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The levels of care, or service intensity described in CALOCUS-CASII represent a graded continuum of treatment and other service options corresponding to the CALOCUS-CASII dimensional assessment and composite score. At each level of service intensity, a broad range of programming options is described, allowing for variations in practice patterns and resources among communities. The continuum encompasses traditional services, as well emphasizing nontraditional forms of care, such as those in programs based on a System of Care approach.

The term "level of care" is used for simplicity, but it is not the intention of this section to imply that the service arrays are static or linear. Rather, each level describes a flexible or variable combination of specific service types and might more accurately be said to describe **levels of service intensity**. The particulars of program development are left to providers to determine based on local circumstances and outcome evaluations. Each level encompasses a multidimensional array of service elements, combining crisis, supportive, clinical, and environmental interventions, which vary independently depending on identified needs.

The CALOCUS-CASII levels of care description also provide rough estimates of the staff time involved in providing services at different levels. The actual service times required by each child or adolescent and family are highly variable. However, in the aggregate, service time estimates may be of value to programs.

There may be instances in which clinicians may feel that a different level of care or service intensity than that recommended through the CALOCUS-CASII assessment is necessary. While parent-child desires and clinician judgment must be a priority, a clear and compelling rationale for deviation from the level of care recommended by the instrument should be documented in the case record by the clinician.

One additional aspect of the role of the CALOCUS-CASII in treatment planning needs to be recognized. It is not just the overall CALOCUS-CASII score but also the scores for specific Dimensions that are important to track. A high score in a given Dimension directs particular attention to services that are needed to address those specific aspects of overall service intensity need. Serial administrations of the CALOCUS-CASII will help to track changes in critical Dimensions (i.e, Dimensions that have been scored highly) over time. For example, Risk of Harm—a high Risk of Harm score reflects that the child's safety is compromised, requiring ongoing monitoring.

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Workforce Characteristics

This document supports the view that many types of agencies and professionals, when providing services within their scope of practice, are integral to the successful treatment of children and adolescents. Programs should be licensed to offer the requisite services for the levels of care provided and should have the staff and program capabilities necessary to provide those services. In addition, while this document does not specify requirements for the levels of clinician training, clinicians should be well trained, with applicable licensure and/or certification (e.g., child and adolescent psychiatrists, pediatricians, family doctors, child and adolescent psychologists, marriage and family therapists, clinical social workers, professional counselors, psychosocial nurses, independent nurse practitioners, substance abuse clinicians, and/or pastoral counselors), and with training specifically in child, adolescent, and family treatment. Clinicians should provide only care that is within their scope of practice. Non-licensed staff, paraprofessionals and peer support specialists providing therapeutic services as part of the treatment, or care plan should receive supervision by licensed practitioners with training and expertise in child, adolescent, and family treatment. In addition, family members and/or members of the child or adolescent's community provide an array of critically important non-clinical supports and should be included in providing direction and oversight to the program at the management level as well as the service level.

This document does not preclude a child and adolescent psychiatrist from being the primary clinician for both psychotherapeutic and medication services, but providers must determine when this arrangement is advantageous in the treatment planning process. At all levels of care beyond Basic Services, including crisis intervention, access to child and adolescent psychiatrists and child psychiatric Nurse Practitioners is an essential element of the service system. In addition, medical care from either a pediatrician, family medicine physician, or a nurse practitioner must be available in the community for all Service Intensity Levels.

The levels of care are described along a continuum of restrictiveness and intensity. No recommendations in this document supersede Federal, State, or local licensing or operating requirements for agencies, programs, or facilities.

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Level 0: BASIC SERVICES: Prevention and Health Maintenance

Basic Services are designed to prevent the onset of illness and/or to limit the magnitude of morbidity associated with individual family or social risk factors, developmental delays, and existing emotional disorders in various stages of improvement or remission. Services may be developed for individual or community application and are generally offered in a variety of community settings. Prevention and community support involve education and referral services and may be provided through traditional means, as well as through print and broadcast media (e.g., public service announcements and/or targeted mailings). The expectation that individuals utilizing these services may have complex needs requires that these services should be designed to be welcoming to all individuals and provide preventive, holistic, co-occurring/complexity capable care.

This level of care should be available to everyone in the community without obtaining a prior authorization from insurers. Professionals providing services should be appropriately licensed and in good standing. Many support services may be provided by appropriately trained and/or certified paraprofessionals, including certified peer and family specialists.

1. **Clinical Services** - It is imperative that Basic Services in all settings provide screening for mental health and developmental disorders. Comprehensive, multidisciplinary assessments for children and adolescents who, after initial screening, emerge with multi-faceted problems should be readily available. Early Periodic Screening, Detection and Treatment (EPSDT) guidelines should be followed and evaluations should be completed on a regular basis. Linkage with appropriately matched co-occurring capable mental health and/or substance use disorder services (e.g., scheduling intakes) should be provided to families identified in screening assessments. Consultative services by mental health clinicians should be effectively integrated into all prevention and support functions. Medical care from either a pediatrician or family physician should be available in the community.
2. **Support Services** - Basic Services should be available to children, adolescents, and families through active collaboration with religious and culturally distinct community groups, and in a variety of community settings, including schools and adult education centers, day care and recreational/social facilities, vocational and social services agencies, family resource centers and medical facilities. Community volunteers and agency staff should be trained to provide prevention services. Parent psychoeducation related to effective child behavioral management and early awareness and detection of developmental difficulties should be available.

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3. **Crisis Stabilization and Prevention Services** - 24-hour crisis services should be publicized, accessible, and fully integrated into Basic Services in all community settings. Crisis services should include emergency evaluation, brief intervention, and disposition. Child and adolescent psychiatrists and/or psychosocial nurses should be available for direct contact and consultation on a 24-hour basis. Additional crisis intervention and stabilization efforts should include outreach to vulnerable populations, such as homeless families, as well as intervention with victims of trauma and disaster.
4. **Care Environment** - Prevention and community support activities may occur in many settings including a child or adolescent's home, to Head Start programs, primary care offices, schools, churches, medical and recreational facilities, or traditional mental health settings. Facilities should address ease of access (e.g., proximity to public transportation, schools, social services agencies); adequate design (e.g., accommodation for families with disabled or special needs members, play areas for children); cultural competence (e.g., ambiance that is welcoming to families of multiple ethnic and socio-economic groups) and specific service needs (e.g., supervised day care so that parents can participate, staff or consultants for non-English speaking and/or hearing-impaired attendees).

Level 0 Placement Criteria

All children, adolescents, and families should have access to Basic Services.

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LEVEL ONE: Recovery Maintenance and Health Management

Level One services are designed to provide initial steps to limit the magnitude of morbidity associated with individual family and/or community risk and protective factors. .Level One services typically provide follow-up care to reinforce family strengths and family connections with natural supports. Those appropriate for Level One services may either be substantially recovered from an emotional disorder or other problem, or their problems are sufficiently manageable within their families, such that the problems are no longer threatening to expected growth and development. This is a "step down" level of care, or service intensity, designed to prevent or mitigate future episodes of illness or deterioration of function. Treatment and service needs do not require supervision or frequent contact when community support plans are in place. Although this is a low intensity service level, there should be an expectation that individuals utilizing these services may have complex needs. As such, these services should be designed to be welcoming to individuals (and caregivers) who have multiple conditions, and to provide co-occurring/complexity capable services.

This low intensity level of care should not require prior authorization from insurers, and should be available as long as it is needed in much the same way as periodic visits to primary care providers are provided. Professionals providing services should be appropriately licensed or certified. Many support services may be provided by appropriately trained and/or certified paraprofessionals, including certified family and peer specialists. Community resources as faith-based organizations, Boys and Girls Clubs, etc. also provide important support for prevention and maintenance of recovery.

1. **Clinical Services** - Treatment programming (i.e. individual, family and/or group therapy) will be available up to one hour per month, and usually not less than one hour every three months. Psychiatric or physician review and/or contact should take place about once every three to six months. While clinical services at Level One may be non-intensive and/or episodic, they should be readily accessible so that families may use services to avert the need for higher levels of care. Clinical consultation and assessment should be culturally competent and should consider the extent to which families can mobilize natural supports in the community. Time-limited professional interventions, opportunities for check-ins for "graduates" who value continuity of a treatment relationship, as well as ongoing case management and follow-up medication services may be provided as part of Level One clinical services. Medical care from either a pediatrician or family physician should be available in the community and should be supported by consultation from a mental health professional as part of an integrated health program such as a Medical Home.

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2. **Support Services** - Level One support services consist mainly of natural supports in the community, including extended family, friends, and neighbors; parent sponsored support groups, church and recreational programs; 12-step and other self-help programs; school-sponsored programs; and employment. Families appropriate to this level of care have the capacity to access these community resources as needed without professional intervention. Family and youth group psychoeducation should be provided through primary mental health care. Provision of these services should not require more than 1-2 hours per month on the average, though there may be occasional life crises, which would require additional support for short periods of time.
3. **Crisis Stabilization and Prevention Services** - 24-hour crisis services should be available to children, adolescents, and families at this level of service intensity. Crisis intervention staff should consult with primary clinicians. Crisis services should include emergency evaluation, brief intervention, and outreach services. Direct services and/or consultation from child and adolescent psychiatrists and/or psychosocial nurses should be available in each community on a 24-hour basis.
4. **Care Environment** - Recovery maintenance and health management services may be provided in a traditional mental health setting (e.g., office or clinic), in integrated primary care settings or in facilities of other components in the system of care. Facilities should address ease of access (e.g., proximity to public transportation, schools, social services agencies, etc.); adequate design (e.g., accommodation for families with disabled or special needs members, play areas for children); and specific service needs (e.g., supervised day care so that parents can participate, resources for non-English speaking and/or hearing-impaired attendees, etc.). For adolescents, facilities should facilitate a mix of adult supervision with privacy for peer group activities. The facilities should be safe and comfortable for children and adolescents at all developmental levels, as well as their families.

Level 1 Placement Criteria

Children and adolescents with composite scores in the range of 10-13 generally may be stepped down to or receive Level One services. Placement at Level One usually indicates that the child or adolescent has successfully completed treatment at a more intensive level of care and primarily needs assistance in maintaining gains realized in the past, or does not need services that are more intensive or restrictive than those offered at Level One. Placement determinations should be made by culturally competent staff or with consultation by culturally competent clinical specialists.

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LEVEL TWO: Low Intensity Community-Based Services

This level of care includes mental health services for children, adolescents, and families living in the community. Level Two services frequently are provided in mental health and/or substance use disorder clinics or clinicians' offices that most resemble traditional "outpatient" services. However, services also may be provided within a Medical Home as part of an integrated behavioral health program, juvenile justice facility, school, social service agency, or other community settings. Children and adolescents appropriate for Level Two services generally do not require the extensive systems coordination and case management of the higher levels of service intensity, since their families are able to use community supports with minimal assistance. The degree of individualization of services at Level Two also may not be as extensive as at higher levels of service intensity but continuity of care will still be important. There should be an expectation that individuals utilizing these services will often have complex needs, that these services should be welcoming to individuals (and caregivers) who have multiple conditions, and designed to provide co-occurring/complexity capable services..

Some payers may require that these services be authorized, but close oversight should not be needed, as it would likely incur more expense than savings. Reviews should not be required more often than every four months. Professionals providing services should be appropriately licensed and certified. Many support services may be provided by appropriately trained and/or certified paraprofessionals, including certified family and peer specialists.

1. **Clinical Services** - Clinical services for outpatient care consist primarily of individual, group, and family therapies with active family participation in treatment planning and implementation. Treatment intensity ranges from one hour every four weeks, to up to two hours per week. Psychiatric and cultural competency consultation to the treatment team should be available. Child Psychiatric evaluation and medication management may be needed at this level of service intensity. Family and youth group psycho-education around illness management and relapse prevention may also be provided. Child and adolescent psychiatrists and advance practice psychiatric nurses or primary care physicians should be part of an integrated primary health care network for medication services and 24-hour backup. Other interventions (e.g., occupational, recreational, vocational, and/or expressive therapies) should be made available as indicated.

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2. **Support Services** - Support services for children, adolescents, and families are most often natural supports within the community, including extended family, friends, and neighbors; church and recreational programs; 12 step and other self-help groups; parent organization support groups; youth empowerment programs; school sponsored programs; and employment. These families should have the capacity to access other elements of the system of care without substantial professional help, but may need referral and minimal care coordination . Families also may need support for financial, housing, or child-care problems, or for accessing vocational and education services. These should be included as part of the child or adolescent's individualized service plan. Provision of professional support services should not average more than 2-3 hours per month at this level.
3. **Crisis Stabilization and Prevention Services** - 24-hour crisis services should be accessible to children, adolescents, and families at this level of care. Furthermore, crisis services should be provided in collaboration with the family's other service providers. Crisis services should include emergency evaluation, brief intervention, and outreach services. Direct services and/or consultation from child and adolescent psychiatrists and psychosocial nurses should be available on a 24-hour basis.
4. **Care Environment** - Outpatient services may be provided in a traditional mental health setting (e.g., office or clinic), in facilities of other components of the service system, or in other community settings, including as part of an integrated behavioral health program within a primary care, or Medical Home setting. Facilities used for treatment should address ease of access (e.g., proximity to public transportation, schools, social services agencies, etc.); adequate design (e.g., accommodation for families with disabled or special needs members, play areas for children); and specific service needs (e.g., supervised day care so that parents can participate, resources for non-English speaking and/or hearing-impaired attendees, etc.). For adolescents, facilities should facilitate a mix of adult supervision with privacy for peer group activities. The facilities should be safe and comfortable for children and adolescents at all developmental levels, as well as their families.

Level 2 Placement Criteria

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

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LEVEL THREE: High Intensity Community-Based Services

This level of care generally is appropriate for children and adolescents who need more intensive outpatient treatment and who are living either with their families or in alternative families or group facilities in the community. The family's strengths and available community resources should allow many, but not all, of the child's needs to be met through natural supports. Treatment may be needed several times per week, with daily supervision of the child or adolescent provided by the family or facility staff. There should be an expectation that individuals utilizing these services will commonly have complex needs, so these services should be welcoming to individuals (and caregivers) who have multiple conditions, and be designed to provide co-occurring/complexity capable services. Targeted or limited care coordination may also be needed at this level of service intensity, services may be provided in a mental health clinic or a clinician's office, but often are provided in other components of the system of care with mental health consultation, including a primary care, or Medical Home setting.

Minimal utilization review should be required for this level of service and reviews should not be required more often than every two weeks for persons with acute conditions and every two months for those with more slowly evolving conditions. Professionals providing services should be appropriately licensed and certified. Many support services may be provided by trained and/or certified paraprofessionals, including certified family and peer specialists.

1. **Clinical Services** - Level Three services include more than one type of therapy service, or contact with a therapist or Child Psychiatrist or Nurse Practitioner may occur at more frequent intervals.. Level Three services may involve the use of wraparound teams as service coordination becomes more complex. Service delivery occurs two or more days a week for Psychiatric consultation to the treatment or wraparound team should occur regularly. Medication management may be an essential part of treatment. Child and adolescent psychiatrists and psychosocial nurses are part of the treatment team, providing medication services and 24-hour backup. Selected adjunct interventions (e.g., educational support, speech, occupational, physical, and/or expressive therapies) must be available when indicated. In addition, referrals for clinical services for other family members may be needed. Transition planning for a lower level of care should be part of the services plan. Close collaboration for medical care with either a pediatrician or family physician should be in place and co-located if possible.

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2. **Support Services** – Care coordination by a culturally competent primary care provider or care coordinator may be included. Family partners and youth peer mentors may be essential to support parent and youth voice in the care planning process and in supporting skill acquisition by the parents and/or youth. Support services for these children, adolescents, and families should emphasize natural and culturally congruent supports within the community, such as extended family, neighborhood, church groups, parents organization sponsored support groups, youth empowerment programs, self-help groups and community employers. Families may have difficulty accessing elements of the system of care without professional help due to the complexity of their child or adolescent's problems. In addition, families may need support for financial, housing, child-care, vocational, or education services. These should be included as part of the child or adolescent's individualized service plan. Although the need for professional support services is variable at this level, an average of two hours per week is commonly required.
3. **Crisis Stabilization and Prevention Services** - 24-hour crisis services, including child and adolescent psychiatric and nursing consultation and/or direct contact, should be available at this level of care. Crisis services should be accessible and, when provided, crisis team personnel should contact the family's primary service providers. Crisis services should include emergency evaluation, brief intervention, and outreach. An individual crisis, or safety plan, may be indicated, depending on the risk of harm to the youth.

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4. **Care Environment** - Intensive outpatient services may be provided in a traditional mental health and/or substance use disorder treatment setting (e.g., office or clinic), in facilities of other components of the service system, or in other community settings, such as the family's home. The site should have the capacity for short-term management of aggressive or other endangering behavior. Facilities should address ease of access (e.g., proximity to public transportation, schools, social services agencies, etc.); adequate design (e.g., accommodation for families with disabled or special needs members, play areas for children); and specific service needs (e.g., supervised day care so that parents can participate, resources for non-English speaking and/or hearing-impaired attendees, etc.). For adolescents, facilities should facilitate a mix of adult supervision with privacy for peer group activities. The facilities should be safe and comfortable for children and adolescents at all developmental levels, as well as their families.

Level 3 Placement Criteria

Children and adolescents with scores in the range of 17-19 generally may begin treatment at, or be stepped down to, Level Three services. Placement at Level Three generally is excluded by a score of 4 or higher on any Dimension. Placement at Level Three indicates that the child or adolescent either does not need more intensive or restrictive services, or has successfully completed treatment at a higher level of care and needs assistance in maintaining gains. Consideration for this level of care should include the age, size, and manageability of the child or adolescent, and the family and community resources available. Placement determinations should be made by culturally competent staff or in consultation with cultural competency specialists.

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LEVEL FOUR: Medically Monitored Community Based Services: Intensive Integrated Services Without 24-hour Psychiatric Monitoring/

This level of care refers to services provided to children and adolescents capable of living in the community with support, either in their family, or in placements such as group homes, foster care, homeless or domestic violence shelters, or transitional housing. To be eligible for Level Four services, a child or adolescent's service needs will require the involvement of multiple service elements or interventions within the system of care (i.e. medical, behavioral health, education, substance use, developmental disabilities, and/or probation), both for the child/adolescent as well as for their families/caregivers. These children and adolescents, therefore, need intensive, clinically informed and integrated care coordination for multi-system and multidisciplinary interventions. Because co-occurring MH, SUD, medical and developmental conditions are an expectation, all services should be designed to be co-occurring/complexity capable. Optimally, an individualized service plan is developed by a wraparound or other team-based planning process that includes a dedicated care coordinator, and when desired by the parents or youth, a family partner and/or youth peer mentor. Services in this level of care include partial hospitalization, intensive day treatment, treatment foster care, and home-based care. In addition, Level Four services also may be provided in schools, substance use disorder treatment programs, juvenile justice facilities, or child welfare congregate care facilities. A detailed Crisis, or Safety Plan and transition planning for discharge to a lower level of service intensity should be part of the plan of care.

Payer oversight may be required for this level of service, but reviews should not be required more often than every four weeks.

1. **Clinical Services** - Clinical services at Level Four should be available at times that meet the needs of the family, including non-traditional periods (e.g., evenings and weekends). The frequency of direct contact and/or consultation by child and adolescent psychiatrists and psychosocial nurses should be determined in consultation with the primary clinician and the wraparound team. Close collaboration with primary medical care should be in place as an integrated part of the comprehensive array of services and should be co-located if possible. Interventions may include individual, group, and family therapy, and may be organized into protocols such as occur in day treatment, or offered as part of a comprehensive wraparound, or Individualized Service Plan. Services may be offered within any of the components of the system of care. Services should be designed for flexibility as part of a comprehensive service plan that includes the mental health individualized treatment plan, and places emphasis on building on the strengths of the child or adolescent and family. Services should be accessible on a daily basis and contact would occur as required by initial and ongoing assessment. Psychiatric services would also be available by in person contact or telehealth on a 24-hour basis. Medication will be carefully monitored, but can be administered by parents when the youth is still living at home. Non-psychiatric clinical services generally average 5-16 hours weekly.

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2. **Support Services** – Care coordination services are provided for the multi-faceted service needs of the children and adolescents and their families at this level of care. Recreational activities, after-school employment, church programs, and other community activities may be integrated into the comprehensive service plan to form an integrated continuum of natural, clinical, and culturally congruent services and supports, that includes natural supports from family, advocacy programs, and youth empowerment programs when available. Families are likely to need support for financial, housing, childcare, vocational, and/or education services. These should be included as part of the child or adolescent's comprehensive service plan. Services should be family-driven and youth-guided, with the goal of either maintaining or reintegrating the child or adolescent into the home and community. The need for supportive services will vary, but will usually require an average 5 to 10 hours per week including indirect service time.
3. **Crisis Stabilization and Prevention Services** - At Level Four, children, adolescents, and families must have access to 24-hour emergency evaluation and brief intervention services that include direct contact and/or consultation by a child and adolescent psychiatrist or psychosocial nurse. Mobile crisis services are essential at this level of service intensity to support stabilization in the community. Crisis services may include a number of components in the system of care in addition to licensed mental health clinicians, including outreach by family organization members and/or youth peer support specialists. Care should be taken to avoid service duplication. The goal of crisis services is to foster family strengths and prevent the need for admission to higher levels of care.

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

   An inability to manage risk of harm may be reflected in a higher score on the Risk of Harm dimension, and may justify transfer to a more restrictive setting, or intensification of the wraparound plan in other ways, including active medical monitoring or management.

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4. **Care Environment** - Level Four services may be provided wherever they are needed to maintain the child or adolescent in the home or community setting such as in an outpatient clinic or hospital (e.g., partial or intensive day treatment), any component in the service system (e.g. public or private day school, juvenile detention center, group home), or in the home (e.g., home-based services). The facility must have the capacity for short-term management of aggressive or other endangering behavior. Transportation needs should be accommodated, both for staff to serve children and adolescents in community settings and to help children, adolescents, and families access services. When home-based treatment is provided, staff transportation needs should be addressed as well as flexible hours to assure continuity of supports for as many hours of the day as is deemed necessary. To optimize family participation, Level Four facilities should be located as near as possible to the child or adolescent's home. Facilities should incorporate ease of access (e.g., proximity to public transportation, schools, social services agencies); adequate design (e.g., accommodation for families with disabled or special needs members, play areas for children); and specific service needs (e.g., supervised day care so that parents can participate, interpretive services for non-English speaking and/or hearing impaired people). For adolescents, facilities should allow for a mix of adult supervision and privacy for peer group activities. The facilities should be safe and comfortable for children and adolescents at all developmental levels, as well as their families.

Level 4 Placement Criteria

Children and adolescents with scores in the range of 20-22 generally may begin treatment at, or be stepped down to, Level Four services. Consideration of the location for this level of care should include ability to maintain the safety of the child or adolescent in their home or other community setting. Placement determinations should be made by culturally competent staff or with consultation by culturally competent specialists.

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LEVEL FIVE: Medically Monitored Intensive Integrated Services: Non-Secure, 24 hour Service with Psychiatric Monitoring

This level of service intensity refers to treatment in which the essential element is the maintenance of a milieu in which the therapeutic needs of the child or adolescent and family can be addressed intensively. This level of care traditionally has been provided in non-hospital settings such as residential treatment facilities or therapeutic foster homes. Equivalent services have been provided in juvenile justice facilities and specialized community based residential schools, hospitals with designated step down program units and could be provided in homeless and/or domestic violence shelters or other community settings. The involvement of a wraparound team is essential and may allow this level of care to be provided in the family's home if adequate resources are available. If so, the Crisis, or Safety Plan must be quite detailed and access to needed "back-up" services must be immediate. Because co-occurring MH, SUD, developmental and/or medical conditions are an expectation, all services should be designed to be co-occurring/complexity capable. Ideally, the transition plan will provide continuity of care for both the child and the family, and integrate the child or adolescent's treatment experiences into their return to less restrictive settings.

Ideally, the step-down plan represents a modification of the Level 5 service plan, providing continuity of care and sustaining the gains made. This is facilitated by the same service team following the child/youth across different levels of service intensity. This means that the child or adolescent's community-based wraparound team should remain involved if the child or adolescent requires out of home placement. If no community-based wraparound team exists, a primary goal of the out of home placement should be to support the family to help create such a team to support subsequent transition to a lower level of services intensity, as explicated by the SAMHSA Building Bridges Initiative.

Payer authorization is often required for this level of service, but reviews should not be more often than every week for sub-acute intensive care settings such as respite or step down facilities, and no more than every three months for extended care services such as residential treatment facilities. Professionals providing services should be appropriately licensed and certified and should include a full array of disciplines including rehabilitation, addiction, and medical specialists. Many support services may be provided by appropriately trained and/or certified paraprofessionals, including family and peer specialists.

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1. **Clinical Services** - Programs for children or adolescents in residential settings are frequently utilized at this level of care. However, the same intensity of clinical programming must be provided whether children or adolescents are in residential settings or in community settings, including the home. The primary clinician should review the child or adolescent's progress daily and debrief back-up staff as needed. Child and adolescent psychiatrists are integral members of the treatment team and serve an important consultative or supervisory function, maintaining daily contact with the team and providing 24-hour psychiatric consultation. Psychiatric care should be available on site at least weekly, but client contact may be required as often as daily. Facilities serving the most acute populations will require 0.5 - 1.0 hours of psychiatric time per client per week. Treatment modalities may include individual, group, and family therapy, with integrated attention to address co-occurring mental health and substance use disorders, as indicated. Primary medical care should be an accessible, integrated part of the comprehensive array of services. Close collaboration with either a pediatrician or family physician should be in place. Non-credentialed child-care staff are an important part of the clinical team, and so will participate in treatment planning, and will be actively supervised and trained. Similarly, parent and youth peer support specialists should be supervised actively and integrated into the service plan when parents or youth request these additional supports. Non-psychiatric clinical services generally average 8-20 hours per client weekly. Staff and programs should be culturally competent, with access to cultural competency consultation as needed. Treatment should be family-driven and youth-guided. The goal of treatment for children or adolescents in out-of-home placements should be a timely return to the family and community. Thus, transition planning should be considered in daily clinical review.
2. **Support Services** - Care coordination is integral to care at this level regardless of which component of the system of care is the lead service provider. Children and adolescents in Level Five programs should receive adequate supervision for activities of daily living. Supervised off-campus passes or excursions into the community from a home-based wraparound program should be provided. Facility or program staff, supportive family members, and/or family friends identified by the "child and family" team may provide basic support services, including recreational, social, or educational activities, and, as needed, escort to substance abuse or self-help groups. Families may need help for problems with their own mental health and substance use challenges, as well as with housing, child-care, finances, and job or school problems. These services should be integrated into the child or adolescent's individual service plan.

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3. **Crisis Stabilization and Prevention Services** - Children and adolescents at Level Five may require higher levels of care for brief periods to manage crises. All staff must be trained in de-escalation and safety maintenance techniques should they be required until a secure placement can be obtained. These interventions must be used in accordance with the legal requirements of the jurisdiction and ethical professional practices.

   More restrictive care may be needed temporarily because the team cannot safely manage acute exacerbations in the child or adolescent's risk of harm status or sudden deteriorations in functioning. Reevaluation using the dimension scales of CALOCUS-CASII may yield a composite score supporting admission to Level Six. When more restrictive or intensive services are provided outside of the residential unit or wraparound plan, the staff of all involved service components should collaborate with the family to plan a timely return to lower levels of care. In addition, the service plan should be reviewed for adequacy in meeting the child or adolescent's fluctuating needs.

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4. **Care Environment** - When care at Level Five is provided institutionally, living space must be provided that offers reasonable protection and safely given the developmental status of the child or adolescent. Physical barriers preventing easy egress from or entry to the facility may be used, but doors at Level Five facilities or other care settings are not locked. Staffing and engagement are the primary methods of providing security both in facilities and in home-based plans. Staffing patterns should be adequate to accommodate episodes of aggressive and/or endangering behavior of moderate duration (e.g., sufficient staff should be available to both monitor a safe room for unlocked seclusion and maintain supervision of the other children or adolescents). Capacity for transporting residents off-campus for educational or recreational activities is a critical element of Level Five services when such services are not available within the Level Five service delivery setting.

   Level Five facilities should be located as near as possible to the child or adolescent's home. In addition, facilities for Level Five activities should incorporate ease of access (e.g., proximity to public transportation, schools, social services agencies, etc.); adequate design (e.g., accommodation for families with disabled or special needs members, play areas for children); and specific service needs (e.g., supervised day care so that parents can participate, resources for non-English speaking and/or hearing-impaired people, etc.). Facilities should be safe and comfortable for children and adolescents at all developmental levels, as well as for their families.

Level 5 Placement Criteria

Children and adolescents with scores in the range of 23-27 generally may begin treatment at, or may be transitioned into, Level Five services. Placement at Level Five indicates that the child or adolescent either does not need more intensive services, or has successfully completed treatment at a more intensive level and primarily needs assistance in maintaining gains. Consideration for Level Five services should include the age, size, and manageability of the child or adolescent, and the family and community resources available. Placement determinations should be made by culturally competent staff or in consultation with culturally competent specialists.

CALOCUS-CASII© LEVEL OF CARE/SERVICE INTENSITY DEFINITIONS & UTILIZATION CRITERIA

LEVEL SIX: Medically Managed Secure, Integrated Intensive Services: Secure, 24 Hour Services with Psychiatric Management

Level Six services are the most restrictive and the most intensive in the level of care continuum. Traditionally, Level Six services have been provided in a secure facility such as a hospital or locked residential program. This level of service intensity also may be provided through intensive application of mental health and medical services in a juvenile detention and/or educational facility, or even in the child's home provided that these settings are able to adhere to medical and psychiatric care standards needed at Level Six. Although high levels of restrictiveness are typically required for effective intervention at Level Six, every effort to reduce, as feasible, the duration and pervasiveness of restrictiveness is desirable to minimize its negative effects. Collaborative transition planning that maintains connections with wraparound planning services should be in place to promote a rapid and safe return to community based services. It is essential that the community-based Wraparound team remain active when a child is in a residential treatment center or hospital setting. With the expectation that individuals (and their caregivers) utilizing these services will almost always have complex needs, these services should be welcoming to individuals and caregivers who have multiple conditions, and should be designed so that all services are co-occurring/complexity capable.

Payer authorization is usually required for this level of service. Reviews of revised CALOCUS-CASII assessments should not be more often than every three days for acute intensive care settings such as inpatient psychiatric hospitals, and no more than every month for long term secure care services such state hospitals or community based locked facilities. Professionals providing services should be appropriately licensed and certified and should include a full array of disciplines including rehabilitation, addiction, and medical specialists. Support services may also be provided by paraprofessionals, including family and peer specialists, who have been trained and/or certified.

CALOCUS-CASII© LEVEL OF CARE/SERVICE INTENSITY DEFINITIONS & UTILIZATION CRITERIA

1. **Clinical Services** - Clinical services must be comprehensive and relevant to safety and other emergent issues that may arise. Children and adolescents at Level Six require monitoring and observation on a 24-hour basis. Treatment modalities may include individual, group, and intensive family therapy as well as medication management, and are aimed at managing the crisis, restoring previous levels of functioning, and decreasing risk of harm. Co-occurring substance use should be treated in an integrated manner and treatment may include medical detoxification. The treatment plan must be family-driven and youth-guided and must address management of aggressive and/or suicidal or self-endangering behavior. Access to pediatric or family medicine physician should be available within the hospital community as consultants as needed for management of medical issues.

   Active child psychiatric care is required at this level of service intensity and daily contact with the child or adolescent is necessary. The child and adolescent psychiatrist supporting or directing this level of intensity should consult regularly with the family and the child or adolescent and the family and the wraparound/intensive care coordination team when the latter is involved to support integration of Level Six services with the care to be provided at a lower levels of care/service intensity level. Uncomplicated or specialized transition plans may be necessary, depending on the child or adolescent's or family's needs during step-down. All children and adolescents leaving Level Six services must have a well-defined crisis plan that anticipates and accommodates complications during transition to lower levels of care. Treatment for co-occurring medical conditions must be integrated into all treatment plans.

2. **Support Services** - All necessities of living and well-being must be provided for children and adolescents treated at Level Six. Children's legal, educational, recreational, vocational, and spiritual needs should be assessed according to individual needs and culture. Social and cultural factors must be considered in discharge planning. A wraparound team should be created, if not already in place, mobilizing the strengths of the child or adolescent and family to provide support during the crisis and in aftercare. When capable, children and adolescents should be encouraged to participate in treatment planning, both with the hospital team and with the wraparound process. Families are likely to need support for financial, housing, child-care, vocational, and/or educational services. Case management for coordination of services provided after transition to lower care levels should begin while the child or adolescent receives Level Six services. Transition planning should include integration of the child or adolescent into the home and community, and linkage with social services, education, juvenile justice, and recreational resources as needed and in coordination with the hospital transition planner. All support services should be described in the comprehensive service plan.

CALOCUS-CASII© LEVEL OF CARE/SERVICE INTENSITY DEFINITIONS & UTILIZATION CRITERIA

3. **Crisis Stabilization and Prevention Services** - At Level Six, crisis services involve rapid response to fluctuations in psychiatric and/or medical status. It is imperative to avoid the trauma of seclusion and restraint whenever possible, so de-escalation and safety techniques must be employed. Emergency medical services should be available on-site or in close proximity and all staff must have training in emergency protocols.
4. **Care Environment** - In most cases, Level Six care is provided in a closed and locked facility. Alternative settings must have an equivalent capacity for providing a secure environment. Facilities should have space that is quiet and free of potentially harmful items, with adequate staffing to monitor child or adolescent using such a space. Facilities and staff also must provide protection from potential abuse from others. Level Six facilities should be capable of providing involuntary care. Adequate temporary accommodations for family members must be available if needed for the family to be available to participate in the child or adolescent's treatment.

   Level Six facilities, or their alternatives, should be located as near as possible to the child or adolescent's home. In addition, these facilities should incorporate ease of access (e.g., proximity to public transportation; adequate design (e.g., accommodation for families with disabled or special needs members and specific service needs (e.g., supervised day care so that parents can visit, resources for non-English speaking and/or hearing-impaired people, etc.). The facilities should be safe and comfortable for all children and adolescents admitted to the facility at all developmental levels, as well as for their families.

Level 6 Placement Criteria

Children and adolescents with scores of 28 or higher are appropriate for treatment at Level Six. Consideration for this level of care should include the age, size, and manageability of the child or adolescent, and the family and community resources available. Placement determinations should be made that are culturally sensitive and/or with consultation by cultural competency specialists.