

**FOOTHILLS BEHAVIORAL HEALTH  
PARTNERS  
CHILD & ADOLESCENT LEVEL OF CARE  
UTILIZATION SYSTEM (CALOCUS)  
WORKSHEET ANSWER KEY**

**I. Risk of Harm**

**1. Low Risk of Harm**

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

**2. Some Risk of Harm**

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

**3. Significant Risk of Harm**

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

**4. Serious Risk of Harm**

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

**5. Extreme Risk of Harm**

- A. Current suicidal or homicidal behavior or such intentions with a plan and available means to carry out this behavior.
  - i. without expressed ambivalence or significant barriers to doing so, or
  - ii. with a history of serious past attempts that are not of a chronic, impulsive, or consistent nature, or
  - iii. in presence of command hallucinations or delusions that threaten to override usual impulse control.
- B. Indication or report of repeated behavior, including physical or sexual aggression, that is clearly injurious to self or others (e.g., fire setting with intent of serious property destruction or harm to others or self, planned violence and/or group violence with other perpetrators) with history, plan, or intent, and no insight or 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.

# FOOTHILLS BEHAVIORAL HEALTH PARTNERS

## II. Functional Status

### 1. Minimal Functional Impairment

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

### 2. Mild Functional Impairment

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

### 3. Moderate Functional Impairment

- A. Conflicted, withdrawn, or otherwise troubled in relationships with peers, adults, and/or family, but without episodes of physical aggression.
- B. Self-care/hygiene deteriorates below usual or expected standards on a frequent basis.
- C. Significant disturbances in vegetative activities, (such as sleeping, eating habits, activity level or sexual interest), that do not pose a serious threat to health.
- D. School behavior has deteriorated to the point that in-school suspension has occurred and the child is at risk for placement in an alternative school or expulsion due to their disruptive behavior. Absenteeism may be frequent. The child is at risk for repeating their grade.
- E. Chronic and/or variably severe deficits in interpersonal relationships, ability to engage in socially constructive activities and ability to maintain responsibilities.
- F. Recent gains and/or stabilization in functioning have been achieved while participating in treatment in a structured, protected and/or enriched setting.

### 4. Serious Functional Impairment

- A. Serious deterioration of interpersonal interactions with consistently conflictual or otherwise disrupted relations with others, which may include impulsive or abusive behaviors.
- B. Significant withdrawal and avoidance of almost all social interaction.
- C. Consistent failure to achieve self-care/hygiene at levels appropriate to age and/or developmental level.
- D. Serious disturbances in vegetative status, such as weight change, disrupted sleep or fatigue, and feeding or elimination, which threaten physical functioning.
- E. Inability to perform adequately even in a specialized school setting due to disruptive or aggressive behavior. School attendance may be sporadic. The child or adolescent has multiple academic failures.

### 5. Severe Functional Impairment

- A. Extreme deterioration in interactions with peers, adults, and/or family that may include chaotic communication or assaultive behaviors with little or no provocation, minimal control over impulses that may result in abusive behaviors.
- B. Complete withdrawal from all social interactions.
- C. Complete neglect of and inability to attend to self-care/hygiene/control of biological functions with associated impairment in physical status.
- D. Extreme disruption in vegetative function causing serious compromise of health and well-being.
- E. Nearly complete inability to maintain any appropriate school behavior and/or academic achievement given age and developmental level.

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

### 1. No Co-Morbidity

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

### 2. Minor Co-Morbidity

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

### 3. Significant Co-Morbidity

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

### 4. Major Co-Morbidity

- A. Medical conditions are present or have a high likelihood of developing that may require intensive, although not constant, medical monitoring (e.g., insulin-dependent diabetes, hemophilia).
- B. Medical conditions are present that will adversely affect, or be affected by, the presenting disorder.
- C. Uncontrolled substance use is present that poses a serious threat to health is unabated and impedes recovery from the presenting problem.
- D. Developmental delay or disorder is present that will adversely affect the course, treatment, or outcome of the presenting disorder.
- E. Psychiatric symptoms are present that clearly impair functioning, persist in the absence of stressors, and seriously impair recovery from the presenting problem.

### 5. Severe Co-Morbidity

- A. Significant medical condition is present that is poorly controlled and/or potentially life threatening in the absence of close medical management (e.g., severe alcohol withdrawal, uncontrolled diabetes mellitus, complicated pregnancy, severe liver disease, debilitating cardiovascular disease).
- B. Medical condition acutely or chronically worsens or is worsened by the presenting problem.
- C. Substance dependence is present, with inability to control use, intense withdrawal symptoms and extreme negative impact on the presenting disorder.
- D. Developmental disorder is present that seriously complicates, or is seriously compromised by, the presenting disorder.
- E. Acute or severe psychiatric symptoms are present that seriously impair functioning, and/or prevent voluntary participation in treatment for the presenting problem, or otherwise prevent recovery from the presenting problem.

# FOOTHILLS BEHAVIORAL HEALTH PARTNERS

## IV. Recovery Environment

### *Environmental Stress*

#### **1. Minimally Stressful Environment**

- A. Absence of significant or enduring difficulties in environment and life circumstances are stable.
- B. Absence of recent transitions or losses of consequence (e.g., no change in school, residence, or marital status of parents, or no birth/death of family member).
- C. Material needs are met without significant cause for concern that they may diminish in the near future, with no significant threats to safety or health.
- D. Living environment is conducive to normative growth, development, and recovery.
- E. Role expectations are normative and congruent with child or adolescent's age, capacities and/or developmental level.

#### **2. Mildly Stressful Environment**

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

#### **3. Moderately Stressful Environment**

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

#### **4. Highly Stressful Environment**

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

#### **5. Extremely Stressful Environment**

- A. Traumatic or enduring and highly disturbing circumstances, such as 1) violence, sexual abuse or illegal activity in the home or community, 2) the child or adolescent is witness to or a victim of a natural disaster, 3) the sudden or unexpected death of a loved one, 4) unexpected or unwanted pregnancy.
- B. Political or racial persecution, immigration, social isolation, language barriers, and/or illegal alien status.
- C. Incarceration, foster home placement or re-placement, inadequate residence and/or extreme poverty or constant threat of such.
- D. Severe pain, injury, or disability, or imminent threat of death due to severe illness or injury.

# FOOTHILLS BEHAVIORAL HEALTH PARTNERS

## *Environmental Support*

1. **Highly Supportive Environment**
  - A. Family and ordinary community resources are adequate to address child's developmental and material needs.
  - B. Continuity of active, engaged, primary care takers, with a warm, caring relationship with at least one primary care taker.
  
2. **Supportive Environment**
  - A. Continuity of family or primary care takers is only occasionally disrupted, and/or relationships with family or primary care takers are only occasionally inconsistent.
  - B. Family/primary care-takers are willing and able to participate in treatment if requested to do so and have capacity to effect needed changes.
  - C. Special needs are addressed through successful involvement in systems of care (e.g., low level special education, tutoring, speech therapy).
  - D. Community resources are sufficient to address child's developmental and material needs.
  
3. **Limited Support in Environment**
  - A. Family has limited ability to respond appropriately to child's developmental needs and/or problems, or is ambivalent toward meeting these needs or addressing these problems.
  - B. Community resources only partially compensate for unmet material and emotional needs and/or child or adolescent has limited or inconsistent access to network.
  - C. Family or primary care-takers demonstrate only partial ability to make necessary changes during treatment.
  
4. **Minimally Supportive Environment**
  - A. Family or primary care taker is seriously limited in ability to provide for the child's developmental, material and emotional needs.
  - B. Few community supports and/or serious limitations in access to sources of support so that material, health, and/or emotional needs are mostly unmet.
  - C. Family and other primary care takers display limited ability to participate in treatment and/or service plan (e.g., unwilling, inaccessible, cultural dissonance).
  
5. **No Support in the Environment**
  - A. Family and/or other primary care takers are completely unable to meet the child's developmental, material and/or emotional needs.
  - B. Community has deteriorated so that it is unsafe and/or hostile to the needs of children and adolescents for education, recreation, constructive peer relations, and mentoring from unrelated adults.
  - C. Lack of liaison and cooperation between child-servicing agencies.
  - D. Inability of family or other primary care takers to make changes or participate in treatment.
  - E. Lack of even minimal attachment to benevolent other, or multiple attachments to abusive, violent and/or threatening others.

# FOOTHILLS BEHAVIORAL HEALTH PARTNERS

## V. Resiliency and Treatment History

### 1. Full Resiliency and/or Response to Treatment

- A. Child has demonstrated significant and consistent capacity to maintain development in the face of normal challenges, or to readily resume normal development following extraordinary challenges.
- B. Prior experience indicates that efforts in most types of treatment have been helpful in controlling the presenting problem in a relatively short period of time.
- C. There has been successful management of extended recovery with few and limited periods of relapse even in unstructured environments or without frequent treatment.
- D. Able to transition successfully and accept changes in 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 has been successful in controlling symptoms but more lengthy treatment is required.
- C. Significant ability to manage recovery has been demonstrated for extended periods, but has required structured settings or ongoing care and/or peer support.
- D. Recovery has been managed for short periods of time with limited support or structure.
- E. Able to transition successfully and accept changes in routine with minimal support.

### 3. Moderate or Equivocal Resiliency and/or Response to Treatment

- A. Child has demonstrated an inconsistent or equivocal capacity to deal with stressors and maintain normal development.
- B. Previous experience in treatment at low level of intensity has not been successful in relief of symptoms or optimal control of symptoms.
- C. Recovery has been maintained for moderate periods of time, but only with strong professional or peer support or in structured settings.
- D. Has demonstrated limited ability to follow through with treatment recommendations.
- E. Developmental pressures and life changes have created temporary stress.
- F. Able to transition successfully and accept change in routine most of the time with a moderate intensity of support.

### 4. Poor Resiliency and/or Response to Treatment

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

### 5. Negligible Resiliency and/or Response to Treatment

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

# FOOTHILLS BEHAVIORAL HEALTH PARTNERS

## VI. Treatment Acceptance and Engagement

### *Child or Adolescent Acceptance and Engagement*

#### 1. **Optimal**

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

#### 2. **Constructive**

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

#### 3. **Obstructive**

- A. Ambivalent, avoidant, or distrustful relationship with clinicians and other care providers.
- B. Acknowledges existence of problem, but resists accepting even limited age-appropriate responsibility for development, perpetuation, or consequences of problem.
- C. Minimizes or rationalizes problem behaviors and consequences.
- D. Unable to accept others' definition of the problem and its consequences.
- E. Frequently misses or is late for treatment appointments and/or is noncompliant with treatment, including medication and homework assignments.

#### 4. **Adversarial**

- A. Actively hostile relationship with clinicians and other care providers.
- B. Accepts no age-appropriate responsibility role in development, perpetuation, or consequences of the problem.
- C. Actively, frequently disrupts assessment and treatment.

#### 5. **Inaccessible**

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

# FOOTHILLS BEHAVIORAL HEALTH PARTNERS

## *Parent and/or Primary Care Taker Acceptance and Engagement*

### **1. Optimal**

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

### **2. Constructive**

- A. Develops positive therapeutic relationship with clinicians and other primary care takers.
- B. Explores the problem and accept others' definition of the problem.
- C. Works collaboratively with clinicians and other primary care takers in development of treatment plan.
- D. Cooperates with treatment plan, with behavior change and good follow-through on interventions, including medications and homework assignments.

### **3. Obstructive**

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

### **4. Adversarial**

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

### **5. Inaccessible**

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