need of care. She also found that many children were inappropriately receiving services at a higher level of care due to a lack of alternative resources. Ms. Knitter was perhaps the first to recommend "a coordinated range of services for troubled children and adolescents" and the development of "placement standards...that ensure children are placed in hospitals only when necessary."

The federal Child and Adolescent Services System Program (CASSP) was founded in 1984 as a response to these identified problems. The 1986 monograph, A System of Care for Children and Youth With Serious Emotional Disturbances, by Beth Stroul, M.Ed. and Robert M. Friedman, Ph.D. clearly articulates the need for a coordinated continuum of care that includes a broad array of community-based services. The monograph also provided a set of "Guiding Principles" for the development of local systems of care. These principles are included in Appendix A.

Also essential in the development of multiple levels of care are the principles of "Wraparound" or "Individualized Services." The development of a Wraparound plan for a child does not rely solely on pre-existing programs or agency services. Rather, it is a comprehensive plan, using both formal and informal supports, to remediate weaknesses and build on existing strengths of the child and his/her family. Augmented by the inclusion of Wraparound services, the System of Care approach has been implemented in some areas so that many children and adolescents can now be safely and effectively treated in community settings.

As managed care has progressed in the 1990's; there has been a greater emphasis on using cost-effective treatments. Though managed care has often been associated with the denial of services; it can be a useful tool for effective utilization of limited mental health and associated resources. Too often, there has been disagreement between payers, providers and consumers as to the most appropriate Level of Care. VanDenBerg and Grealish pointed out in a 1996 article that, "If the adults disagree, the child fails." It is hoped that the CALOCUS will help to provide a consensus on level of care determination that is urgently needed.

PART II

FOUNDATIONS AND PRINCIPLES

There have been a number of previous attempts to use clinical assessments as a method of determining level of care needs in children and adolescents. However there has been no clearly defined method for linking the clinical assessment to the need for treatment, or the level of care best suited to deliver this treatment. The previous instruments gave us some idea of the child or adolescent's clinical status with regard to mood, anxiety, or thought process and other clinical areas of relevance, but they did not always have a direct connection with his/her holistic treatment needs.

Another approach to children and adolescent treatment placement focused on the development of criteria, which were specific to a given child or adolescent's mental health program. For example, a day hospital might have a set of criteria, which would describe the type of patient that was deemed most appropriate for that program. This idea evolved into the concept of "level of care" which attempted to group services of similar intensity together. Standardized and specific criteria were also developed along with "level of care" definitions.

Finally, the combination of these two concepts resulted in the development of "dimensional", assessments for "level of care" determinations. This process now combines the assessment related to a child or adolescent's clinical needs, or functional status, with a set of clearly defined levels of care, and subsequently develops a methodology for matching clinical needs to treatment resources. This structure for assigning appropriate level of care was first developed for LOCUS, by the American Association of Community Psychiatrists.

The CALOCUS instrument is a method of quantifying the clinical severity and service needs of three quite different populations of children and adolescents. It may be used in children with psychiatric disorders, substance use disorders, or developmental disorders, and has the ability to integrate these as overlapping clinical issues. This differs from the adult instrument LOCUS, which did not incorporate patients with developmental disorders.

CALOCUS begins by defining a set of dimensions for assessment that, although limited in number, are all relevant to the type of services that a child or adolescent would need. Our intent was that the ratings used would be simple, yet specific in their content, so there would not be a great deal of complexity, or confusion, in making decisions. The ratings would be quantifiable in order to convey information easily, but also provide a spectrum along which a child or adolescent may lie on any given dimension. Thus, these quantifiable ratings would allow a composite rating score to be obtained that would be the result of the interaction of each of the individual dimension scores. This integration of multiple dimensions is the essence of the CALOCUS instrument. It is this that guides the user to an appropriate CALOCUS level of care assignment.

Cultural competency is essential to accurate use of CALOCUS. A clear understanding of the cultural factors influencing each dimension is important; the dimension of Treatment, Acceptance and Engagement is particularly sensitive to these factors. The use of a cultural consultant may be very helpful in situations where there is a lack of clarity.

In order to develop an instrument applicable to a wide variety of treatment environments and child or adolescent needs it was important to develop a set of definitions for levels of care that described the resource intensities needed at each specific level of care. These definitions needed to be flexible and adaptable, in order to be broadly applicable to the wide variety of treatment environments in which care would be given. This approach was chosen to allow service providers to give adequate clinical services and quality care in the most economic and realistic fashion.

Administration or ease of use, of the instrument was also important. It was anticipated that ease of use, time and universal adaptability would be critical factors in establishing the broad acceptability of CALOCUS. This could lead to the establishment of a single standard agreed upon for use with children and adolescents by insurance agencies, service providers and consumers.

CALOCUS employs multi-disciplinary/multi-informant perspectives on children and adolescents and is designed to be used by a variety of mental health professionals. Although it is primarily used for initial level of care placement decisions, it can be used at all stages of treatment to assess the level of intensity of services needed. An important aspect of CALOCUS is its potential use for fee for service utilization management. Many instruments in the past have developed separate criteria for hospital admissions, continuing care and discharge planning. The CALOCUS instrument makes it unnecessary to use different criteria because of the “dynamic” nature of the quantifiable dimensional ratings. CALOCUS could also be applied to activities such as treatment planning, outcome monitoring and program development.

There are a number of things that CALOCUS will not do. It will not prescribe program design, but rather the type and intensity of resources that need to be available in that program. It does not specify treatment intervention, and it does not invalidate the importance of clinical judgement. CALOCUS also does not limit our creativity in developing specific treatment programs that meet the needs of special populations or localities. This will continue to be the role of the professional clinician.

The following sections of this manual will provide you with more detail regarding the CALOCUS instrument and its appropriate use with children and adolescents.

PART III

CALOCUS DIMENSIONAL RATING SYSTEM

The CALOCUS dimensional rating system is used to determine the intensity of a child or adolescent's service needs. It operationalizes many of the factors clinicians would consider in determining the most appropriate services and level of care needed. Each dimension has a five point rating scale, from least to most severe. For each of the five possible ratings within each dimension, a set of criteria is clearly defined. Only one criterion needs to be met for that rating to be selected. Therefore, for each dimension, the highest rating in which at least one of the criteria is met is the rating that should be assigned.

CALOCUS has six dimensions:

RISK OF HARM: This dimension is an expansion of the LOCUS dangerousness dimension, necessitated by a child's developmental vulnerability to victimization. Thus, this dimension is the measurement of a child or adolescent's risk of self-harm by various means and an assessment of his/her potential for being a victim of physical or sexual abuse, neglect or violence.

FUNCTIONAL STATUS: This dimension measures the impact of a child or adolescent's primary condition on his/her daily life. It is an assessment of the child's ability to function in all age-appropriate roles: family member, friend and student. It is also a measure of the effect of the primary problem on such basic daily activities as eating, sleeping and personal hygiene.

CO-MORBIDITY: This dimension measures the co-existence of disorders across four domains: Developmental Disability, Medical, Substance Abuse, and Psychiatric. Remember, if the primary condition is a substance abuse problem or a developmental disability, then any psychiatric condition also present would be considered a co-morbid condition.

RECOVERY ENVIRONMENT: This dimension is divided into 2 sub-scales: Environmental Stress and Environmental Support. An understanding of the strengths and weaknesses of the child or adolescent's family is essential to choosing an accurate rating in this dimension. It is also a measure of the neighborhood and community's role in either worsening or improving the child or adolescent's condition. Thus, high ratings on both these sub-scales (Extremely Stressful Environment and No Support in Environment) will have a major impact on both the composite score and the actual level of care chosen.

RESILIENCY AND TREATMENT HISTORY: Resiliency refers to a child or adolescent's innate or constitutional emotional strength, as well as the capacity for successful adaptation (Rutter, 1990). The concept of resiliency is familiar to clinicians who treat children or adolescents who have the most severe disorders and/or survive the most traumatic life circumstances, yet who either maintain high functioning and developmental progress, or use treatment for a rapid return to that state. This dimension also measures the extent to which the child or adolescent and his/her family have responded favorably to past treatment.

ACCEPTANCE AND ENGAGEMENT (Scale A-Child/Adolescent, Scale-B Parents/Primary Caretaker): This dimension is divided into two sub-scales to allow for

measurement of both the child or adolescent's and his/her family's acceptance and engagement. Clearly, the child or adolescent's treatment benefits when the family is proactively and positively engaged, and conversely, treatment suffers when the family is disinterested, disruptive or openly hostile toward the process. Only the highest sub-scale score (the sub-scale indicating the most significant challenge to treatment) is used in calculating the composite score.

Use of Dimensions

In order to understand what each parameter is measuring, it is important to review the introductory paragraphs for each dimension carefully, beginning on page 12. *Remember, you want to select the highest rating in each dimension, where at least one of the criteria is met.* In some cases, the actual clinical picture may not fit any of the criteria on the rating scales exactly. In that situation, users should pick the closest fit or choose the criterion that most closely approximates the actual condition of the child or adolescent they are considering.

When there is some confusion about which rating should be assigned, and you are not certain which is the closest fit, you should choose the higher rating. No instrument can anticipate every circumstance, or be so general that it can be applied to every situation, so a great deal of clinical judgement will be needed. Although the instrument does supply some guidelines, the clinician is required to make a determination as to which rating within each dimension is most appropriate. The clinician should base their decision on the interview with the child or adolescent, and all other available clinical information. The sources of information may include, but not be limited to other clinical reports, school records, other agency reports, mental health status examinations and/or family interviews.

In the evaluation of children and adolescents, a multi-informant approach that integrates information about the child and family from multiple sources and observers should be used. Scores in CALOCUS are based on the child or adolescent's status at the time of administration of the instrument. Scores for a particular child or adolescent can be expected to change, especially in crisis situations and as interventions are implemented. When an individual's life circumstances are stable or functioning has not deviated much from baseline, scores likewise may not change dramatically. Clinicians should use judgment to determine how frequently to re-administer the instrument during treatment. As a general rule, CALOCUS should be administered at the beginning of treatment, at points of significant change (such as on consideration of a change in level of care), and at the termination of services. Under most circumstances, CALOCUS should be administered more frequently at the higher levels of care.

PART IV

LEVEL OF CARE SERVICES

The Levels of Care in CALOCUS are organized in a unique way. In CALOCUS, the focus is on the level of resource intensity, which is more flexibly defined in order to meet the child or adolescent's needs. Each level of care is defined by a combination of service variables: physical facilities (care environment), clinical services, support services, crisis stabilization and prevention services. Some levels of care may contain the same resources found at other levels of care. With higher levels of care, a greater number and variety of services are utilized. In addition, the need for active case management of services will increase at the higher levels.

The levels of care are defined so that they can be effectively used regardless of the extent of collaboration in a local system of care. In a community with a more traditional array of services, the higher levels of care will necessarily be provided in residential or inpatient settings. In areas where there is an active use of the Wraparound process in a community-based system of care, the higher levels of intensity of service can be provided in the least restrictive environment possible.

One way to think about the levels of care is to compare them with the difference between the services available in a single pediatrician's office (the lower levels of care) and a major medical center (higher levels of care). For well-baby checks and most common medical conditions, a child or adolescent can be treated in the pediatrician's office. For more complex problems, especially those that are potentially disabling or life threatening, treatment at a major medical center would be appropriate due to the wider array of services and the availability of specialists.

In CALOCUS, there are seven levels of care:

- Level 0: Basic Services. This is a basic package of prevention and health maintenance services that are available to everyone in the population being served, whether or not they need mental health care.
- Level 1: Recovery Maintenance and Health Management. This level of service is usually reserved for those stepping down from higher levels of care who need minimal system involvement to maintain their current level of function or need brief intervention to return to their previous level of functioning. Examples of this level of service are children or adolescents who only need ongoing medication services for a chronic condition or brief crisis counseling.
- Level 2: Outpatient Services. This level of care most closely resembles traditional office based practice and requires limited use of community-based services.

- Level 3: Intensive Outpatient Services. It is at this level that services begin to become more complex and more coordinated. The use of case management begins at this level. The use of child and family teams to develop Individualized Service (Wraparound) Plans also begins, using mostly informal community supports such as church or self-help groups and “Big Brothers/Big Sisters.” This level requires more frequent contact between providers of care and the youth and his family as the severity of disturbance increases.
- Level 4: Intensive Integrated Service Without 24-Hour Psychiatric Monitoring. This level of care best describes the increased intensity of services necessary for the “multisystem, multi-problem” child or adolescent requiring more extensive collaboration between the increased number of providers and agencies. A more elaborate Wraparound plan is also required, using an increased number of formal supports. Additional supports may include respite, homemaking services or paid mentors. In more traditional systems, this level of service is often provided in a day treatment or a partial hospitalization setting. Active case management is essential at this level of care.
- Level 5: Non-Secure, 24-Hour, Services with Psychiatric Monitoring. Traditionally, this level of care is provided in group homes or other unlocked residential facilities, but may be provided in foster care and even family homes if the level of Wraparound services in the community is extraordinarily high. In either case, a complex array of services should be in place around the child and a higher level of care coordination is needed in order to manage the child’s multiple needs.
- Level 6: Secure, 24-Hour, Services With Psychiatric Management. Most commonly, these services are provided in inpatient psychiatric settings or highly programmed residential facilities. If security needs could be met through the Wrap Around process, then this level of intensity of service could also be provided in a community setting. Case management remains essential to make sure that the time each child spends at this level of care is held to the minimum required for optimal care and that the transition to lower levels of care are smooth.

All of these levels will be discussed in greater detail, beginning on page 24 of this document.

PART V

PLACEMENT METHODOLOGY

As noted earlier, each dimension is defined along a scale of one to five. Each score in the scale is defined by one or more criteria. Only one of these criteria needs to be met for a score to be assigned to the subject. The clinician should select the highest rating level in each dimension that most accurately identifies the child or adolescent's condition.

Having provided you an overview of the dimensions, the rating system should be discussed. Once you have chosen a rating in each dimension, you use the composite score to arrive at a placement recommendation. The recommendation describes a level of resource intensity which best suits a given patient according to their needs. It does not mean that the child, adolescent or family needs to comply with the recommendation, nor that these are the only services that can be offered. The child, adolescent or family may have an option to choose a lower level of care than that being recommended, unless they are being involuntarily committed for their own safety or the safety of others.

Once scores have been assigned in all six-dimension parameters, they should be recorded on the worksheet and summed to obtain the composite score. Using the CALOCUS determination grid will now give you a rough estimate of the level of care recommendation. It is important to remember that in some cases, independent criteria are defined that will automatically place the child or adolescent in a specific level of care. This may be indicated regardless of their scores in other dimensions. For example, if an adolescent scores very high in suicidal or dangerous behavior, and has no ability to protect their safety outside of the protected setting, then that particular score would indicate placing the child or adolescent in at a level six intensity of service (usually provided in a locked psychiatric setting) no matter what other circumstances existed. These independent criteria are marked in the AACP/AACAP Level of Care Determination Decision Tree (see page 38) and the AACP/AACAP Level of Care Determination Grid (see page 40). The CALOCUS decision tree should be used for the most accurate recommendation. Though the independent criteria may predetermine the level of care, please complete the CALOCUS to obtain ratings in each dimension and a composite score.

When you come to assigning levels of care, there will be some treatment systems that do not have comprehensive services for all populations at every level of the continuum. If this is the case, then the level of care recommended by the CALOCUS 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. In most cases, the higher level of care should be selected, unless there is a clear and compelling rationale to do otherwise. This again will lead us to err on the side of caution and safety, rather than risk and instability. The CALOCUS Decision Tree is the most accurate way of determining what level of care a child/adolescent child or adolescent should be offered. Although it may at first sight look complicated, it is fairly simple to use once you become familiar with it. When using the CALOCUS Decision Tree, always begin at the appropriate "Entry Point" found at the top of the page. Then questions pertaining to the score in each dimension will help you arrive at a recommended level of care. It is important, when first using the Decision Tree, to read the questions carefully and pay close attention to the "ands" and "ors" before selecting a Yes or No response.

As a busy clinician you neither have to memorize the definition of each level of care, nor do you have to know the criteria for placement at that level. However, as you become more familiar with the criteria you will then be able to complete your assessments quicker and easier. Eventually you will want to develop an array of services that are available within your treatment system, for each level of care outlined in CALOCUS. So, when a level of care placement recommendation is given, you will know what services are needed to approach the requirements of that level, and also what pieces may need to be appended in order to complete the treatment plan. Services can always be customized according to local and cultural needs.

CALOCUS is a system that is not overly prescriptive. It is flexible and adaptable, and describes an array of services, and level of service or resource intensity, rather than a level of care per se. This quality should allow your treatment system to incorporate CALOCUS with ease.



CALOCUS 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.

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 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.

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.

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
 - iii. 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.

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 vegetative status, (such as sleeping, eating habits activity level, or sexual interest), and capacity for self-care. Functioning may be compared against what would be expected for a given 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 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. An example would be the failure of an autistic child 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 vegetative status.

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 self-care/hygiene/control of bodily functions are compromised.
- 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 vegetative activities, (such as sleeping, eating habits, activity level, or sexual interest), 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 is at risk for placement in an alternative school or expulsion due to their disruptive behavior. Absenteeism may be frequent. The child 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 treatment in a structured, protected, and/or enriched setting.

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 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 disruptive or aggressive behavior. School attendance may be sporadic. The child or adolescent has multiple academic failures.

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

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 vegetative function causing serious compromise of health and well being.

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

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 & IV B = 2, indicating both a minimally stressful and a highly supportive recovering environment.

DIMENSION III. CO-MORBIDITY: DEVELOPMENTAL, MEDICAL, SUBSTANCE USE, AND PSYCHIATRIC

This dimension measures the coexistence of disorders across four domains (developmental, medical, substance use, and psychiatric); but does not consider co-occurring disturbances within each domain. Coexisting disorders 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 co-morbidity for scoring purposes. Clinicians must be alert to the under-recognition of co-morbidity in children from lower socioeconomic backgrounds and culturally distinct backgrounds that are underserved.

NOTE: If a child or adolescent has more than one disorder in the same domain (e.g., two medical, developmental, substance use, or psychiatric disorders), the second does not count as “co-morbidity” for purposes of scoring on CALOCUS. 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-morbidity for the purposes of scoring CALOCUS.

1. NO CO-MORBIDITY

- 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.

2. MINOR CO-MORBIDITY

- 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.

3. SIGNIFICANT CO-MORBIDITY

- a. Developmental disability is present that may adversely affect the presenting problem, and/or may require significant augmentation or alteration of treatment for the presenting problem or co-morbid 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.

4. MAJOR CO-MORBIDITY

- 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 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.

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

5. SEVERE CO-MORBIDITY

- 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.
- d. Developmental disorder is present that seriously complicates, or is seriously compromised by, the presenting disorder.
- e. Acute or severe psychiatric symptoms are present that seriously impair functioning, and/or prevent voluntary participation in treatment for the presenting problem, or otherwise prevent recovery from the presenting problem.

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

DIMENSION IV. RECOVERY ENVIRONMENT

This dimension considers factors in the environment that may contribute to the onset or maintenance of the primary disorder, 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, where such strengths/resources may not be evident or may not be readily mobilized. Stressful circumstances may include interpersonal conflict 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, 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.

Environmental Stress

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 normative and congruent with child or adolescent's age, capacities and/or developmental level.

2. MILDLY STRESSFUL ENVIRONMENT

- 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.

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 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.
- 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.

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, 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.

5. EXTREMELY STRESSFUL ENVIRONMENT

- 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.

Environmental Support

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 care takers, with a warm, caring relationship with at least one primary care taker.

2. SUPPORTIVE ENVIRONMENT

- 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 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'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 care-takers demonstrate only partial ability to make necessary changes during treatment.

4. MINIMALLY SUPPORTIVE ENVIRONMENT

- a. Family or primary care taker 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 care takers display limited ability to participate in treatment and/or service plan (e.g., unwilling, inaccessible, cultural dissonance).

5. NO SUPPORT IN THE ENVIRONMENT

- a. Family and/or other primary care takers 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 care takers 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 TREATMENT HISTORY

This dimension records that 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 treatment 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 in the autistic spectrum struggle with particular sensitivities that leave them much less flexible to manage the minor bumps of life.

With regard to treatment, children may respond well to some treatment situations and poorly to others. The treatment response in some cases may not be related to level of intensity, but rather to the characteristics, attractiveness, and/or cultural competency of the treatment provided. However, children and adolescents rarely have long histories of prior treatment upon which to evaluate resiliency, thus responses to stressors and life changes with no professional involvement should be considered as well.

Most recent experiences in treatment or care take precedence over more remote experiences in determining the score. For younger children who may not have extensive involvement in any treatment, responses to developmental challenges without professional involvement may be as indicative of resiliency as treatment 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 TREATMENT

- a. Child 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 treatment 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 treatment.
- d. Able to transition successfully and accept changes in routing without support; optimal flexibility.

2. SIGNIFICANT RESILIENCY AND/OR RESPONSE TO TREATMENT

- a. Child demonstrated average ability to deal with stressors and maintain developmental progress.
- b. Previous experience in treatment has been successful in controlling symptoms but more lengthy treatment 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.

3. MODERATE OR EQUIVOCAL RESILIENCY AND/OR RESPONSE TO TREATMENT

- a. Child 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 support or in structured settings.
- d. Has demonstrated limited ability to follow through with treatment recommendations.

- e. Developmental pressures and life changes have created temporary stress.
- f. Able to transition successfully and accept change in routine most of the time with a moderate intensity of support.

4. POOR RESILIENCY AND/OR RESPONSE TO TREATMENT

- 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 treatment
- c. Attempts to maintain whatever gains that can be 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 TREATMENT

- 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 this treatment exposure.
- 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. TREATMENT ACCEPTANCE AND ENGAGEMENT

The Acceptance and Engagement dimension measures both the child or adolescent's, as well as the parent and/or primary care taker's, acceptance of and engagement in treatment. For the purpose of this document, treatment includes an array of therapeutic interventions to address the child's, adolescent's, and parent and/or primary care taker's needs. The sub-scales reflect the importance of the parent and/or primary care taker's willingness and ability to participate proactively in the intake, planning, implementation, and maintenance phases of treatment. It also is critical to note that a parent or primary care taker's cultural background influences understanding and acceptance of a problem, as well as choice of care options for solving it. Care should be taken to note barriers to proper assessment and treatment based on cultural differences between the youth and parent and/or primary care taker and the clinician. If needed, consultation with or

addition of culturally congruent staff may eliminate cultural barriers to effective assessment and treatment.

Only the highest 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 emancipated, the parent and/or primary care taker sub-scale is not scored.

Child or adolescent acceptance and engagement

The child or adolescent 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 treatment, to define the presenting problems, to accept his or her role in the development and perpetuation of the primary problem, and to accept his or her role in the treatment planning and treatment process, and to actively cooperate in treatment.

1. OPTIMAL

- a. Quickly forms a trusting and respectful positive therapeutic relationship with clinicians and other care providers.
- b. Able to define problem(s) 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. Actively participates in treatment planning and cooperates with treatment.

2. CONSTRUCTIVE

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

3. OBSTRUCTIVE

- 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 problem 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 is noncompliant with treatment, including medication and homework assignments.

4. ADVERSARIAL

- a. Actively hostile 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 treatment.

5. INACCESSIBLE

- 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.

Parent and/or primary care taker acceptance and engagement

The parent and/or primary care taker sub-scale measures the ability of the parents or other primary care taker to form a positive therapeutic relationship, to engage with the clinician in defining the presenting problem, to explore their role as it impacts on the primary problem, and to take an active role in the treatment planning 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 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 in participating in assessment and treatment.

2. CONSTRUCTIVE

- 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 treatment plan.
- d. Cooperates with treatment plan, with behavior change and good follow-through on interventions, including medications and homework assignments.

3. OBSTRUCTIVE

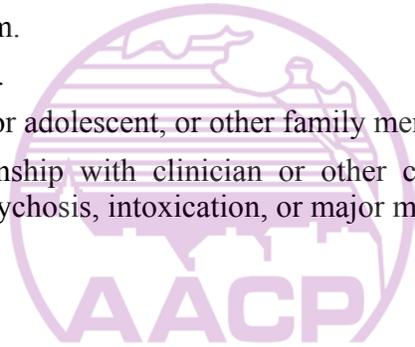
- a. Inconsistent and/or avoidant relationship with clinicians and other care providers.
- b. Defines problem, but has difficulty creating a shared definition of development, perpetuation, or consequences of the problem.
- c. Unable to collaborate in development of treatment plan.
- d. Unable to participate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

4. ADVERSARIAL

- a. Contentious and/or hostile 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 treatment plan.

5. INACCESSIBLE

- 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.



PART VII

CALOCUS LEVELS OF CARE UTILIZATION CRITERIA

The levels of care described in CALOCUS represent a graded continuum of treatment responses designed for use with the CALOCUS 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 programs inspired by CASSP Principles. Each level of care subsumes the services at every level of care 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 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 & Grealish, 1996)

The CALOCUS levels of care 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 Care Transitions

The service needs of a child or adolescent and family in treatment are likely to change as treatment progresses. For example, the needed level of care may drop below the provided level of care, and/or the youth’s status may indicate that care may be better provided in either traditional or wraparound configurations. Level of care transitions need not occur sequentially. It may be desirable for a child or adolescent to remain at a higher level of care 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 care when, after an adequate period of stabilization and based on the family's and treatment team's clinical judgment, the child or adolescent meets the criteria for the other level of care. Re-administration of CALOCUS can help clinicians determine a child or adolescent's readiness for another level of care, and can help identify the foci of subsequent treatment. A flexible Individualized Service (Wraparound) Plan can facilitate seamless transitions, with the same clinicians and staff providing care at multiple service levels whenever possible.

Multidisciplinary Treatment 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 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 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, 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-credentialed staff or paraprofessionals providing therapeutic services as part of the treatment 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 may provide an array of basic (non-clinical) services.

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 care including crisis intervention, back-up coverage by child and adolescent psychiatrists is an essential element of the service system.

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.

Even with conscientious assessment and scoring of CALOCUS, critical differences among children and adolescents and their families may demand an Individualized Service Plan encompassing services at more than one level of care. Measured and informed clinical judgment and service planning with the family take precedence. Reasons for deviation from the level of care 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).

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 settings, including schools and adult education centers, day care and recreational/social facilities, vocational and social services agencies, and medical facilities. 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 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, from a child or adolescent's home, to 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).

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 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.

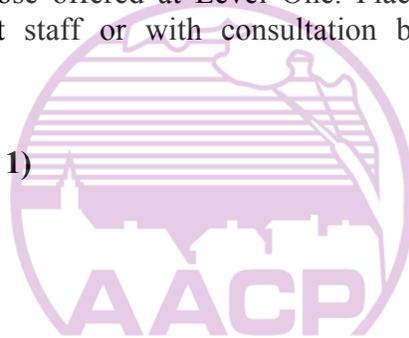
1. **CLINICAL SERVICES.** While clinical services at Level One may be non-intensive and/or episodic, they should be readily accessible so that families may use services to avert the need for higher levels of care. Clinical consultation and assessment should be culturally competent and should consider the extent to which families can mobilize natural supports in the community. Time-limited professional interventions, 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 care 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 care. Crisis intervention staff should consult with primary clinicians. Crises 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.

- CARE ENVIRONMENT.** Recovery maintenance and health management services may be provided in a traditional mental health setting (e.g., office or clinic), 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.

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.

COMPOSITE SCORE (Level 1)



10 - 13

LEVEL TWO. OUTPATIENT 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 clinics or clinicians' offices. Services also may be provided within a juvenile justice facility, school, social service agency, or other community setting. Children and adolescents appropriate for Level Two services generally do not require the extensive systems coordination and case management of the higher levels of care, 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 care, but continuity of at least one treatment relationship often is essential to maintenance at optimal levels of functioning. Clinicians offering follow-up at Level Two must provide continuing individual and family assessment with the capacity to add needed services as necessary.

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 other week, to two hours per week, unless the primary service consists of monthly medication management. Psychiatric and cultural competency consultation to the treatment team should occur regularly. Medication, evaluation and management may be an essential element. Child and adolescent psychiatrists and psycho-social nurses should be part of the primary treatment team for medication services and 24-hour back-up. Selected adjunct interventions (e.g., occupational, recreational, vocational, and/or expressive therapies) should be made available as indicated. Medical care from either a pediatrician or family physician should be available in the community.

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; 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 case management. 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.

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. 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.

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 does not need services that are more intensive/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.

COMPOSITE SCORE (Level 2)

14 - 16

LEVEL THREE. INTENSIVE OUTPATIENT SERVICES

This level of care generally is appropriate for children and adolescents who need more intensive outpatient treatment and who are living either in their families with support, or in alternative families or group facilities in the community. The family's strengths 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 provided by the family or facility staff. Services may be provided in a mental health clinic or clinician's office, but often are provided in other components of the system of care with mental health consultation. Service coordination is essential for maintaining the child or adolescent in the community at Level Three. Medical care from either a pediatrician or family physician should be available in the community.

- 1. CLINICAL SERVICES.** Level Three services incorporate individual, group, and family therapy. Level Three services increasingly depend on the use of "child and family" teams as service coordination becomes more complex. Service intensity averages approximately three days per week. Psychiatric consultation to the treatment or "child and family" 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 back-up. Selected adjunct interventions (e.g., occupational, recreational, vocational, and/or expressive therapies) may be used as indicated. In addition, referrals for clinical services for other family members may be needed. Transition planning for discharge to a lower level of care should be part of the services plan. Medical care from either a pediatrician or family physician should be available in the community.
- 2. SUPPORT SERVICES.** Level Three support services include case management by a culturally competent primary clinician or case manager, or with cultural competency consultation as needed. 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, 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.

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.
4. **CARE ENVIRONMENT.** Intensive 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. 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.

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.

COMPOSITE SCORE (Level 3)

17 - 19

LEVEL FOUR. 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 must require the involvement of multiple components within the system of care. For example, an adolescent may require the services of a probation officer, a mental health clinician, a child and adolescent psychiatrist, and a special education teacher to be maintained in the community. These children and adolescents, therefore, need intensive, clinically informed case management to coordinate multi-system and multidisciplinary interventions. Optimally, an individualized service plan is developed by a "child and family" team. Services are delivered more frequently and for more extended periods than at lower levels of care. Services in this level of care include partial hospitalization, intensive day treatment, and home-based wraparound care. Level Four services also may be provided in schools, substance abuse programs, juvenile justice facilities, social services group care facilities, mental health facilities, or in the child or adolescent's home.

- 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 child and family team. Primary medical care should be accessible as an integrated part of the comprehensive array of services. 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 plan. Services may be offered within any of the components of the system of care. Services should be designed for flexibility, as part of an Individualized Service Plan, and with emphasis on building on the strengths of the child or adolescent and family. Medical care from either a pediatrician or family physician should be available in the community.
- 2. SUPPORT SERVICES.** Level Four case management services are provided to coordinate 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 Individualized Service Plan to form a graded continuum of natural, clinical, and culturally congruent supports, with emphasis on natural supports when available. Families are likely to need support for financial, housing, child-care, vocational, and/or education services. These should be included as part of the child or adolescent's Individualized Service Plan.

Services should be family-centered, with the goals of either maintaining or reintegrating the child or adolescent in to the home and community.

- 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. Crisis services must be mobile and integrated into the care plan. Crisis services may be offered by a number of components in the system of care, although 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.

A Wraparound team’s capacity for managing a child or adolescent at Level Four is partially determined by their age, size, and developmental level, as well as the strengths and size of the team. An inability to manage risk of harm may be reflected in a higher composite score on CALOCUS, and justifies transfer to a more restrictive setting or intensification of the wraparound program to offer active medical monitoring or management.

- 4. CARE ENVIRONMENT.** Level Four services may be provided 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. 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, resources 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.

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. Placement at Level Four 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 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 with consultation by culturally competent specialists.

COMPOSITE SCORE (Level 4)

20 - 22

LEVEL FIVE. NON-SECURE, 24-HOUR SERVICES WITH PSYCHIATRIC MONITORING

This level of care 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 residential schools, and could be provided in homeless and/or domestic violence shelters or other community settings. It also is possible to provide Level Five services in a child or adolescent's home, if wraparound planning and resources can provide the needed service intensity in the less restrictive environment. Level Five services include development of a Wraparound program, initiated by the "child and family team" preparing them for the child or adolescent's re-integration into their family and community and/or treatment in lower levels of care. Ideally, the step-down plan represents a modification of the comprehensive Level Five service plan, providing continuity of care and integrating the child or adolescent's treatment experiences into the return to the community setting.

- 1. CLINICAL SERVICES.** Programs for children or adolescents in residential settings, or with wraparound plans offering Level Five services in the community, comprise the core treatment at this level of care. 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, if not the primary mental health clinician, serve an important consultative or supervisory function, maintaining daily contact with the team and providing 24-hour psychiatric consultation. Medication management should be available. Treatment modalities may include individual, group, and family therapy, with substance abuse services, either as the primary treatment or as an element of a comprehensive program, available as indicated. Primary medical care should be an accessible integrated part of the comprehensive array of services. Non-credentialed child care staff who work in residential programs and who participate as part

of intensive Wraparound programs should be considered part of the clinical team, participate in treatment planning, be actively supervised and trained, and follow the treatment plan. Staff and programs should be culturally competent, with access to cultural competency consultation as needed. Treatment should be family-centered. 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. Medical care from either a pediatrician or family physician should be available in the community.

2. **SUPPORT SERVICES.** Active case management is integral to care at Level Five 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 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. Services may include seclusion and/or restraint interventions, as well as crisis medication, with supervision by a child and adolescent psychiatrist or other senior clinician within their scope of practice. The treatment team should address with the family the conditions under which seclusion and restraint or other behavioral interventions are initiated and terminated. These interventions should 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 may yield a composite score supporting admission 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 treatment 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 safety 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 are not

regularly locked. Staffing and engagement are the primary methods of providing security both in facilities and in Wraparound 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.

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.

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 with consultation by culturally competent specialists.

COMPOSITE SCORE (Level 5)

23 - 27

LEVEL SIX. SECURE, 24-HOUR SERVICES WITH PSYCHIATRIC MANAGEMENT

Level Six services are the most restrictive and often, but not necessarily, 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 care also may be provided through intensive application of mental health and medical services in a juvenile detention and/or educational facility, provided that these facilities are able to adhere to medical and psychiatric care standards needed at Level Six. Level Six services also may be provided in community settings, including a child or adolescent's home, if mental health and medical services are organized at the required intensity and security measures are adequate. 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.

- 1. CLINICAL SERVICES.** Every child or adolescent requiring Level Six services can be presumed to be in a crisis or near crisis state, and therefore, clinical services should reflect the highest level of service intensity and restrictiveness for the protection of the child or adolescent, the family, and the community. Clinical services must be comprehensive and relevant to the emergent and safety issues at hand. 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. Substance abuse treatment at Level Six may include social or medical detoxification. Occupational and recreational therapy may be helpful as indicated. The treatment plan must be family-centered and must address management of aggressive and/or suicidal or self-endangering behavior. Access to pediatric or family physician should be available in the community.

Treatment at Level Six may be organized by a child and adolescent psychiatrist supervising the care provided by the multi-disciplinary treatment team. Child and adolescent psychiatric and nursing services should be available on a 24-hour basis. A member of the treatment team leadership (e.g., a child and adolescent psychiatrist, psychosocial nurse, or other senior clinician) should have daily contact with the child or adolescent. The child and adolescent psychiatrist should consult regularly with the family and the "child and family" team to assure integration of Level Six services with the care provided at previous levels of care. Review of the child or adolescent's status by the treatment team should occur daily, with the goal of transition planning for a rapid return to lower levels of care. 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. Medical care from either a pediatrician or family physician should be available in the community.

2. **SUPPORT SERVICES.** All necessities of living and well-being must be provided for children and adolescents treated at Level Six. The 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 “child and family” 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, and should maintain activities of daily living, such as hygiene, grooming, and maintenance of their immediate environment. 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. Discharge 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. All support services should be described in the Individualized Service Plan.

3. **CRISIS STABILIZATION AND PREVENTION SERVICES.** At Level Six, crisis services involve rapid response to fluctuations in psychiatric and/or medical status. Crisis stabilization may include seclusion and/or restraint interventions as well as crisis medication, under the supervision of a child and adolescent psychiatrist or other professional within their scope of practice. The treatment team should address with the family the conditions under which seclusion and restraint interventions are initiated and terminated, and these interventions should be in accordance with legal requirements and ethical professional practices. Emergency medical services should be available on-site or in close proximity and all staff should 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 (e.g., seclusion, restraint, and/or holding). Facilities and staff also should provide protection from potential abuse from others. Level Six facilities should be capable of providing involuntary care.

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, 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.). The facilities should be safe and comfortable for children and adolescents at all developmental levels, as well as for their families.

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 by culturally competent staff and/or with consultation by cultural competency specialists.

COMPOSITE SCORE (Level 6)

28 or higher

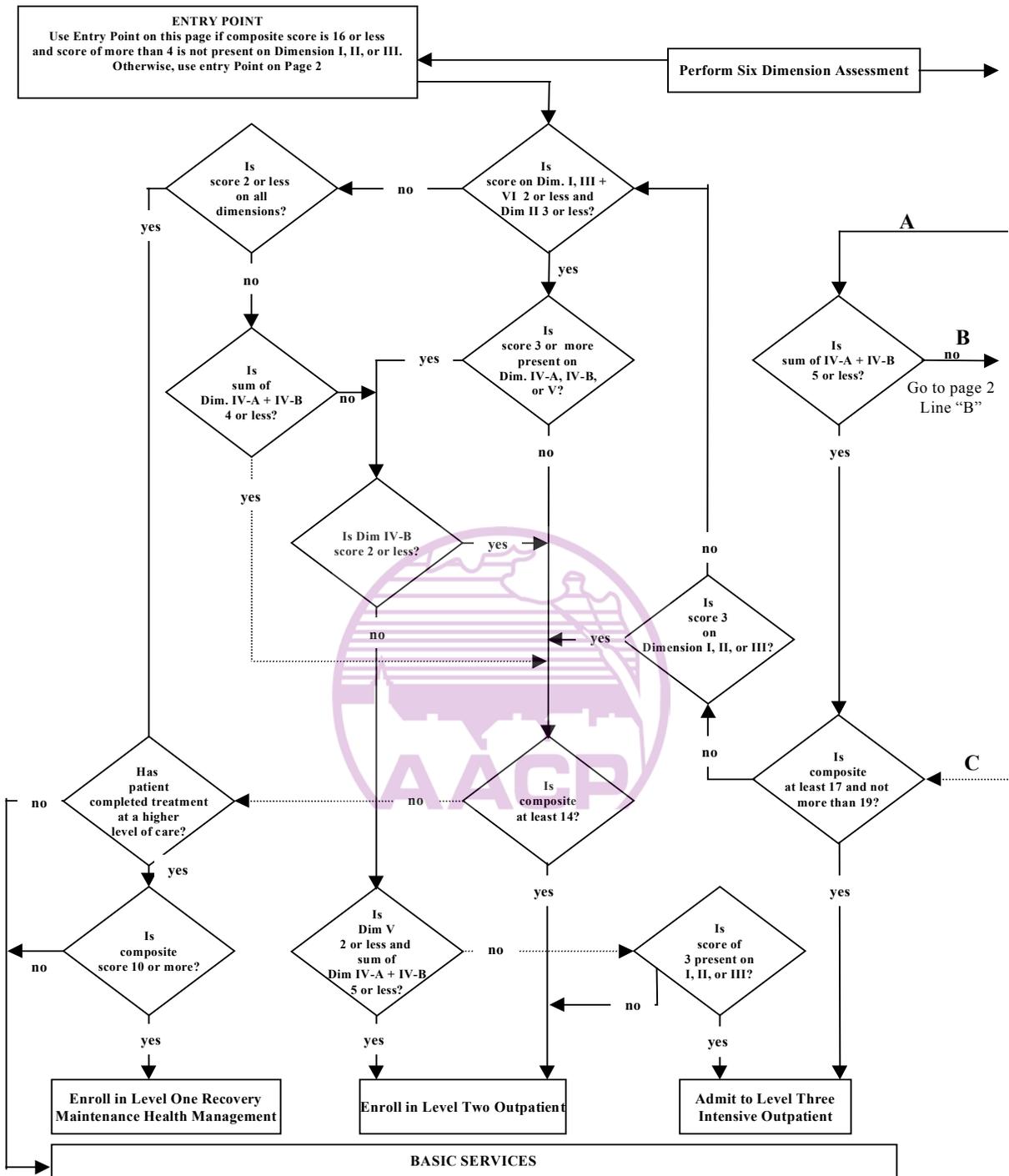


LEVEL OF CARE COMPOSITE SCORE TABLE

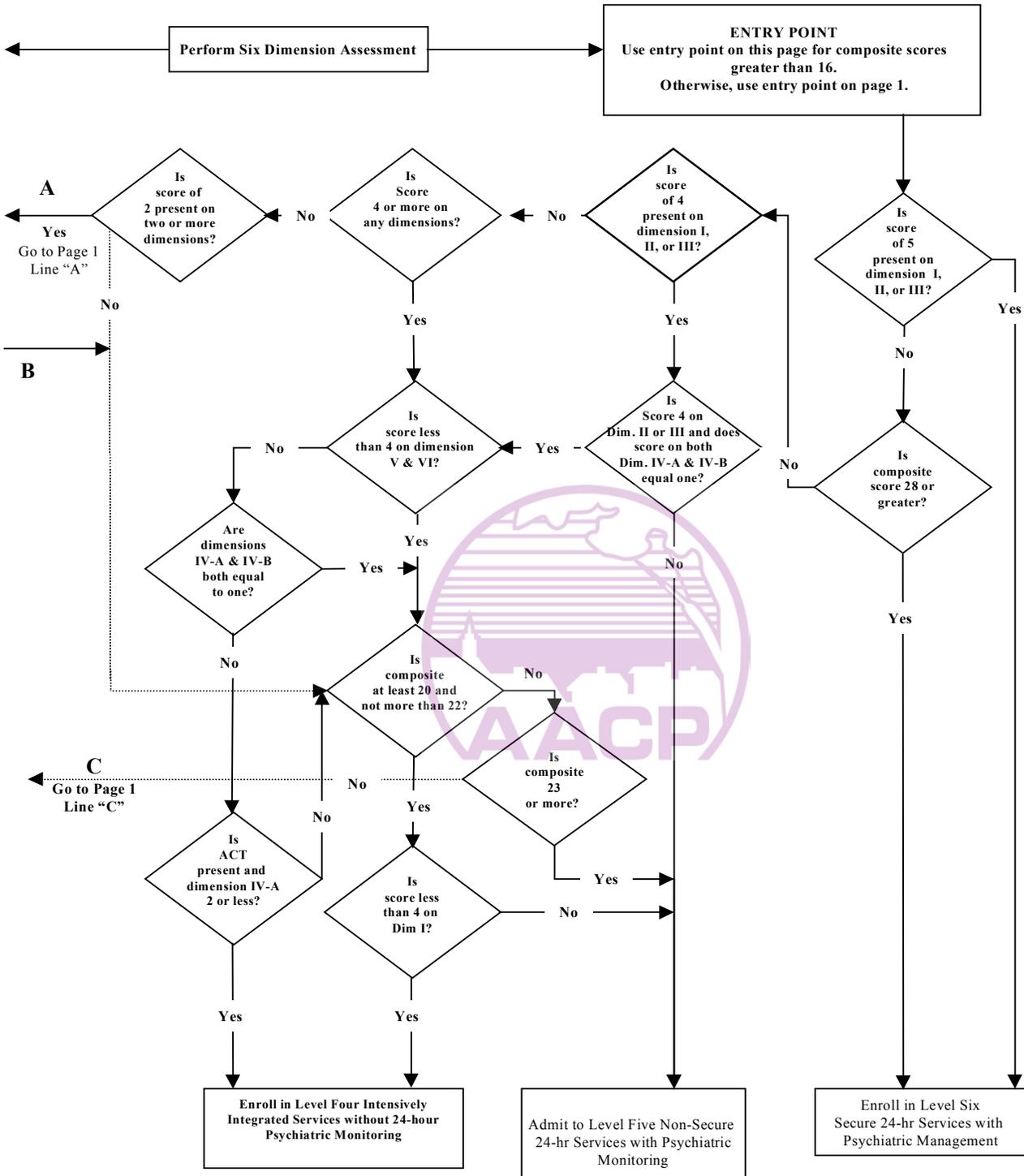
<u>LEVEL</u>	<u>DESCRIPTION</u>	<u>SCORE</u>
Zero	Basic Services for Prevention and Maintenance	7-9
One	Recovery Maintenance and Health Management	10-13
Two	Outpatient Services	14-16
Three	Intensive Outpatient Services	17-19
Four	Intensive Integrated Services Without 24-Hour Psychiatric Monitoring	20-22
Five	Non Secure, 24-Hour psychiatric Monitoring	23-27
Six	Secure, 24-Hour Psychiatric Monitoring	28+



LEVEL OF CARE DECISION TREE Part A
CALOCUS LEVEL OF CARE DETERMINATION DECISION TREE



LEVEL OF CARE DECISION TREE Part B
CALOCUS LEVEL OF CARE DETERMINATION DECISION TREE



AACP / AACAP LEVEL OF CARE DETERMINATION GRID

Level of Care Dimensions	Recovery Maintenance Health Management	Outpatient	Intensive Outpatient	Intensively Integrated w/o 24-hr Psych Mon.	Non-Secure 24-hr Services with Psych Monitoring	Secure 24-hr Services with Psych Management
	Level 1	Level 2	Level 3	Level 4	Level 5	Level 6
I. Risk of Harm	2 or less	2 or less	3 or less	3 or less	④	⑤
II. Functional Status	2 or less	2 or less	3 or less	3 or less	④*	⑤
III. Co-Morbidity	2 or less	2 or less	3 or less	3 or less	④*	⑤
IV A. Recovery Environment “Stress”	Sum of IV A + IV B	Sum of IV A + IV B	Sum of IV A + IV B	3 or 4 ⁺	4 or more	4 or more
IV B. Recovery Environment “Support”	is 4 or less	is 5 or less	is 5 or less	3 or less	4 or more	4 or more
V. Resiliency & Treatment History	2 or less	2 or less	3 or less	3 or 4 ⁺	3 or more	4 or more
VI. Acceptance & Engagement	2 or less	2 or less	3 or less	3 or 4 ⁺	3 or more	4 or more
Composite Rating	10 to 13	14 to 16	17 to 19	20 to 22	23 to 27	28 or more

* Unless sum of IV A and IV B equals 2

+ See text for special circumstances

○ indicates independent criteria - requires admission to this level regardless of composite score

CALOCUS WORKSHEET

Rater Name _____ Date _____

Please check the applicable ratings within each dimension and record the score in the lower right hand corner. Total your score and determine the recommended level of care using either the Placement Grid or the Decision Tree.

<p>I. Risk of Harm</p> <p><input type="checkbox"/> 1. Low Potential for Risk of Harm</p> <p><input type="checkbox"/> 2. Some Potential for Risk of Harm</p> <p><input type="checkbox"/> 3. Significant Potential for Risk of Harm</p> <p><input type="checkbox"/> 4. Serious Potential for Risk of Harm</p> <p><input type="checkbox"/> 5. Extreme Potential for Risk of Harm</p> <p style="text-align: right;">Score _____</p>	<p>IV-B. Recovery Environment - Level of Support</p> <p><input type="checkbox"/> 1. Highly Supportive Environment</p> <p><input type="checkbox"/> 2. Supportive Environment</p> <p><input type="checkbox"/> 3. Limited Support in Environment</p> <p><input type="checkbox"/> 4. Minimal Support in Environment</p> <p><input type="checkbox"/> 5. No Support in Environment</p> <p style="text-align: right;">Score _____</p>
<p>II. Functional Status</p> <p><input type="checkbox"/> 1. Minimal Impairment</p> <p><input type="checkbox"/> 2. Mild Impairment</p> <p><input type="checkbox"/> 3. Moderate Impairment</p> <p><input type="checkbox"/> 4. Serious Impairment</p> <p><input type="checkbox"/> 5. Severe Impairment</p> <p style="text-align: right;">Score _____</p>	<p>V. Resiliency and Treatment History</p> <p><input type="checkbox"/> 1. Full Response to Treatment</p> <p><input type="checkbox"/> 2. Significantly Resilient and/or Response to Treatment</p> <p><input type="checkbox"/> 3. Moderate or Equivocal Response to Treatment And Recovery Management</p> <p><input type="checkbox"/> 4. Poor Response to Treatment and Recovery Management</p> <p><input type="checkbox"/> 5. Negligible Response to Treatment</p> <p style="text-align: right;">Score _____</p>
<p>III. Co-Morbidity</p> <p><input type="checkbox"/> 1. No Co-Morbidity</p> <p><input type="checkbox"/> 2. Minor Co-Morbidity</p> <p><input type="checkbox"/> 3. Significant Co-Morbidity</p> <p><input type="checkbox"/> 4. Major Co-Morbidity</p> <p><input type="checkbox"/> 5. Severe Co-Morbidity</p> <p style="text-align: right;">Score _____</p>	<p>VI-A. Acceptance and Engagement - Child/Adolescent</p> <p><input type="checkbox"/> 1. Optimal</p> <p><input type="checkbox"/> 2. Constructive</p> <p><input type="checkbox"/> 3. Obstructive</p> <p><input type="checkbox"/> 4. Destructive</p> <p><input type="checkbox"/> 5. Inaccessible</p> <p style="text-align: right;">Score _____</p>
<p>IV-A. Recovery Environment - Level of Stress</p> <p><input type="checkbox"/> 1. Minimally Stressful Environment</p> <p><input type="checkbox"/> 2. Mildly Stressful Environment</p> <p><input type="checkbox"/> 3. Moderately Stressful Environment</p> <p><input type="checkbox"/> 4. Highly Stressful Environment</p> <p><input type="checkbox"/> 5. Extremely Stressful Environment</p> <p style="text-align: right;">Score _____</p>	<p>VI-B. Acceptance and Engagement - Parent/Primary Caretaker</p> <p><input type="checkbox"/> 1. Optimal</p> <p><input type="checkbox"/> 2. Constructive</p> <p><input type="checkbox"/> 3. Obstructive</p> <p><input type="checkbox"/> 4. Destructive</p> <p><input type="checkbox"/> 5. Inaccessible</p> <p style="text-align: right;">Score _____</p>
<p>Composite Score</p> <p style="text-align: right;"> <input style="width: 80px; height: 20px;" type="text"/> </p>	<p>Level of Care Recommendation</p> <p style="text-align: right;"> <input style="width: 80px; height: 20px;" type="text"/> </p>

SCORING SHEET
Child and Adolescent Level of Care Utilization System

A. Clinical Level of Care Recommendation (Assign before using CALOCUS) _____

B. Calculation of Composite CALOCUS Score _____

<u>Dimension</u>	<u>Dimension Rating</u> (circle score)					
1. Risk of Harm	1	2	3	4	5	_____
2. Functional Status	1	2	3	4*	5	_____
3. Co-Morbidity	1	2	3	4*	5	_____
4. Recovery Environment						
Environmental Stressors	1	2	3	4	5	_____
Environmental Support	1	2	3	4	5	_____
5. Resiliency and Treatment History	1	2	3	4	5	_____
6. Acceptance and Engagement						
Child/Adolescent	1	2	3	4	5	
Parent and/or primary care taker	1	2	3	4	5	_____

(Note: please record the higher of the two scores)

*Note: **Bold** indicates independent criteria-requires automatic admission to a higher level of care regardless of combined score. A score of 4 results in placement at level 5 and a score of 5 results in placement at level six.
 * = independent criteria may be waived if sum of IV-A and IV-B scores equal 2.*

COMPOSITE CALOCUS SCORES (add right column) _____

C. CALOCUS Derived Level of Care Recommendation (Consult Grid and Decision Tree) _____

D. Actual (Disposition) Level of Care _____

Reason for Variance from CALOCUS Level of Care Recommendation

Patient/Family Name: _____

Date of Scoring: _____ Name of Scorer: _____