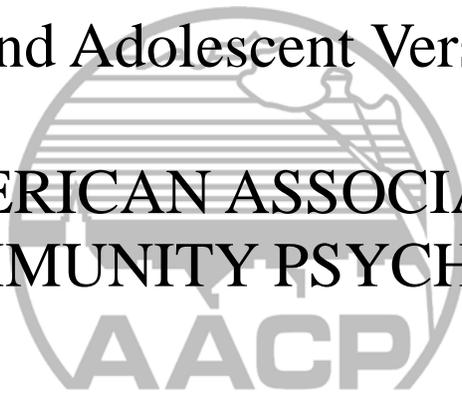


CALOCUS

CHILD AND ADOLESCENT LEVEL OF CARE UTILIZATION SYSTEM

Child and Adolescent Version 2010

AMERICAN ASSOCIATION
OF COMMUNITY PSYCHIATRISTS



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Version 2010

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PART I

HISTORICAL PERSPECTIVE

The need for the Child and Adolescent Level of Care Utilization System (CALOCUS) stems from two trends in child and adolescent mental health. 1. The advent of managed care throughout the health care system in the United States as states encountered limits in their ability to fund health services, including mental health services. 2. Progressive developments in child and adolescent mental health and allied services with recognition of the need for better collaboration between elements of the system of care. This culminated in federal action in the mid-1980's with policies known as Systems of Care (SoC) reforms. These two threads in children's mental health have resulted in an emphasis on treatment in community settings with limits on 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, Unclaimed Children: The Failure of Public Responsibility to Children and Adolescents In Need of Mental Health Services, in 1982 identified significant services gaps for those children most in need of care. She found that many children were inappropriately receiving services at a higher level of care due to a lack of alternative resources. Ms. Knitter recommended "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 Values and Principles" for the development of local systems of care.

A key element in the SoC reform was the concept of the Wraparound Process. It focuses on empowering parents to be effective partners with therapists and other service providers. It emphasizes a client centered, strength based approach with a high value on creating a team that can coordinate care and bring highly individualized services to the child and their family. Wraparound plans for a child or adolescent do not rely solely on pre-existing programs, agency services or conventional levels of care. It is a comprehensive plan, using both formal and informal supports, to remediate unmet needs. It builds on existing strengths of the child and family. Implementation of the SoC approach with its Wraparound Process has been associated with an improved ability to serve children and adolescents safely and effectively in their communities, albeit with specific plans that may represent a definable increase in the intensity of services. Central to this process has been the rise of family organizations where experienced parents teach parents newer to the system ways of navigating the system as empowered individuals. Experienced parents providing advocacy and support are now considered part of the array of consumer peer support specialists and are recognized by many states as non-credentialed mental health workers. Similarly older youth solid in their own recovery may be trained to provide peer support services as well and are beginning to take formal support and advocacy roles with youth in the system of care. CALOCUS has been designed to accommodate the CASSP and SoC principles and facilitate their implementation.

As managed care progressed in the 1990's and matured in the new millennium, there has been a greater emphasis on using cost-effective treatments. Modern use of managed care has been found to 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 regarding the most appropriate Level of Care. VanDenBerg and Grealish pointed out in a 1996 article that, "If the adults disagree, the child fails." CALOCUS provides a process that facilitates the development of 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 child 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 each 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 issues will influence the application of CALOCUS criteria in many cases and users must be sensitive to these determinants for the accurate use of CALOCUS. A clear understanding of the cultural factors that may influence each dimension is important. The dimension of Treatment Acceptance and Engagement are most often affected by 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. The rating process may be enhanced by collaboration between professionals, parents and care givers, and mature youth. This may be done as a patient/therapist activity, a family group activity or as a Wraparound group activity in which dialogue over criteria applicability may have distinct clinical and coordination benefits.

CALOCUS has six dimensions:

RISK OF HARM: This dimension is an expansion of the same dimension in LOCUS, 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. Developmental Disability is defined here as including both intellectual disabilities and pervasive developmental syndromes such as Autistic Spectrum Disorders. They also include borderline intellectual functioning and brain damage syndromes common in childhood due to fetal alcohol exposure, nutritional deprivation and non-lateralizing traumatic brain injury. 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 two 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.

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 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. When indicated the evaluation process may be a collaborative Wraparound Process activity. 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 level of care change), 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.

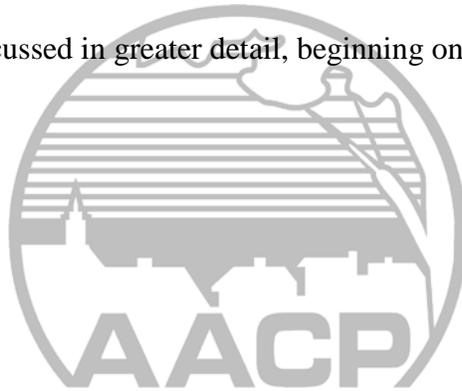
One way to think about the levels of care is to compare them with the difference between the services available in a single pediatrician's office (the lower levels of care) and a major medical center (higher levels of care). For well-baby checks and most common medical conditions, a child or adolescent 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 and developmental status. Examples of this level of service are children or adolescents who only need ongoing medication services for a chronic condition or brief crisis or supportive counseling, or to maintain a relationship with a therapist where long term minimal contact will reinforce developmental achievement and self maintenance skills.
- Level 2: Low Intensity Community Based Services. This level of care relies heavily on family and community resources and natural supports. Treatment and monitoring may be conducted in an office based practice or other community settings such as school or faith based programs, activity or recreational centers.

- Level 3: High Intensity Community Based Services. Youth at this level of care requires more significant engagement by behavioral health providers and at least one other child serving agency. Service coordination is an important aspect of this level of care. The use of the Wraparound Process may be a preferred option.
- Level 4: Medically Monitored Community Based Services. The child or adolescent is at risk for or already has involvement with multiple systems. A more elaborate Wraparound plan is required. Additional supports may include respite, homemaking services or paid parent or youth peer supports.
- Level 5: Medically Monitored Residence Based Services. 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 safe and sufficient supports are provided through the Wraparound Process.
- Level 6: Medically Managed Residence Based Services. Commonly, these services are provided in inpatient psychiatric settings or highly programmed residential facilities. If security needs could be met through the Wraparound Process, then this level of intensity of service could also be provided in a community setting.

All of these levels will be discussed in greater detail, beginning on page 25 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 Level of Care Determination Decision Tree (see page 38) and the AACP 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, users should complete the CALOCUS to obtain ratings in each dimension and a composite score.

When 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.

There is no need to memorize definitions of the levels of care or the dimensional rating criteria. As you gain experience with instrument, you will be able to complete the assessment more rapidly. An initial classification of existing services into the levels of care describing them in CALOCUS will allow rapid identification of options available once a LOC recommendation is determined via the grid or decision tree. This will also allow the identification of elements that may need to be added to the continuum. 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.



PART VI

CALOCUS Instrument Version 2010

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, temper impulses, use good judgment; or avoid gross mishandling of alcohol or drugs of abuse. Children of any age who have experienced severe and/or repeated abuse in a hostile environment may be unable to perceive threat or take adequate measures to increase their safety.

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

1 - Low Risk of Harm

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

2 - Some Risk of Harm

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

3 - Significant Risk of Harm

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

4 - Serious Risk of Harm

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

5 - Extreme Risk of Harm

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

Dimension II: Functional Status

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

1 - Minimal Functional Impairment

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

2 - Mild Functional Impairment

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

3 - Moderate Functional Impairment

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

4 - Serious Functional Impairment

- a- Serious deterioration of interpersonal interactions with consistent conflict or otherwise disrupted interactions with others, which may include impulsive or abusive behaviors.
- b- Significant withdrawal and avoidance of almost all social interaction.

- c- Consistent failure to achieve self-care/hygiene at levels appropriate to age and/or developmental level.
- d- Serious disturbances in physical function.
- e- Inability to perform adequately even in a specialized school setting due to disruptive behavior, or inattentiveness. School attendance may be sporadic. The child or adolescent has multiple academic failures.

5 - Severe Functional Impairment

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

Dimension III: Co-Morbidity: Developmental, Medical, Substance Use and Psychiatric

This dimension measures the coexistence of disorders across four domains (psychiatric, substance use, medical and developmental): but does not consider co-occurring disturbances within each domain. If a child or adolescent has more than one disorder in the same domain (e.g., two psychiatric, substance use, medical, or developmental disorders), the second does not count as a “co-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. Coexisting disorders across domains may prolong the course of illness, or necessitate the use of more intensive or restrictive services. Physiologic withdrawal states related to substance use should be considered medical co-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.

It is crucial to include a broad range of developmental problems into the domain of developmental disabilities. This category includes not only formally defined mental retardation but functionally significant low intelligence. It also includes subtle brain damage syndromes such as Traumatic Brain Injury and Fetal Alcohol Spectrum Disorder, as well as Autistic Spectrum Disorders. Specific Learning Disorders, significant enough to impair a child’s development, are also included. As with the psychiatric and medical conditions only one developmental disruptive condition is needed to count this domain in the co-morbidity.

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

1 - No Co-Morbidity

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

2 - Minor Co-Morbidity

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

3 - Significant Co-Morbidity

- a- Developmental disability is present that may adversely affect the presenting condition, and/or may require significant augmentation or alteration of treatment for the presenting condition or co-morbid condition, or adversely affects the presenting condition.
- b- Medical conditions are present requiring significant medical monitoring (e.g., diabetes or asthma).
- c- Medical conditions are present that may adversely affect, or be adversely affected by, the presenting condition.
- d- Substance abuse is present, with significant adverse effect on functioning and the presenting condition.
- e- Recent substance use that has significant impact on the presenting condition has been arrested due to use of a highly structured or protected setting or through other external means.
- f- Psychiatric signs and symptoms are present, that persist in the absence of stress, are moderately debilitating, and adversely affect the presenting condition.

4 - Major Co-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 condition.
- c- Uncontrolled substance use is present that poses a serious threat to health if unabated and impedes recovery from the presenting condition.
- d- Developmental delay or disorder is present that significantly alters functional capacity and ability to participate meaningfully in a psychiatric or substance abuse treatment.
- e- Psychiatric symptoms are present that clearly impair functioning, persist in the absence of stressors, and seriously impair recovery from the presenting condition.

5 - Severe Co-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 condition.
 - c- Substance dependence is present, with inability to control use, intense withdrawal symptoms and extreme negative impact on the presenting condition.
 - d- Developmental disorder is present that seriously complicates, or is seriously compromised by, the presenting condition.
 - e- Acute or severe psychiatric symptoms are present that seriously impair functioning, and/or prevent voluntary participation in treatment for the presenting condition, or otherwise prevent recovery from the presenting condition.
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Dimension IV: Recovery Environment

This dimension considers factors in the environment that may contribute to the onset or maintenance of illness or disability, and factors that may support a child or adolescent's efforts to achieve or maintain recovery. Supportive elements in the environment include, first and foremost, the presence of stable, supportive, and ongoing relationships with family (biological or adoptive) members. Other important supportive factors include the availability of adequate housing and material resources, stable and supportive relationships with friends, employers or teachers, clergy, professionals, and other community members. Clinicians must be alert to underestimation of family, cultural, and community strengths, 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 Sub-Scale

1 - Minimally Stressful Environment

- a- Absence of significant or enduring difficulties in environment and life circumstances are stable.
- b- Absence of recent transitions or losses of consequence (e.g., no change in school, residence, or marital status of parents, or no birth/death of family member).
- c- Material needs are met without significant cause for concern that they may diminish in the near future, with no significant threats to safety or health.

- d- Living environment is conducive to normative growth, development, and recovery.
- e- Role expectations are consistent with child or adolescent's age, capacities and/or developmental level.

2 - Mildly Stressful Environment

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

3 - Moderately Stressful Environment

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

4 - Highly Stressful Environment

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

5 - Extremely Stressful Environment

- a- Highly traumatic and/or enduring and disturbing circumstances, such as daily exposure to violence, sexual abuse or illegal activity in the home or community, the child or adolescent is witness to or a victim of a natural disaster, the sudden or unexpected death of a loved one, or an unexpected or unwanted pregnancy.
- b- Political or racial persecution, immigration, social isolation, language barriers, and/or illegal alien status.
- c- Youth faces incarceration, foster home placement or re-placement, inadequate residence, and/or extreme poverty or constant threat of such.
- d- Severe pain, injury, or disability, or imminent threat of death due to severe illness or injury.

Environmental Support Sub-Scale

1 - Highly Supportive Environment

- a- Family and ordinary community resources are adequate to address child's developmental and material needs.
- b- Continuity of active, engaged primary caretakers, with a warm, caring relationship with at least one primary caretaker.
- c- Effective involvement in a Wraparound Process, or use of other highly supportive resources. *(Selection of this criterion pre-empts higher ratings)*

2 - Supportive Environment

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

3 - Limited Support in Environment

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

4 - Minimally Supportive Environment

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

5 - No Support in Environment

- a- Family and/or other primary caretakers are completely unable to meet the child's developmental, material, and/or emotional needs.
- b- Community has deteriorated so that it is unsafe and/or hostile to the needs of children and adolescents for education, recreation, constructive peer relations, and mentoring from unrelated adults.
- c- Lack of liaison and cooperation between child-servicing agencies (a chaotic service environment).
- d- Inability of family or other primary caretakers to make changes or participate in treatment.
- e- Lack of even minimal attachment to benevolent other, or multiple attachments to abusive, violent, and/or threatening others.

Dimension V: Resiliency and Treatment History

It is well known that children are born with widely varying levels of resilience in the face of stress. Resilience can be enhanced through a therapeutic process and/or the provision of supports as in a Wraparound Process. This section addresses a child's or youth's success or failure to make use of treatment and natural supports that foster resilience and help them get back on track developmentally. This section aims to measure how well a child or adolescent copes with all types of adversity and uses treatment and/or natural and formal community supports. Natural responses to stressors and life changes with no professional involvement or other specific supports should be considered as well.

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

1 - Full Resiliency and/or Response to Treatment

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

2 - Significant Resiliency and/or Response to Treatment

- a- Child demonstrated average ability to deal with stressors and maintain developmental progress.
- b- Previous experience in treatment or with formal supports have been successful in controlling symptoms.
- c- Significant ability to manage recovery has been demonstrated for extended periods, but has required formal supports or ongoing care in alternative supportive relationships.
- d- Recovery has been managed for short periods of time with limited support or structure.
- e- Able to transition successfully and accept changes in routine with minimal support.

3 - Moderate or Equivocal Resiliency and/or Response to 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 supports or in structured settings.
- d- Has demonstrated limited ability to follow through with treatment recommendations.
- e- Developmental pressures and life changes have caused some deterioration in function.
- f- Able to transition successfully and accept change in routine most of the time with moderate intensity support.

4 - Poor Resiliency and/or Response to 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 were attained in intensive treatment have limited success, even for limited time periods or in structured settings.
- d- Developmental pressures and life changes have created episodes of turmoil or sustained distress.
- e- Transitions with changes in routine are difficult even with a high degree of support.

5 - Negligible Resiliency and/or Response to 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 intensive 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 Treatment Acceptance and Engagement dimension measures the child or adolescent's, as well as the parent and/or primary caretaker's, acceptance 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's and/or primary caretaker's needs. The sub-scales reflect the importance of the child/youth's willingness to be involved in an intake, care planning, implementation and maintenance phases of treatment and/or Wraparound Process, as well as the parent and/or primary caretaker's willingness and ability to participate pro-actively in the same elements of a treatment/care plan. It also is critical to note that a youth and their parent or primary caretaker'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 caretaker and the clinician or other involved professionals.

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

Child or Adolescent Acceptance and Engagement Sub-Scale

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 care, to define the issues of concern, to accept his or her role in the development and perpetuation of their distress of disability, and to accept his or her role in the treatment, or care 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 understands consequences and how others may see them differently.
- c- Accepts age-appropriate responsibility for behavior that causes and/or exacerbates primary problem.
- d- Actively participates in treatment planning and cooperates 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 can understand and accept how others define the problem and its consequences.
- c- Accepts limited age-appropriate responsibility for behavior.
- d- Passively cooperates in treatment planning and 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 distressing behaviors and consequences.
- d- Unable to accept others' definition of the problem and its consequences.
- e- Frequently misses or is late for treatment appointments and/or is not invested in treatment, including medication and homework assignments.

4 - Adversarial

- a- Actively hostile relationship with clinicians and other care providers despite competent efforts to engage with the child or youth.
- b- Accepts no age-appropriate responsibility role in development, perpetuation, or consequences of the problem.
- c- Actively, frequently disrupts or “stonewalls” assessment and treatment.

5 - Inaccessible

- a- Unable to form therapeutic working relationship with clinicians or other care providers, severe withdrawal, psychosis, or other profound disturbance in relatedness.
- b- Unaware of problem or its consequences and does not understand or accept explanations.
- c- Unable to communicate with clinician due to severe cognitive delay or speech/language impairment.

Parental and/or Primary Caretaker Acceptance and Engagement Sub-Scale

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

1 - Optimal

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

2 - Constructive

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

3 - Obstructive

- a- Inconsistent and/or avoidant relationship with clinicians and other care providers despite competent attempts at engagement.
- 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 changes 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- Actively avoidant of and unable to form relationship with clinician or other care provider, in context of 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 System of Care Principles. Each level of care subsumes the services that occur at every level of care below it.

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, recreational agencies, and peer support specialists 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 Wraparound 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 empower families to take a leadership role in directing care by bringing together an experienced parent advocate and a professional Wraparound facilitator with the family to form a team with 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 Process principles form the basis for sharing resources and blending services in an individualized service plan for a child or adolescent and family. (VanDenBerg and Grealish, 1996.)

The 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 highly variable. However, in the aggregate, service time estimates may be of value to programs.

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, paraprofessionals and peer support specialists 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 in the case record by the clinician.

The Levels of Care

Level Zero: 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 involve education and referral services and may be provided through traditional means, as well as through print and broadcast media (e.g., public service announcements and/or targeted mailings).

- 1. Care Environment** - Prevention and community support activities may occur in many settings, from a child or adolescent's home, to Head Start programs, 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).
- 2. 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 assessments. Consultative services by mental health clinicians should be effectively integrated into all prevention and support functions. Medical care from either a pediatrician or family physician should be available in the community.
- 3. Supportive 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.
- 4. 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.

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. **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.
2. **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, opportunities for check-ins for “graduates” who value continuity of a treatment relationship, as well as ongoing case management and follow-up medication services may be provided as part of Level One clinical services. Medical care from either a pediatrician or family physician should be available in the community.
3. **Supportive Services** - Level One support services consist mainly of natural supports in the community, including extended family, family Friends, and neighbors: parent sponsored support groups, church and recreational programs; 12-step and other self-help programs; school-sponsored programs; and employment. Families appropriate to this level of care have the capacity to access these community resources as needed without professional intervention.
4. **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. Crisis services should include emergency evaluation, brief intervention, and outreach services. Direct services and/or consultation from child and adolescent psychiatrists and/or psychosocial nurses should be available in each community on a 24-hour basis.

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: Low Intensity Community Based Services

This level of care includes mental health services for children, adolescents, and families living in the community. Level Two services frequently are provided in mental health 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. 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.
- 2. 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 backup. 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.
- 3. Supportive Services** - Support services for children, adolescents, and families are most often natural supports within the community, including extended family, friends, and neighbors; church and recreational programs; 12 step and other self-help groups; parent organization support groups; youth empowerment programs; school sponsored programs; and employment. These families should have the capacity to access other elements of the system of care without substantial professional help, but may need referral and minimal 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.
- 4. 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.

Placement Criteria

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

COMPOSITE SCORE (Level 2)

14-16

Level Three: High Intensity Community Based Services

This level of care generally is appropriate for children and adolescents who need more intensive outpatient treatment and who are living either 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. 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. They should provide easy access to, or be co-located with, parent organization run support groups and teen empowerment programs.
- 2. Clinical Services** - Level Three services incorporate individual, group, and family therapy. Level Three services increasingly depend on the use of Wraparound teams as service coordination becomes more complex. Service intensity averages approximately three days per week. Psychiatric consultation to the treatment or Wraparound team should occur regularly. Medication management may be an essential part of treatment. Child and

adolescent psychiatrists and psychosocial nurses are part of the treatment team providing medication services and 24-hour backup. Selected adjunct interventions (e.g., educational support, 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.

- 3. Supportive 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, parents organization sponsored support groups, youth empowerment programs, self-help groups and community employers. Families may have difficulty accessing elements of the system of care without professional help due to the complexity of their child or adolescent's problems. In addition, families may need support for financial, housing, child-care, vocational, or education services. These should be included as part of the child or adolescent's individualized service plan.
- 4. 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.

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: Medically Monitored Community Based Services

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 Wraparound 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, treatment foster care, and home-based care determined by a Wraparound plan that may involve both support and clinical services brought to the home and various support services for parents/caregivers. 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 adolescents home.

- 1. 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 as well as flexible hours to assure continuity of supports for as many hours of the day as is deemed necessary. To optimize family participation, Level Four facilities should be located as near as possible to the child or adolescent's home. Facilities should incorporate ease of access (e.g., proximity to public transportation, schools, social services agencies): adequate design (e.g., accommodation for families with disabled or special needs members, play areas for children); and specific service needs (e.g., supervised day care so that parents can participate, 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.
- 2. Clinical Services** - Clinical services at Level Four should be available at times that meet the needs of the family, including non-traditional periods (e.g., evenings and weekends). The frequency of direct contact and/or consultation by child and adolescent psychiatrists and psychosocial nurses should be determined in consultation with the primary clinician and the Wraparound team. 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, the Wraparound plan which encompasses the mental health individualized treatment plan and places 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.
- 3. Supportive 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 Wraparound plan to form a graded continuum of natural, clinical, and culturally congruent supports, with emphasis on natural supports from family support and advocacy programs and youth empowerment programs when available. Families are likely to need support for financial, housing, childcare, vocational, and/or education services. These should be included as part of the child or adolescent's Wraparound plan. Services should be family-centered, with the goals of either maintaining or reintegrating the child or adolescent in to the home and community.

- 4. 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 including outreach by family organization members and/or youth peer support specialists. Care should be taken to avoid service duplication. The goal of crisis services is to foster family strengths and prevent the need for admission to higher levels of care.

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

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.

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: Medically Monitored Residence Based Services

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 community based residential schools, hospitals with designated step down program units and could be provided in homeless and/or domestic violence shelters or other community settings. 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 the modification and continuation of a Wraparound plan, or, if the youth is new to services the development of a Wraparound team that can determine a program, that will prepare the family for the child or adolescent’s re-integration into their family and community with treatment in lower levels of care. Ideally, the step-down plan represents a modification of the comprehensive Level Five Wraparound plan, providing continuity

of care and integrating the child or adolescent's treatment experiences while in more restricted Level 5 services into their return to a more open community setting.

- 1. 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 home based plans. Staffing patterns should be adequate to accommodate episodes of aggressive and/or endangering behavior of moderate duration (e.g., sufficient staff should be available to both monitor a safe room for unlocked seclusion and maintain supervision of the other children or adolescents). Capacity for transporting residents off-campus for educational or recreational activities is a critical element of Level Five services.

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.

- 2. Clinical Services** - Programs for children or adolescents in residential settings, or with Wraparound plans offering equivalent 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 an intensive Wraparound plan should be considered part of the clinical team, participate in treatment planning, be actively supervised and trained, and follow the treatment plan. Similarly, parent and youth peer support specialist should be supervised actively and integrated into the treatment plan. Coordination with a residential facility for inclusion of such supports is a critical element of the Wraparound Process at this level of care. 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 and integrated into any residential treatment program.

3. **Supportive 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.
4. **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. Only individual trained in de-escalation and safe restraint techniques should be employed to provide such a service, never as a treatment technique and only as a last resort. 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.

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: Medically Managed Residence Based Services

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. 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; adequate design (e.g., accommodation for families with disabled or special needs members and specific service needs (e.g., supervised day care so that parents can visit, resources for non-English speaking and/or hearing-impaired people, etc.)). The facilities should be safe and comfortable for all children and adolescents admitted to the facility at all developmental levels, as well as for their families.

- 2. 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 supports for abstinence or medical detoxification. Occupational and recreational therapy may be helpful as indicated. The treatment plan must be a modification of the Wraparound crisis plan that remains family-centered and must address management of aggressive and/or suicidal or self-endangering behavior. Access to pediatric or family physician should be available within the hospital community as consultants as needed.

Treatment at Level Six may be organized by a child and adolescent psychiatrist supervising care provided by the outpatient multi-disciplinary treatment team which is part of the Wraparound team. If care at this level is hospital based and the Wraparound team psychiatrist is not privileged in that hospital, then a hospital based psychiatrist must be contacted by the team psychiatrist who will serve as the teams liaison with the care provided in the in-patient setting. Child and adolescent psychiatric and nursing services should be available on a 24-hour basis, if it is decided to create a hospital like program in the patients home, just as they are in an in-patient setting. 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 and their family. The team's child and

adolescent psychiatrist should consult regularly with the hospital and the family and the Wraparound 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.

3. **Supportive Services** - All necessities of living and well being must be provided for children and adolescents treated at Level Six. Children's legal, educational, recreational, vocational, and spiritual needs should be assessed according to individual needs and culture. Social and cultural factors must be considered in discharge planning. A Wraparound team should be created, if not already in place, mobilizing the strengths of the child or adolescent and family to provide support during the crisis and in aftercare. When capable, children and adolescents should be encouraged to participate in treatment planning, both with the hospital team and with the Wraparound Process. Families are likely to need support for financial, housing, child-care, vocational, and/or educational services. Case management for coordination of services provided after transition to lower care levels should begin while the child or adolescent receives Level Six services. 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 and in coordination with the hospital discharge planner. All support services should be described in the Wraparound plan.
4. **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. Emergency medical services should be available on-site or in close proximity and all staff should have training in emergency protocols.

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)

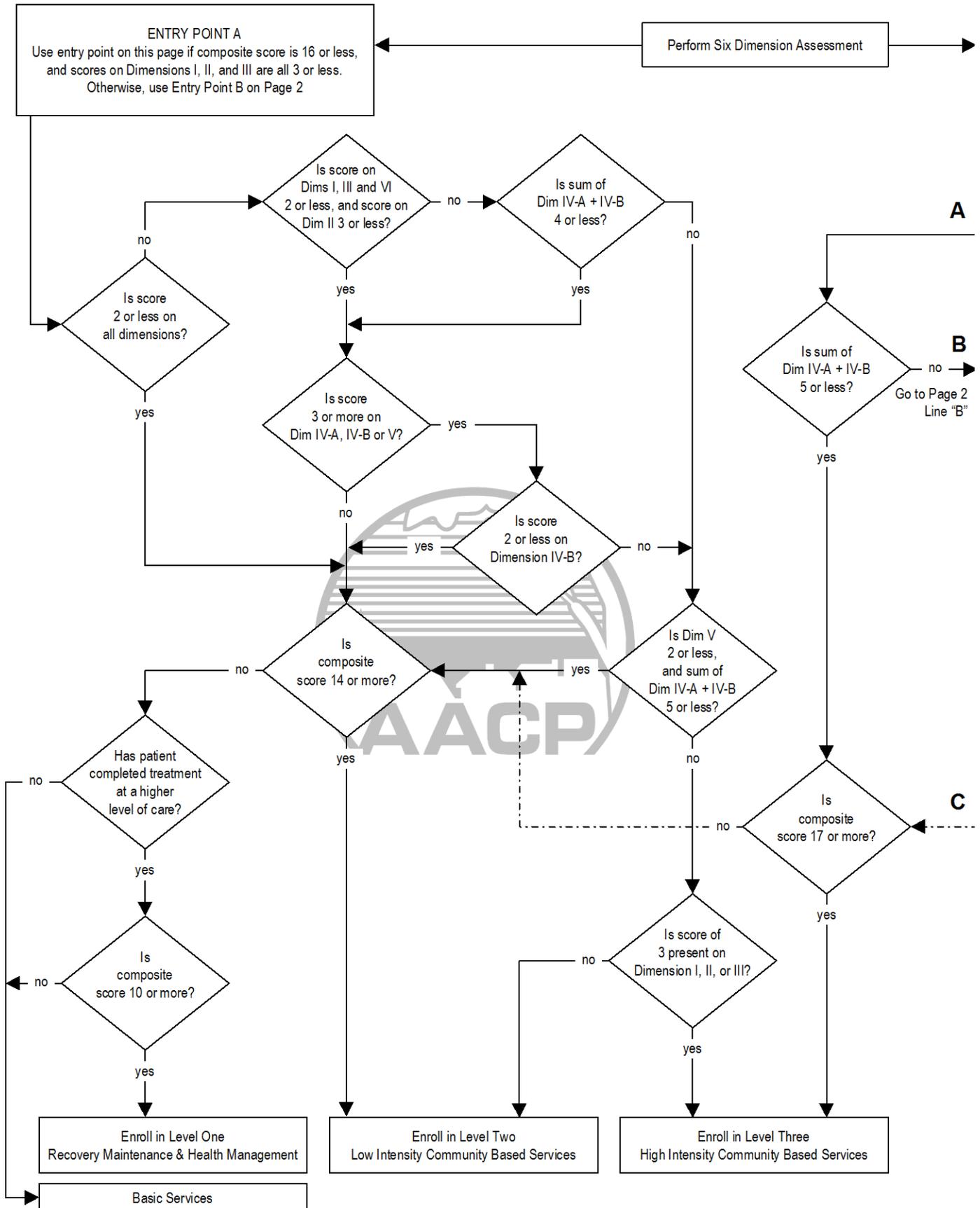
28 and Up

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	Low Intensity Community Based Services	14-16
Three	High Intensity Community Based Services	17-19
Four	Medically Monitored Community Based Services	20-22
Five	Medically Monitored Residence Based Services	23-27
Six	Medically Managed Residence Based Services	28+

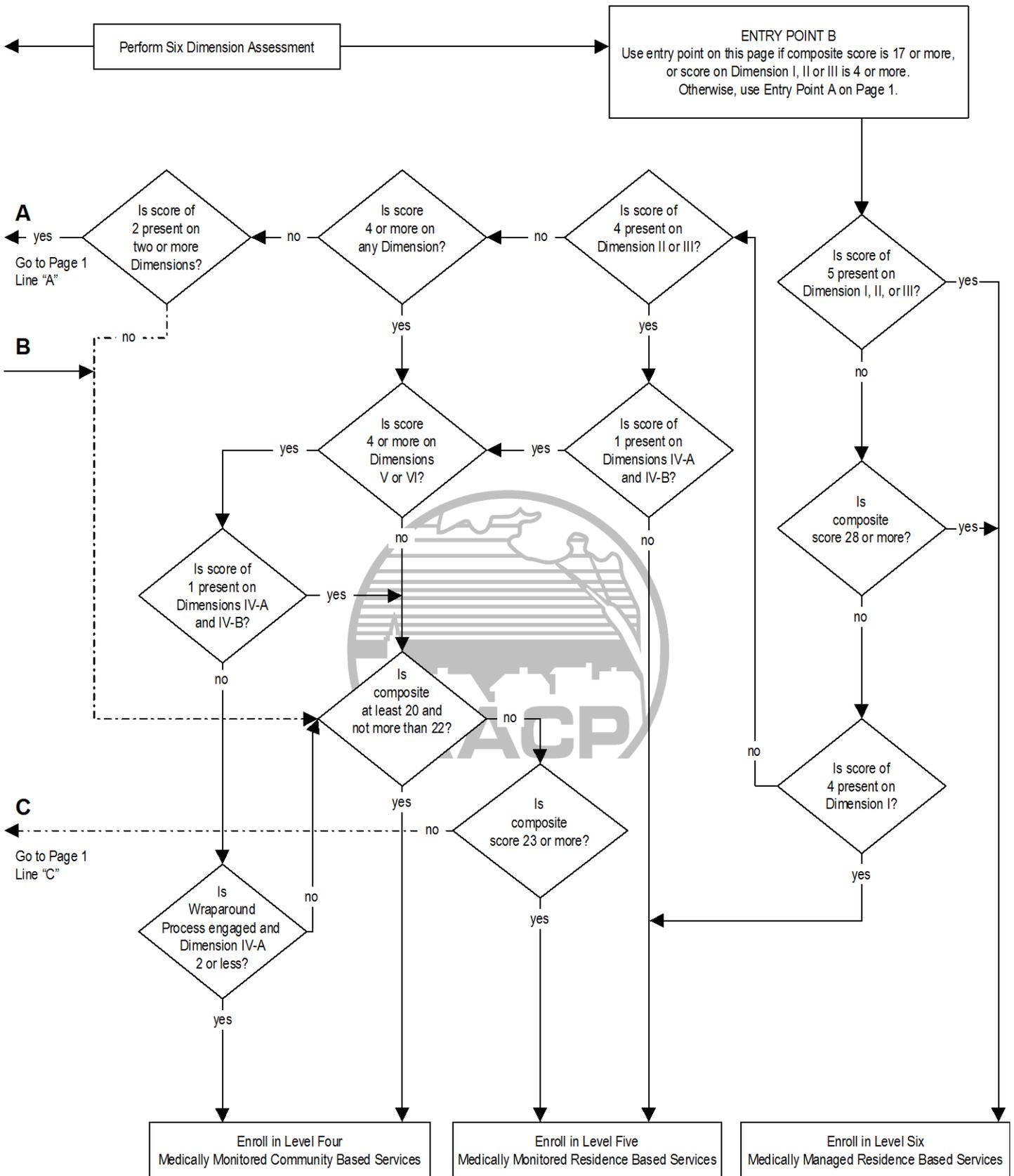


AACP LEVEL OF CARE DETERMINATION DECISION TREE



Decision Tree, Page 1

AACP LEVEL OF CARE DETERMINATION DECISION TREE



Decision Tree, Page 2

AACP LEVEL OF CARE DETERMINATION GRID

Level of Care	Recovery Maintenance and Health Management	Low Intensity Community Based Services	High Intensity Community Based Services	Medically Monitored Community Based Services	Medically Monitored Residence Based Services	Medically Managed Residence Based Services
Dimensions	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 3	⑤ 4
II. Functional Status	2 or less	2 or less	3 or less	3 or less	④* 3	⑤ 4
III. Co-Morbidity	2 or less	2 or less	3 or less	3 or less	④* 3	⑤ 4
IV-A. Recovery Environment "Environmental Stress"	Sum of IV A + IV B is 4 or less	Sum of IV A + IV B is 5 or less	Sum of IV A + IV B is 5 or less	3 or 4	4 or more	4 or more
IV-B. Recovery Environment "Environmental Support"	2 or less	2 or less	3 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 and 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

○ 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 Risk of Harm</p> <p><input type="checkbox"/> 2. Some Risk of Harm</p> <p><input type="checkbox"/> 3. Significant Risk of Harm</p> <p><input type="checkbox"/> 4. Serious Risk of Harm</p> <p><input type="checkbox"/> 5. Extreme Risk of Harm</p> <p style="text-align: right;">Score _____</p>	<p>IV-B. Recovery Environment - Environmental 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. Minimally Supportive 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 Functional Impairment</p> <p><input type="checkbox"/> 2. Mild Functional Impairment</p> <p><input type="checkbox"/> 3. Moderate Functional Impairment</p> <p><input type="checkbox"/> 4. Serious Functional Impairment</p> <p><input type="checkbox"/> 5. Severe Functional Impairment</p> <p style="text-align: right;">Score _____</p>	<p>V. Resiliency and Treatment History</p> <p><input type="checkbox"/> 1. Full Resiliency and/or Response to Treatment</p> <p><input type="checkbox"/> 2. Significant Resiliency and/or Response to Treatment</p> <p><input type="checkbox"/> 3. Moderate or Equivocal Resiliency and/or Response to Treatment</p> <p><input type="checkbox"/> 4. Poor Resiliency and/or Response to Treatment</p> <p><input type="checkbox"/> 5. Negligible Resiliency and/or 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. Adversarial</p> <p><input type="checkbox"/> 5. Inaccessible</p> <p style="text-align: right;">Score _____</p>
<p>IV-A. Recovery Environment - Environmental 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. Adversarial</p> <p><input type="checkbox"/> 5. Inaccessible</p> <p style="text-align: right;">Score _____</p>
<p>Composite Score </p>	<p>Level of Care Recommendation </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 Stress	1	2	3	4	5	_____
Environmental Support	1	2	3	4	5	_____
5. Resiliency and Treatment History	1	2	3	4	5	_____
6. Treatment Acceptance and Engagement						
Child/Adolescent	1	2	3	4	5	
Parent and/or Primary Caretaker	1	2	3	4	5	_____

Note: please record the higher of the two scores in Dimension Six

*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 five (or higher) 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: _____