Child and Adolescent Services Intensity Instrument (CASII)
&
CUMHA Training

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CASII Training

- Introduction & Overview
- CASII Background & Rationale
- The 6 CASII Evaluation Dimensions
- Scoring the CASII
- The CASII Levels of Care
- Case Studies

CASII: Rationale

- Objective, quantifiable criteria for level of care placement, continued stay, and outcomes for children and adolescents with SED
- **Designed for clinicians with training and experience with children and adolescents.**
- **Designed as a clinical tool, not a checklist. Clinical judgment (including justification) determines final CASII level of care determination, not CASII score**
- Applies to children ages **6 through18 years;** developmental status determines LOCUS/ CASII cut-off
- **ECSII** for 0-5 years.

Introduction and Historical Perspective

- The *CASII* is based on the Level of Care Utilization System (*LOCUS*), and was originally called the *CALOCUS*
- Companion to the adult *LOCUS*, but with developmental, family, and community systems of care perspectives.

Historical Perspective

In the past, there was often disagreement between providers, consumers, and payers as to the most appropriate level of treatment and services for children and adolescents. The *CASII* helps provide a consensus on level of support determination that is needed to help our children succeed

Who Qualifies?

- The *CASII* instrument applies equally well to children and adolescents with a full range of presenting problems, including mental illness, substance use disorders, and developmental disorders
- Other instruments are typically used for individuals under 6 and over 18 years old

CASII: Values and Resources

CASSP Guiding Principles for the System of Care (Strohl & Friedman, 1986): Community-based, child-centered, family-driven treatment in the least restrictive, clinically appropriate environment.

Developmental theory: Trajectory of normative physical, emotional, cognitive, and social changes of childhood and adolescence

Family empowerment: Family is lead agent in assessment, treatment, and case management; and primary agent for fostering development and growth.

Cultural competence: Respect for all ethnic/racial/ SES origins; culturally appropriate assessment and treatment, language interpretation; services by culturally competent professionals and diverse staff.

CASII: Values and Resources (Cont.)

Wraparound services model: Integration of a comprehensive network of professional and support services using natural community supports, inter-agency structures, and blended funding streams to provide services (VanDenBerg and Grealish, 1996). This model supports the use of a **strengths-based, individualized treatment plan (ITP)** for each child or adolescents served.

Combined clinical and research expertise of AACAP and AACP: Organizations comprised of psychiatrists serving children, adolescents, and adults.

CASII Dimensional Rating System

- The *CASII* has six dimensions
- Each dimension has a five point rating scale, from least to most severe

Tips to Remember

- When there is confusion about which rating should be assigned, and more than one is a close fit, choose the higher rating (scoring on the side of caution)

CASII: Evaluation Dimensions

I. Risk of Harm

II. Functional Status

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

IV. Recovery Environment

- Scale A: Environmental Stressors
- Scale B: Environmental Supports

V. Resiliency and/or Response to Services

VI. Involvement in Services

- Scale A: Child/Adolescent: Involvement in Services
- Scale B: Parental/Primary Caretaker: Involvement in Services

CASII scoring

- Anchor points provide objective criteria.
- Clinical criteria can also be used with the following general criteria to judge a client issue:

  - **Level 1: Not on your mind at this time.**
  - **Level 2: On your mind but no action needed at this time.**
  - **Level 3: On your mind and planning needed as soon as possible.**
  - **Level 4: Planning needed immediately.**
  - **Level 5: Imminent harm without immediate treatment**

Dimension I
RISK OF HARM

This dimension is the measurement of a child or adolescent's risk of **self-harm** and **harm to others** by various means and an assessment of his/her potential for being a **victim of physical or sexual abuse, neglect or violence.**

Risk of Harm

- Potential to be **harmed by others** or cause significant **harm to self or others**
- **May embody unintentional harm** from distorted reality, inability to care for self, impaired judgment, or intoxication.
- Differentiates between chronic or acute

CASII Dimension I: Risk of Harm

1. LOW RISK OF HARM

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

CASII Dimension I: Risk of Harm

2. SOME RISK OF HARM

- Past history of **fleeting suicidal or homicidal thoughts** with no current ideation, plan, or intention and no signi6cant distress.
- **Mild suicidal ideation** with no intent or conscious plan and with no past history.
- Indication or report of occasional impulsivity, and/or some physically or sexually **aggressive impulses** with **minimal consequences for self or others.**
- **Substance use without significant endangerment** of self or others.
- **Infrequent, brief lapses** in the **ability to care for self** and/or use environment for safety
- **Some risk for victimization,** abuse, or neglect.

CASII Dimension I: Risk of Harm

3. SIGNIFICANT RISK OF HARM

- **Significant current or homicidal ideation** with **some intent and plan,** with the ability of the child or adolescent and his/her family to contract for safety and carry out a safety plan. Child or adolescent expresses some aversion to carrying out such behavior.
- No active suicidal/homicidal ideation, but extreme distress and/or history of suicidal/homicidal behavior.
- Indication or report of episodic impulsivity or **physically or sexually aggressive impulses** that are **moderately endangering to self or others** (e.g. status offenses, impulsive acts while intoxicated, self mutilation, running away from home or placement with voluntary return, fire setting, violence toward animals, affiliation with dangerous peer group).
- Binge or excessive use of **alcohol or other drugs** resulting in **potentially harmful behaviors.**
- **Episodic inability to care for self** and/or maintain physical safety in developmentally appropriate ways.
- **Serious or extreme risk for victimization,** abuse or neglect.

CASII Dimension I: Risk of Harm

4. SERIOUS RISK OF HARM

- **Current suicidal or homicidal ideation with either clear, expressed intentions and/or past history** or 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.
- Indication or report of significant **impulsivity and/or physical or sexual aggression** with poor judgment and insight that is/are **significantly endangering to self or others** (i.e. property destruction; repetitive fire setting or violence toward animals).
- Indication or **significant deficits in ability to care for self** and/or use environment for safety.
- Recent pattern of **excessive substance use resulting in clearly harmful behaviors** with no demonstrated ability of child/adolescent or family to restrict use.
- **Clear and persistent inability,** given developmental abilities, **to maintain physical safety** and/or use environment for safety.
- **Note: A rating of serious risk of harm allows care at Level 5 (non-secure, 24-hour services with psychiatric monitoring), independent of other dimensions.**.

CASII: Dimension I: Risk of Harm

5. EXTREME RISK OF HARM

- **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 doings 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.
- 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).
- Relentlessly engaging in **acutely self endangering behaviors.**
- A pattern or nearly **constant and uncontrolled use of alcohol or other drugs, resulting in behavior that is clearly endangering.**
- **Note: A rating of extreme risk of harm allows care at Level 6 (secure, 24-hour services with psychiatric monitoring), independent of other dimensions.**

Dimension II
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.

Functional Status

- 4 factors considered:
  - Ability to **fulfill responsibilities**
  - Ability to **interact with others**
  - **Vegetative status**
  - Ability to **care for themselves**

Compare to baseline of “expected” level based on developmental/cultural norms

CASII Dimension II: Functional Status

1. MINIMAL FUNCTIONAL IMPAIRMENT

- **Consistent functioning appropriate to age and developmental level** in school behavior and/or academic achievement, relationships with peers, adults and family, and self care/hygiene/control of bodily functions.
- **No more than transient impairment in functioning following exposure to an identifiable stressor** with consistent and normative sleep, eating, energy and self-care.

CASII Dimension II: Functional Status

2. MILD FUNCTIONAL IMPAIRMENT

- Evidence of **minor deterioration, or episodic failure to achieve expected levels of functioning,** in relationships with peers, adults, and/or family (e.g., defiance, provocative behavior, lying/cheating/not sharing, or avoidance/lack of follow through); school behavior and/or academic achievement (difficulty turning homework, occasional attendance problems), or biologic functions (feeding or elimination problems) but with **adequate functioning in at least some areas** and/or ability to respond to redirection/intervention.
- **Sporadic episodes** during which **some aspects of self-care/ hygiene/control of bodily** functions are **compromised.**
- **Demonstrative significant improvement in function following a period of deterioration.**

CASII Dimension II: Functional Status

3. MODERATE FUNCTIONAL IMPAIRMENT

- **Conflicted, withdrawn, or troubled in relationships** with peers, adults, family, **without episodes of aggression.**
- **Self-care/hygiene deteriorates** below usual or expected standards **on a frequent basis.**
- **Significant disturbances in vegetative activities** such as sleeping, eating habits, activity level, or sexual interest that **do not pose a serious threat to health.**
- School behavior/ **academic achievement fall below expected standards,** may be avoided/ unattended.
- **Chronic and/or variably severe deficits in interpersonal relationships,** ability to engage in socially constructive activities, and ability to maintain responsibilities.
- **Recent gains/stabilization in functioning achieved while participating in treatment in structured/enriched setting.**

CASII Dimension II: Functional Status

4. SERIOUS FUNCTIONAL IMPAIRMENT

- Serious deterioration of interpersonal interactions **with consistently conflictual or otherwise disrupted relations with others** which may include **impulsive or abusive behaviors.**
- Significant **withdrawal and avoidance of almost all social interaction.**
- Consistent **failure to achieve self-care/hygiene** at levels appropriate to age and/or developmental level.
- **Serious disturbances in vegetative status,** such as weight change, disrupted sleep or fatigue and feeding or elimination, which threaten physical functioning.
- **Inability to perform adequately even in a specialized school setting** due to disruptive or aggressive behavior. School attendance may be sporadic. The child or adolescent has multiple academic failures.
- **Note: A rating of serious functional impairment allows care at Level 5 (non-secure, 24-hour services with psychiatric monitoring), independent of other dimensions. The only exception to this is if the sum of IVA and IVB = 2, indicating both a minimally stressful and a highly supportive recovering environment.**

CASII Dimension II: Functional Status

5. SEVERE FUNCTIONAL IMPAIRMENT

- **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.
- **Complete withdrawal from all social interactions.**
- **Complete neglect of and inability to attend to self-care**, hygiene, and/or control of biological functions with associated impairment in physical status.
- **Extreme disruption in vegetative function** causing serious compromise of health and well-being.
- **Nearly complete inability to maintain any appropriate school behavior** and/or academic achievement given age and developmental level.
- **Note: A rating of extreme functional impairment allows care at Level 6 (secure, 24-hour services with psychiatric monitoring), independent of other dimensions. The only exception to this is if the sum of IVA and IVB = 2, indicating both a minimally stressful and a highly supportive recovering environment.**

Dimension III
CO-OCCURRENCE

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

Co-Morbidity

- Co-morbid issues may prolong illness and necessitate more intensive/additional services

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

1. NO OCCURRENCE

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

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

2. MINOR OCCURRENCE

- **Minimal developmental delay or disorder** is present that has no impact on the presenting problem and for which the child or adolescent has achieve satisfactory adaptation and/or compensation.
- **Self-limited medical problems** are present that are not immediately threatening or debilitating and that have no impact on the presenting problem and are not affected by it.
- **Occasional,** self-limited episodes of **substance use** are present that show no pattern of escalation, with **no indication of adverse effect** on functioning or the presenting problem.
- Transient, **occasional stress-related psychiatric symptoms** are present that have no discernible impact on the presenting problem.

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

3. SIGNIFICANT OCCURRENCE

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

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

4. MAJOR OCCURRENCE

- **Medical conditions** are present or have a high likelihood of developing that may require **intensive although no constant, medical monitoring** (e.g., insulin-dependent diabetes, hemophilia).
- Medical conditions are present that will adversely affect, or be affected by, the presenting disorder.
- **Uncontrolled substance use** is present that poses a **serious threat to health** if unabated and impedes recovery from the presenting problem.
- **Developmental delay** or disorder is present that **will adversely affect** the course, treatment, or outcome of the **presenting disorder.**
- Psychiatric symptoms are present that clearly impair functioning, persist in the absence of stressors, and seriously impair recovery from the presenting problem.
- **Note: A rating of major co-morbidity allows care at Level 5 (non-secure, 24-hour services with psychiatric monitoring), independent of other dimensions. The only exception to this is if the sum of IVA and IVB = 2, indicating both a minimally stressful and a highly supportive recovering environment.**

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

5. SEVERE OCCURRENCE

- **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 cardio-vascular disease).
- Medical condition acutely or chronically worsens or is worsened by the presenting problem.
- **Substance dependence** is present, with inability to control use, intensive withdrawal symptoms and extreme negative impact on the presenting disorder.
- **Developmental disorder** is present that **serious complicates or is seriously compromised by the presenting disorder.**
- Acute or severe psychiatric symptoms are present that seriously impair functioning, and/or prevent voluntary participation in treatment for the presenting problem, or otherwise prevent recovery from the presenting problem.
- **Note: A rating of severe co-morbidity allows care at Level 6 (secure, 24-hour services with psychiatric monitoring), independent of other dimensions.**

Dimension IV
RECOVERY ENVIRONMENT

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

Recovery Environment

- Stressful Elements:
  - Interpersonal conflicts
  - Trauma
  - Life transitions
  - Losses
  - Worries related to health/safety
  - Difficulty maintaining role responsibilities
  - Based on **client and family's** perception of stress in the environment.

More … **Recovery Environment**

- The recovery environment should not be considered narrowly, but should include elements of family and natural supports, school, juvenile justice services, medical, and other community supports.

- This should also include relationships with others, including friends, employers, teachers, clergy, professionals, etc.

Tip

- If a child is in an out of home placement such as a group home or treatment center, it will be important to consider both the current environment as well as the potential discharge environment when determining your score, as it may be necessary to mobilize additional services to support stabilization and recovery and increase the potential of success.

CASII Dimension IV: *Recovery Environment*
A. *Environmental Stress*

1. ABSENT STRESSFUL ENVIRONMENT

- **Absence of significant** or enduring **difficulties** in environment and life circumstances are stable.
- **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).
- **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.
- Living environment is conducive to normative growth, development and recovery.
- **Role expectations are normative** and congruent with child or adolescent's age, capacities and/or developmental level.

CASII Dimension IV: *Recovery Environment*
A. *Environmental Stress*

2. MILD STRESSFUL ENVIRONMENT

- **Significant normative transition** requiring adjustment, such as change in household members, or new school or teacher.
- **Minor interpersonal loss or conflict,** such as peer relationship ending due to change in residence or school, illness or death of distant extended family member.
- **Transient but significant illness or injury** (pneumonia, broken bone).
- **Somewhat inadequate material resources or threat of loss of resources** due to parental underemployment, separation, etc.
- **Expectations** for performance at home or school **create discomfort.**
- **Potential for exposure to substance use** exists.

CASII Dimension IV: *Recovery Environment*
A. *Environmental Stress*

3. MODERATE STRESSFUL ENVIRONMENT

- **Disruption of family/social milieu** (e.g., move to different living situation, absence/addition of parent or care giver, serious drop in capacity of parent, with expectation of return to functioning).
- **Interpersonal or material loss** that has **significant impact** child/ family.
- **Serious prolonged illness/ injury,** unremitting pain, other disability.
- **Danger/threat in community;** sustained harassment by peers/ others.
- **Exposure to substance abuse** and its effects.
- **Role expectations that exceed** child's or adolescent's **capacity.**

CASII Dimension IV: *Recovery Environment*

A. *Environmental Stress*

4. SERIOUS STRESSFUL ENVIRONMENT

- **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.
- **Threat of severe disruption in life circumstances,** including imminent incarceration, lack of residence, or alien/ hostile culture.
- **Inability to meet needs** for physical and/or material well-being.
- **Exposure to endangering criminal activities** in family/community.
- **Difficulty avoiding substance use** and its effects.

CASII Dimension IV: *Recovery Environment*
A. *Environmental Stress*

5. SEVERE STRESSFUL ENVIRONMENT

- **Traumatic or enduring/ highly disturbing circumstances,** including witnessing/ victim of violence, sexual abuse, illegal activity, disaster, sudden death of loved one, unexpected pregnancy.
- **Political or racial persecution, immigration, social isolation, language barriers, and/or illegal status.**
- **Incarceration (of child), foster home placement or re-placement, inadequate residence, and/or extreme poverty or constant threat of such.**
- **Severe pain/injury/disability, imminent threat of death due to illness.**

Recovery Environment

- Supportive Elements:
  - Stable, supportive relationships w/ family
  - Adequate housing
  - Adequate material resources
  - Stable, supportive relationships with friends, employers, teachers, clergy, professionals, and other community members
  - Based on client's perception of support.

CASII Dimension IV: *Recovery Environment*
B. Environmental Support

1. **OPTIMAL SUPPORTIVE ENVIRONMENT**

- **Family and ordinary community resources are adequate** to address child's developmental and material needs.
- **Continuity of active, engaged care givers,** with a warm, caring relationship with at least one care giver.

CASII Dimension IV: *Recovery Environment*
B. Environmental Support

2. ADEQUATE SUPPORTIVE ENVIRONMENT

- Continuity of family members/care givers is only **occasionally disrupted,** and/or relationships with family members/care givers are only occasionally inconsistent.
- **Family/care givers willing & able to participate in treatment** if requested and have capacity to effect needed changes.
- **Special needs addressed** through successful involvement in systems of care (special education, speech therapy.)
- **Community resources are sufficient** to address child's developmental and material needs.

CASII Dimension IV: *Recovery Environment*
B. Environmental Support

3. LIMITED SUPPORT IN ENVIRONMENT

- **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.
- **Community resources only partially compensate** for unmet material and emotional needs and/or child or adolescent has limited or inconsistent access to network.
- **Family or primary care givers demonstrate only partial ability to make necessary changes** during treatment.

CASII Dimension IV: *Recovery Environment*
B. Environmental Support

4. MINIMAL SUPPORTIVE ENVIRONMENT

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

CASII Dimension IV: *Recovery Environment*

B. Environmental Support

5. NO SUPPORT IN ENVIRONMENT

- **Family and/or other care givers are completely unable** to meet the child's developmental, material, and/or emotional needs.
- **Community system** is fragmented, ineffective, or **unable to meet child's needs.**
- Fragmentation and/or lack of effectiveness of multiple system involvement.
- **Inability of family or other care givers to make changes or participate in treatment**.
- **Lack of even minimal attachment to benevolent other,** or multiple attachments to abusive, violent, and/or threatening others.

Dimension V
RESILIENCY AND/OR RESPONSE TO SERVICES

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.**

CASII Dimension V: *Resiliency and/or Response to Services*

1. FULL RESILIENCY AND/ OR RESPONSE TO TREATMENT

- Child/youth has demonstrated **significant and consistent capacity to maintain development** in the face of normal challenges, or to readily resume normal development following extraordinary challenges.
- Prior experience indicates that **efforts in most types of treatment have been helpful** in controlling the presenting problem in a relatively short period of time.
- There has been **successful management of extended recovery with few and limited periods of relapse** even in unstructured environments or without frequent services.
- Able to transition successfully and accept changes in routine without support; optimal flexibility.

CASII Dimension V: *Resiliency and/or Response to Services*

2. SIGNIFICANT RESILIENCY AND/OR RESPONSE TO TREATMENT

- Child/youth has demonstrated **average ability to deal with stressors** and maintain developmental progress.
- **Previous experience** with services has been **successful** in controlling symptoms but more **lengthy intervention is required.**
- **Significant ability to manage recovery** has been demonstrated for extended periods, but has **required structured settings** or ongoing care and/or peer support.
- **Recovery** has been managed for **short periods** of time with **limited support or structure.**
- Able to **transition successfully** and accept changes in routine **with minimal support.**

CASII Dimension V: *Resiliency and/or Response to Services*

3. MODERATE/ EQUIVOCAL RESILIENCY/RESPONSE TO TREATMENT

- Child/youth has demonstrated an **inconsistent or equivocal capacity to deal with stressors** and maintain normal development.
- Previous experience with **services at low level of intensity has not been successful** in relief of symptoms or optimal control of symptoms.
- **Recovery has been maintained for moderate periods of time,** but only with **strong professional or peer support** or in structured settings.
- Developmental pressures and life changes have created temporary stress
- Able to transition successfully and accept change in routine most of the time with a moderate intensity of support.

CASII Dimension V: *Resiliency and/or Response to Services*

4. POOR RESILIENCY AND/OR RESPONSE TO TREATMENT

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

CASII Dimension V: *Resiliency and/or Response to Services*

5. NEGLIGIBLE RESILIENCY AND/OR RESPONSE TO TREATMENT

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

Dimension VI
INVOLVEMENT IN SERVICES
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.**

INVOLVEMENT IN SERVICES

- Child and Adolescent Factors:
  - Forms positive therapeutic relationship
  - Define presenting problem
  - Accept responsibility for the presenting problem
  - Accepts role in the treatment process
  - Actively participates in treatment

CASII Dimension VIA: Child and Adolescent *Involvement in Services*

1. OPTIMAL

- **Quickly forms a trusting and respectful positive therapeutic** relationship with clinicians and other care providers.
- **Able to define problem(s)** and accepts others' definition of the problem(s), and consequences.
- Accepts **age-appropriate responsibility** for behavior that causes and/or exacerbates primary problem.
- Actively **participates in treatment planning** and cooperates in services.

CASII Dimension VIA: Child and Adolescent *Involvement in Services*

2. ADEQUATE

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

CASII Dimension VIA: Child and Adolescent *Involvement in Services*

3. LIMITED

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

CASII Dimension VIA: Child and Adolescent *Involvement in Services*

4. MINIMAL

- **A difficult and unproductive relationship with clinician** and other are providers.
- **Accepts no age-appropriate responsibility** role in development, perpetuation, or consequences of the problem.
- **Actively, frequently disrupts assessment and service.**

5. ABSENT

- **Unable to form therapeutic working relationship** with clinicians or other care providers due to severe withdrawal, psychosis, or other profound disturbance in relatedness.
- **Unaware of problem or its consequences.**
- **Unable to communicate with clinician** due to severe cognitive delay or speech/language impairment.

Acceptance and Engagement

- Caretaker Factors:
  - Forms positive therapeutic relationship
  - Engages with clinician in defining presenting problem.
  - Explores their role as it impacts the problem
  - Takes an active role in the treatment planning and process

CASII Dimension VIB: Parent and/or Primary Caretaker Involvement in Services

1. OPTIMAL

- **Quickly and actively engages** in a trusting and positive relationship with clinician and care providers.
- **Sensitive and aware of child or adolescent's needs and strengths** as they pertain to the presenting problem.
- **Sensitive and aware of their child or adolescent's problems** and how they can contribute to their child's recovery.
- **Active and enthusiastic in participation in services.**

CASII Dimension VIB: Parent and/or Primary Caretaker Involvement in Services

2. ADEQUATE

- **Develop positive therapeutic relationship** with clinicians and other primary care takers.
- **Able to explore the problem and accept others' definition of the problem.**
- **Works collaboratively with clinicians** and other care takers in development of service plan.
- **Cooperates with service plan,** with behavior change and good follow-through on interventions.

CASII Dimension VIB: Parent and/or Primary Caretaker Involvement in Services

3. LIMITED

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

CASII Dimension VIB: Parent and/or Primary Caretaker Involvement in Services

4. MINIMAL

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

CASII Dimension VIB: Parent and/or Primary Caretaker Involvement in Services

5. ABSENT

- **No awareness of problem.**
- **Not physically available.**
- **Refuses to accept child or adolescent, or other family members' need to change.**
- **Unable to form relationship with clinician or other care provider** due to significant cognitive difficulties, psychosis, intoxication, or major mental illness or impairment.

Reminder

- Consider the “bigger picture” if applicable. If a child is in an out of home placement, it may be necessary to look at the current care provider as well as the natural parent that the child will be returning to when determining the score.

Reminder

- When considering these dimensions, we must be careful to be culturally competent

  i.e. A non-English speaking client may appear to be obstructive when it comes to treatment acceptance and engagement, when in reality, it may be a language barrier or the product of a different family culture

CASII Scoring

- Review Introductory Paragraph for each dimension.
- Select the highest level in each dimension where at least ONE of the anchor point applies.
- If no anchor point applies, pick the CLOSEST fit, or write in your own description under “other”.
- If confusion between two levels, choose the HIGHER level.
- Base ratings on face to face interview with child/adolescent and all other available clinical information, including caretakers and records.
- Scores are based on the child’s status at the TIME OF ADMINISTRATION.

CASII Scoring (cont.)

- Use total CASII score and clinical judgment to determine level of service intensity. Discrepancies between CASII derived level of care and actual level of care must include written clinical justification.

- Do not “inflate” CASII score to justify a level of care. Use written clinical justification if CASII derived level of care does not meet child’s clinical needs.

CASII Level of Care Overview

- The Level of Care portion of the *CASII* describes a graded continuum of treatment responses
- At each level of service, examples are provided to illustrate a broad range of options, allowing for variations in practice patterns and resources among communities, and within different agencies
- Each level subsumes the services at every level of care below it
- Children with multiple problems require an inter-agency and multi-disciplinary approach, involving multiple professionals of differing levels of training and expertise

CASII Level of Care Overview Cont:

- Levels of care described include services provided by mental health, social services, juvenile justice, health, educational, substance abuse, vocational, developmental disability, and recreational agencies, as well as informal community supports
- *CASII* assumes and advocates for the use of child and family teams (CFT)
  - *CFT's empower families to assume a leadership role by bringing together and case managing all services and service providers using a wraparound approach with an individualized care coordination plan*

CASII Level of Care Transitions

- The child and family's service needs are likely to change as treatment progresses
- A flexible care coordination plan can facilitate seamless transitions, with the same clinicians and staff providing care at multiple service levels whenever possible
- Re-administration of the CASII can help determine a child's readiness for alternative services

CASII Identifies Seven Levels of Care

- Level 0: Basic Services for Prevention and Maintenance
- Level 1: Recovery Maintenance and Health Management
- Level 2: Outpatient Services
- Level 3: Intensive Outpatient Services
- Level 4: Intensive Integrated Service w/o 24-Hour Psychiatric Monitoring
- Level 5: Non-Secure 24-Hour Services with Psychiatric Monitoring
- Level 6: Secure 24-Hour Services with Psychiatric Management

Level 0: Basic Services for Prevention and Health Maintenance

- Composite score of 7-9
- Basic Services are designed to prevent the onset of mental health challenges, as well as to limit the magnitude of risk factors and existing disorders in various stages of improvement and remission
- Services are generally offered in a variety of community settings

Level 1: Recovery Maintenance and Health Management

- Composite score of 10-13
- Provides treatment to children and adolescents who are living either with their families or are placed in an alternative family setting in the community
- These services usually utilize family strengths, and reinforce linkages to natural supports
- Those appropriate for Level One services are often times recovered from an emotional disorder or other problem, or at the least are well managed within their family

Level 2: Outpatient Services

- Composite score of 14-16
- Level Two includes mental health services for those typically living in the community, either with their families or in alternative (natural) families
- These services are usually provided in mental health clinics, clinician's/provider's offices, schools, social service agencies, or a juvenile justice facility
- Community supports are accessed and utilized by families, often with minimal assistance. Individualization of services is essential in maintaining the youth at his/her current level of functioning

Level 3: Intensive Outpatient Services

- Composite score of 17-19
- This level is typically appropriate for those who need intensive outpatient treatment, and are living with their families or a group home in the community
- Family strengths allow most, but not all, of the child's needs to met through natural and informal supports
- Treatment may be needed several times a week, with daily supervision by family or facility staff
- Service coordination is essential for maintaining the child or adolescent in the community

Level 4: Intensive Integrated Services w/o 24-Psychiatric Monitoring

- Composite score of 20-22
- Service includes involvement of multiple components/individuals within the system of care (i.e. PO, mental health clinician, psychiatrist, teacher)
- Intensive case management is used to coordinate multi-system and multidisciplinary interventions
- Partial hospitalization, intensive day treatment, and home based wraparound care are often utilized
- An individualized care coordination plan directed by the CFT is recommended to maintain placement/treatment progress

Level 5: Non-Secure 24-Hour Services with Psychiatric Monitoring

- Composite score of 23-27
- Essential element of treatment is the maintenance of a milieu in which therapeutic needs can be addressed immediately
- Can often be provided in non-hospital settings, such as a therapeutic foster home or residential treatment center
- Intensive wraparound services and a Child and Family Team are often required for planning and coordinating

Level 6: Secure 24-Hour Services with Psychiatric Management

- Composite score of 28 or higher
- Level six services are the most restrictive and typically the most intensive within the care continuum
- These services are usually provided in a secure and/or locked facility
- In the community, success may be achieved through intense mental health and medical services. In a non-secure community setting, enriched staffing, unique location, and/or use of specialized monitoring devices may create a comparable level of safety, security, supervision, and service as traditional facilities
- Protection of children in Level Six may include restricting freedom of movement and others' access. However, every effort to reduce duration and pervasiveness of restrictions is desirable to minimize negative effects of institutionalization
- Psychiatric and nursing staff should be immediately available

CASII: Level of Care Transitions

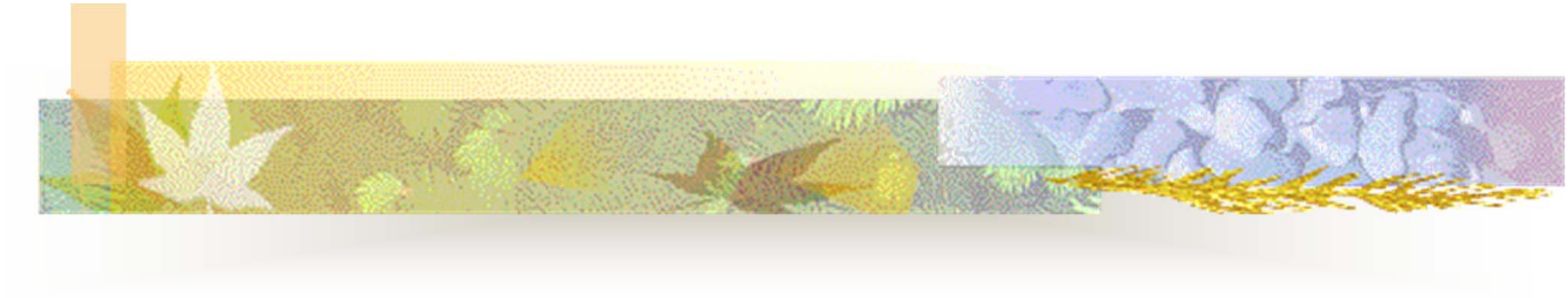
- The child and family's service needs are likely to change as treatment progresses.
- Level of Care transitions do not have to occur sequentially.
- Children may make a transition to another level of care after an adequate period of stabilization and based on the family's and treatment team's clinical judgment.
- Re-administration of CASII can help determine a child's readiness for another level of care, and can identify areas of subsequent treatment. Frequency of re-administration should be proportionate to level of care or agency policy and standards.
- It may be desirable for a youth to be continued at a higher level of care to preclude relapse and unnecessary disruption of care and to achieve lasting stability.

When to Administer the *CASII*

- As a general rule, the *CASII* is scored at the beginning of treatment, at points of significant change, and at termination of services

- For most agencies, the *CASII* is completed along with a 90-day progress report. Check with your agency to ensure that you are following proper policy and procedures.

Case Studies: Laura and James



Children's Mental Health Assessment (CUMHA)

- The CUMHA was constructed about 10 years ago here in Nevada by a committee comprised of public and private providers.
- The purpose was to standardize assessment to support seamless transitions between services in the Nevada system of care.
- Nevada agencies agreed to use the CUMHA to reduce the number of interviews for families seeking multiple services.
- There was a revision in 2015 when the DSM-5 was published to:
  - Update the diagnosis module from DSM-IV to DSM-5
  - Reduce redundant questions across modules.
  - Add a symptom checklist to strengthen the clinical summary and diagnosis section. The APA cross-cutting measures were chosen to do this.

Children's Mental Health Assessment (CUMHA)

- The CUMHA provides comprehensive psychosocial information that can assist in completing the CANS.
- It is completed at intake and is required by Medicaid to be updated annually.

CUMHA Modules and Sections

- There are **fourteen Sections** of the CUMHA organized into **four Modules.**
  - **Module 1: Presenting Concerns**
    - Reason for Seeking Services
  - **Module 2: Current Situation**
    - Safety Concerns
    - Family Information
  - **Module 3: History**
    - Child's Developmental History
    - Trauma History
    - Medical History
    - Substance Abuse
    - Child's Sexual History
    - Child's Legal History
    - Child's Educational History and Current Status

CUMHA modules and sections (cont.)

- **Module 4: Mental Health Assessment**
  - Current Mental Status
  - Diagnoses
  - Summary and Recommendations

CUMHA Module 1: Presenting Concerns

- **Module 1** assesses the reason for services, from the point of view of the parent, child and/or referral sources
- **Level 1 Cross-cutting measures** are given to the family before the CUMHA assessment session and results are reviewed in the CUMHA session. Any significant symptoms identified on the level 1 measures should be further assessed using level 2 measures.
- All Cross cutting measures are available to copy at www.psychiatry.org/dsm5

Cross-cutting measures

- **Level 1 Cross-cutting Symptom Measures:**
  - Contain symptoms relevant to most psychiatric disorders (hence "cross-cutting").
  - Self-administered by adults and children 11+ years.
  - Screen for symptoms, not necessarily for **diagnoses.**
  - Scoring information is provided.
  - APA encourages use for assessment and tracking treatment progress. May be reproduced by clinicians for use with their patients. Available on **www.psychiatry.org/dsm5**

DSM-5 Parent/Guardian-Rated Level 1 Cross-Cutting Symptom Measure—Child Age 6–17

Child's Name: _____ **Age:** ____ **Sex:** ❑ **Male** ❑ **Female** **Date:**_____

Relationship with the child: _____

Instructions *(to the parent or guardian of child)*: **The questions below ask about things that might have bothered your child. For each question, circle the number that best describes how much (or how often) your child has been bothered by each problem during the past TWO (2) WEEKS.**

		During the past **TWO (2) WEEKS**, how much (or how often) has your child…	**None** Not at all	**Slight** Rare, less than a day or two	**Mild** Several days	**Moderate** More than half the days	**Severe** Nearly every day	**Highest Domain Score** (clinician)
I.	1.	Complained of stomachaches, headaches, or other aches and pains?	0	1	2	3	4	
	2.	Said he/she was worried about his/her health or about getting sick?	0	1	2	3	4	
II.	3.	Had problems sleeping—that is, trouble falling asleep, staying asleep, or waking up too early?	0	1	2	3	4	
III.	4.	Had problems paying attention when he/she was in class or doing his/her homework or reading a book or playing a game?	0	1	2	3	4	
IV.	5.	Had less fun doing things than he/she used to?	0	1	2	3	4	
	6.	Seemed sad or depressed for several hours?	0	1	2	3	4	
V. &	7.	Seemed more irritated or easily annoyed than usual?	0	1	2	3	4	
VI.	8.	Seemed angry or lost his/her temper?	0	1	2	3	4	
VII.	9.	Started lots more projects than usual or did more risky things than usual?	0	1	2	3	4	
	10.	Slept less than usual for him/her, but still had lots of energy?	0	1	2	3	4	
VIII.	11.	Said he/she felt nervous, anxious, or scared?	0	1	2	3	4	
	12.	Not been able to stop worrying?	0	1	2	3	4	
	13.	Said he/she couldn't do things he/she wanted to or should have done, because they made him/her feel nervous?	0	1	2	3	4	
IX.	14.	Said that he/she heard voices—when there was no one there—speaking about him/her or telling him/her what to do or saying bad things to him/her?	0	1	2	3	4	
	15.	Said that he/she had a vision when he/she was completely awake—that is, saw something or someone that no one else could see?	0	1	2	3	4	
X.	16.	Said that he/she had thoughts that kept coming into his/her mind that he/she would do something bad or that something bad would happen to him/her or to someone else?	0	1	2	3	4	
	17.	Said he/she felt the need to check on certain things over and over again, like whether a door was locked or whether the stove was turned off?	0	1	2	3	4	
	18.	Seemed to worry a lot about things he/she touched being dirty or having germs or being poisoned?	0	1	2	3	4	
	19.	Said that he/she had to do things in a certain way, like counting or saying special things out loud, in order to keep something bad from happening?	0	1	2	3	4	
		In the past **TWO (2) WEEKS**, has your child …						
XI.	20.	Had an alcoholic beverage (beer, wine, liquor, etc.)?	☐ Yes	☐ No	☐ Don't Know			
	21.	Smoked a cigarette, a cigar, or pipe, or used snuff or chewing tobacco?	☐ Yes	☐ No	☐ Don't Know			
	22.	Used drugs like marijuana, cocaine or crack, club drugs (like ecstasy), hallucinogens (like LSD), heroin, inhalants or solvents (like glue), or methamphetamine (like speed)?	☐ Yes	☐ No	☐ Don't Know			
	23.	Used any medicine without a doctor's prescription (e.g., painkillers [like Vicodin], stimulants [like Ritalin or Adderall], sedatives or tranquilizers [like sleeping pills or Valium], or steroids)?	☐ Yes	☐ No	☐ Don't Know			
XII.	24.	In the past **TWO (2) WEEKS**, has he/she talked about wanting to kill himself/herself or about wanting to commit suicide?	☐ Yes	☐ No	☐ Don't Know			
	25.	Has he/she EVER tried to kill himself/herself?	☐ Yes	☐ No	☐ Don't Know			

DSM-5 Self-Rated Level 1 Cross-Cutting Symptom Measure—Child Age 11–17

Name: _____ Age: ____ Sex: ❑ Male ❑ Female Date:_____

Instructions: The questions below ask about things that might have bothered you. For each question, circle the number that best describes how much (or how often) you have been bothered by each problem during the **past TWO (2) WEEKS.**

		During the past **TWO (2) WEEKS**, how much (or how often) have you…	None Not at all	Slight Rare, less than a day or two	Mild Several days	Moderate More than half the days	Severe Nearly every day	Highest Domain Score (clinician)
I.	1.	Been bothered by stomachaches, headaches, or other aches and pains?	0	1	2	3	4	
	2.	Worried about your health or about getting sick?	0	1	2	3	4	
II.	3.	Been bothered by not being able to fall asleep or stay asleep, or by waking up too early?	0	1	2	3	4	
III.	4.	Been bothered by not being able to pay attention when you were in class or doing homework or reading a book or playing a game?	0	1	2	3	4	
IV.	5.	Had less fun doing things than you used to?	0	1	2	3	4	
	6.	Felt sad or depressed for several hours?	0	1	2	3	4	
V. & VI.	7.	Felt more irritated or easily annoyed than usual?	0	1	2	3	4	
	8.	Felt angry or lost your temper?	0	1	2	3	4	
VII.	9.	Started lots more projects than usual or done more risky things than usual?	0	1	2	3	4	
	10.	Slept less than usual but still had a lot of energy?	0	1	2	3	4	
VIII.	11.	Felt nervous, anxious, or scared?	0	1	2	3	4	
	12.	Not been able to stop worrying?	0	1	2	3	4	
	13.	Not been able to do things you wanted to or should have done, because they made you feel nervous?	0	1	2	3	4	
IX.	14.	Heard voices—when there was no one there—speaking about you or telling you what to do or saying bad things to you?	0	1	2	3	4	
	15.	Had visions when you were completely awake—that is, seen something or someone that no one else could see?	0	1	2	3	4	
X.	16.	Had thoughts that kept coming into your mind that you would do something bad or that something bad would happen to you or to someone else?	0	1	2	3	4	
	17.	Felt the need to check on certain things over and over again, like whether a door was locked or whether the stove was turned off?	0	1	2	3	4	
	18.	Worried a lot about things you touched being dirty or having germs or being poisoned?	0	1	2	3	4	
	19.	Felt you had to do things in a certain way, like counting or saying special things, to keep something bad from happening?	0	1	2	3	4	
		In the past **TWO (2) WEEKS**, have you…						
XI.	20.	Had an alcoholic beverage (beer, wine, liquor, etc.)?		❑ Yes		❑ No		
	21.	Smoked a cigarette, a cigar, or pipe, or used snuff or chewing tobacco?		❑ Yes		❑ No		
	22.	Used drugs like marijuana, cocaine or crack, club drugs (like Ecstasy), hallucinogens (like LSD), heroin, inhalants or solvents (like glue), or methamphetamine (like speed)?		❑ Yes		❑ No		
	23.	Used any medicine without a doctor's prescription to get high or change the way you feel (e.g., painkillers [like Vicodin], stimulants [like Ritalin or Adderall], sedatives or tranquilizers [like sleeping pills or Valium], or steroids)?		❑ Yes		❑ No		
XII.	24.	In the last 2 weeks, have you thought about killing yourself or committing suicide?		❑ Yes		❑ No		
	25.	Have you EVER tried to kill yourself?		❑ Yes		❑ No		

Cross-cutting measures

- **Level 2 Cross-Cutting Measures**
  - Completed when Level I measure indicates area of possible clinical importance (score of 2, 3 or 4).
  - Provides more detailed questions regarding the symptom domain.
  - Based on well-validated measures (e.g. SNAP-IV) of various symptom domains
  - Scoring information is provided.

Severity Measure for Depression—Child Age 11–17*

*PHQ-9 modified for Adolescents (PHQ-A)—Adapted

Name:_____ **Age:** _____ **Sex: Male** ❑ **Female** ❑ **Date:**_____

Instructions: How often have you been bothered by each of the following symptoms during the past 7 days? For each symptom put an "X" in the box beneath the answer that best describes how you have been feeling.

						Clinician Use
						Item score
		(0) Not at all	(1) Several days	(2) More than half the days	(3) Nearly every day	
1.	Feeling down, depressed, irritable, or hopeless?					
2.	Little interest or pleasure in doing things?					
3.	Trouble falling asleep, staying asleep, or sleeping too much?					
4.	Poor appetite, weight loss, or overeating?					
5.	Feeling tired, or having little energy?					
6.	Feeling bad about yourself—or feeling that you are a failure, or that you have let yourself or your family down?					
7.	Trouble concentrating on things like school work, reading, or watching TV?					
8.	Moving or speaking so slowly that other people could have noticed? Or the opposite—being so fidgety or restless that you were moving around a lot more than usual?					
9.	Thoughts that you would be better off dead, or of hurting yourself in some way?					
					Total/Partial Raw Score:	
					Prorated Total Raw Score: (if 1-2 items left unanswered)	

Modified from the PHQ-A (J. Johnson, 2002) for research and evaluation purposes

CUMHA Module 2: Current Situation

- If there are safety concerns identified by the CUMHA section 2, further evaluation beyond the CUMHA questions and supervisor consultation is recommended to make a risk assessment.
- If the youth is currently in crisis, safety planning and/or hospitalization procedures are initiated.
- If there is no current crisis, continue with family information questions in Module 2.
- At the end of each Module there is a General Comments section to record significant information that may not be covered by the CUMHA questions.

CUMHA Modules 3 and 4: History and Mental Health Assessment

- In Module 3, complete all historical sections using the questions and checklists.
- In Module 4, conduct mental status evaluation and record preliminary diagnosis and SED determination. Medicaid currently considers a child with a CAFAS/PECFAS score of 40 and higher and with a DSM diagnosis as SED.
- The CANS may also be a Medicaid-approved functional assessment scale.

Children with a **Severe Emotional Disturbance (SED)** are persons age 4 to age 18 who currently or at anytime during the past year (continuous 12-month period) have a:

a. **Diagnosable mental, behavioral or diagnostic criteria that meet the coding and definition criteria specified in the DSM.** This excludes substance abuse or addictive disorders, irreversible dementias, as well as mental retardation and V codes, unless they co-occur with another serious mental illness that meets DSM criteria that results in functional impairment which substantially interferes with or limits the child's role or functioning in family, school, or community activities, and

b. These disorders include any mental disorder (including those of biological etiology) listed in DSM or their ICD-9-CM equivalent (and subsequent revisions), **with the exception of DSM "V" codes, substance use, and developmental disorders,** which are excluded unless they co-occur with another diagnosable serious emotional disturbance. All of these disorders have episodic, recurrent, or persistent features; however they vary in terms of severity and disabling effects; and

c. **Have a functional impairment defined as difficulties that substantially interfere with or limit a child or adolescent from achieving or maintaining one or more developmentally appropriate social, behavioral, cognitive, communicative or adaptive skills.** Functional impairments of episodic, recurrent, and continuous duration are included unless they are temporary and expected responses to stressful events in the environment. Children who would have met functional impairment criteria during the referenced year without the benefit of treatment or other support services are included in this definition.

CUMHA Modules 3 and 4: History and Mental Health Assessment (cont.)

- **Summary and Recommendations** section should include relevant information that led to the diagnosis.
- **Family strengths** should be included to assist in treatment plan formulation
- Family **expectations for treatment** come from a discussion of everyone's role in treatment and responsibilities to reach positive outcomes.
- **Clinical recommendations** should include treatment modalities and frequencies.
- **Discharge plan** should include levels of improvement that will prompt discharge.