

FOOTHILLS BEHAVIORAL HEALTH PARTNERS

CALOCUS Dimensions

I. Risk of Harm

This dimension considers a child or adolescent's potential to be harmed by others or cause significant harm to self or others. Each category contains items that assess a child or adolescent's risk of harming him/herself and of harming others. While Risk of Harm most frequently is manifested by suicidal or homicidal behavior, it also may embody unintentional harm from misinterpretations of reality; inability to adequately care for oneself or temper impulses with judgment; or intoxication. Furthermore, Risk of Harm may be manifested by a child or adolescent's inability to perceive threats to safety and to take appropriate action to be safe. In this regard, younger children and children with developmental or other disabilities, unless protected, are more vulnerable. It is also true that children of any age who have experienced severe and/or repeated abuse in a hostile environment may be unable to perceive threat or take adequate measures to increase their safety.

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

II. Functional Status

This dimension measures changes in the degree to which a child or adolescent is able to fulfill responsibilities and to interact with others, changes in vegetative status, (such as sleeping, eating habits, activity level, or sexual interest), and capacity for self-care. Functioning may be compared against what would be expected for a given child or adolescent at a given developmental level, or may be compared to a baseline functional level for that individual. For the purposes of this dimension, only sources of impairment directly related to developmental, psychiatric, and/or substance use problems should be considered. While other types of disabilities may play a role in determining the support services required, they generally will not be considered in determining level of care placement in the behavioral treatment continuum. Functional deficits that are ongoing and may place a child or adolescent at risk of harm are rated on Dimension I. An example would be the failure of an autistic child to understand the risk of safety when crossing a busy intersection. Clinicians also need to be aware that psychosocial functioning may be under-estimated in the context of low socioeconomic status or different expectations about functions for children and adolescents of culturally distinct backgrounds.

III. Medical, Substance Use, Developmental and Psychiatric Co-Morbidity

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

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

IV. Recovery Environment

This dimension considers factors in the environment that may contribute to the onset or maintenance of the primary disorder, and factors that may support a child or adolescent's efforts to achieve or maintain

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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.

V. Resiliency and Treatment History

This dimension recognizes a child or adolescent's natural history of response to developmental challenges and stressors or resiliency may indicate how that child or adolescent may respond to treatment.

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

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

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

VI. Acceptance and Engagement (Child or Adolescent)

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

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

The child or adolescent sub-scale measure the ability of the child or adolescent, within developmental constraints, to form a positive therapeutic relationship with people in component of the system providing treatment, to define the presenting problems, to accept his or her role in the development and

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perpetuation of the primary problem and to accept his or her role in the treatment planning and treatment process and to actively cooperate in treatment.

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