

Risk of Harm

This dimension considers a child or adolescent's potential to be harmed by others or cause significant harm to self or others. Each category contains items that assess a child or adolescent's risk of harming him/herself and of harming others. While Risk of Harm most frequently is manifested by suicidal or homicidal behavior, it also may embody unintentional harm from misinterpretations of reality; inability to adequately care for oneself, temper impulses, use good judgment; or avoid gross mishandling of alcohol or drugs of abuse. Children of any age who have experienced severe and/or repeated abuse in a hostile environment may be unable to perceive threat or take adequate measures to increase their safety.

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

1 - Low Risk of Harm

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

2 - Some Risk of Harm

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

3 - Significant Risk of Harm

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

4 - Serious Risk of Harm

- a- Current suicidal or homicidal ideation with either clear, expressed intentions and/or past history of carrying out such behavior. Child or adolescent has expressed ambivalence about carrying out the safety plan and/or his/her family's ability to carry out the safety plan is compromised.

- b- Indication or report of significant impulsivity and/or physical or sexual aggression, with poor judgment and insight, and that is/are significantly endangering to self or others (property destruction; repetitive fire setting or violence toward animals).
- c- Signs of consistent deficits in ability to care for self and/or use environment for safety.
- d- Recent pattern of excessive substance use resulting in clearly harmful behaviors with no demonstrated ability of child/adolescent or family to restrict use.
- e- Clear and persistent inability, given developmental stage, to maintain physical safety and/or use environment for safety.
- f- Imminent risk of severe victimization, abuse, or neglect.

5 - Extreme Risk of Harm

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

Functional Status

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

1 - Minimal Functional Impairment

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

2 - Mild Functional Impairment

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

3 - Moderate Functional Impairment

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

4 - Serious Functional Impairment

- a- Serious deterioration of interpersonal interactions with consistent conflict or otherwise disrupted interactions with others, which may include impulsive or abusive behaviors.
- b- Significant withdrawal and avoidance of almost all social interaction.
- c- Consistent failure to achieve self-care/hygiene at levels appropriate to age and/or developmental level.
- d- Serious disturbances in physical function.
- e- Inability to perform adequately even in a specialized school setting due to disruptive behavior, or inattentiveness. School attendance may be sporadic. The child or adolescent has multiple academic failures.

5 - Severe Functional Impairment

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

Co-Morbidity: Developmental, Medical, Substance Use & Psychiatric

This dimension measures the coexistence of disorders across four domains (psychiatric, substance use, medical and developmental): but does not consider co-occurring disturbances within each domain. If a child or adolescent has more than one disorder in the same domain (e.g., two psychiatric, substance use, medical, or developmental disorders), the second does not count as a “co-morbidity” for purposes of scoring on CALOCUS. For example, two medical disorders, such as diabetes and asthma or two psychiatric disorders, such as attention deficit hyperactivity disorder and major depressive disorder, are not counted as additional co-morbidity. Coexisting disorders across domains may prolong the course of illness, or necessitate the use of more intensive or restrictive services. Physiologic withdrawal states related to substance use should be considered medical co-morbidity for scoring purposes. Clinicians must be alert to the under-recognition of co-morbidity in children from lower socioeconomic backgrounds and culturally distinct backgrounds.

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

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

1 - No Co-Morbidity

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

2 - Minor Co-Morbidity

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

3 - Significant Co-Morbidity

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

4 - Major Co-Morbidity

- a- Medical conditions are present or have a high likelihood of developing that may require intensive, although not constant, medical monitoring (e.g., insulin-dependent diabetes, hemophilia).
- b- Medical conditions are present that will adversely affect, or be affected by, the presenting condition.
- c- Uncontrolled substance use is present that poses a serious threat to health if unabated and impedes recovery from the presenting condition.
- d- Developmental delay or disorder is present that significantly alters functional capacity and ability to participate meaningfully in a psychiatric or substance abuse treatment.
- e- Psychiatric symptoms are present that clearly impair functioning, persist in the absence of stressors, and seriously impair recovery from the presenting condition.

5 - Severe Co-Morbidity

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

Recovery Environment

This dimension considers factors in the environment that may contribute to the onset or maintenance of illness or disability, and factors that may support a child or adolescent's efforts to achieve or maintain recovery. Supportive elements in the environment include, first and foremost, the presence of stable, supportive, and ongoing relationships with family (biological or adoptive) members. Other important supportive factors include the availability of adequate housing and material resources, stable and supportive relationships with friends, employers or teachers, clergy, professionals, and other community members. Clinicians must be alert to underestimation of family, cultural, and community strengths, where such strengths/resources may not be evident or may not be readily mobilized. Stressful circumstances may include interpersonal conflict or trauma, life transitions, losses, worries relating to health and safety, and difficulty in maintaining role responsibilities.

Because children and adolescents are more dependent on, and exert less control over, their environment than adults, in the CALOCUS, the recovery environment encompasses the family milieu, as well as the school, medical, social services, juvenile justice, and other components in which the child or adolescent may receive services or be involved on an ongoing basis. Two sub-scales are used to measure this dimension: Environmental Stress and Environmental Support. These two sub-scales are designed to balance the relative contributions of these factors.

It should be noted that the presence of wraparound or intensive professional supports pre-empts higher ratings, allowing treatment in a less restrictive environment. However, when transitions are being considered, the child or adolescent's rating on the supports scale must be considered as if those supports were not present. This will prevent premature transitions and inadequate intensity of treatment.

Environmental Stress Sub-Scale

1 - Minimally Stressful Environment

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

2 - Mildly Stressful Environment

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

3 - Moderately Stressful Environment

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

4 - Highly Stressful Environment

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

5 - Extremely Stressful Environment

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

Environmental Support Sub-Scale

1 - Highly Supportive Environment

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

2 - Supportive Environment

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

3 - Limited Support in Environment

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

- c- Family or primary caretakers demonstrate only partial ability to make necessary changes during treatment.

4 - Minimally Supportive Environment

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

5 - No Support in Environment

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

Resiliency & Treatment History

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

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

1 - Full Resiliency and/or Response to Treatment

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

2 - Significant Resiliency and/or Response to Treatment

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

3 - Moderate or Equivocal Resiliency and/or Response to Treatment

- a- Child has demonstrated an inconsistent or equivocal capacity to deal with stressors and maintain normal development.
- b- Previous experience in treatment at low level of intensity has not been successful in relief of symptoms or optimal control of symptoms.
- c- Recovery has been maintained for moderate periods of time, but only with strong professional or peer supports or in structured settings.
- d- Has demonstrated limited ability to follow through with treatment recommendations.
- e- Developmental pressures and life changes have caused some deterioration in function.
- f- Able to transition successfully and accept change in routine most of the time with moderate intensity support.

4 - Poor Resiliency and/or Response to Treatment

- a- Child has demonstrated frequent evidence of innate vulnerability under stress and difficulty resuming progress toward expected developmental level.
- b- Previous treatment has not achieved complete remission of symptoms or optimal control of symptoms even with intensive and/or repeated exposure to treatment.

- c- Attempts to maintain whatever gains that were attained in intensive treatment have limited success, even for limited time periods or in structured settings.
- d- Developmental pressures and life changes have created episodes of turmoil or sustained distress.
- e- Transitions with changes in routine are difficult even with a high degree of support.

5 - Negligible Resiliency and/or Response to Treatment

- a- Child has demonstrated significant and consistent evidence of innate vulnerability under stress, with lack of any resumption of progress toward expected developmental level.
- b- Past response to treatment has been quite minimal, even when treated at high levels of care for extended periods of time.
- c- Symptoms are persistent and functional ability shows no significant improvement despite intensive treatment exposure.
- d- Developmental pressures and life changes have created sustained turmoil and/or developmental regression.

Unable to transition or accept changes in routine successfully despite intensive support.

Treatment Acceptance & Engagement

The Treatment Acceptance and Engagement dimension measures the child or adolescent's, as well as the parent and/or primary caretaker'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's and/or primary caretaker's needs. The sub-scales reflect the importance of the child/youth's willingness to be involved in an intake, care planning, implementation and maintenance phases of treatment and/or wraparound process, as well as the parent and/or primary caretaker's willingness and ability to participate pro-actively in the same elements of a treatment/care plan. It also is critical to note that a youth and their parent or primary caretaker's cultural background influences understanding and acceptance of a problem, as well as choice of care options for solving it. Care should be taken to note barriers to proper assessment and treatment based on cultural differences between the youth and parent and/or primary caretaker and the clinician or other involved professionals.

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

Child or Adolescent Acceptance and Engagement Sub-Scale

The child or adolescent sub-scale measures the ability of the child or adolescent, within developmental constraints, to form a positive therapeutic relationship with people in components of the system providing care, to define the issues of concern, to accept his or her role in the development and perpetuation of their distress or disability, and to accept his or her role in the treatment, or care planning and treatment process, and to actively cooperate in treatment.

1 - Optimal

- a- Quickly forms a trusting and respectful positive therapeutic relationship with clinicians and other care providers.
- b- Able to define problem(s) and understands consequences and how others may see them differently.
- c- Accepts age-appropriate responsibility for behavior that causes and/or exacerbates primary problem.
- d- Actively participates in treatment planning and cooperates with treatment.

2 - Constructive

- a- Able to develop a trusting, positive relationship with clinicians and other care providers.
- b- Unable to define the problem, but can understand and accept how others define the problem and its consequences.
- c- Accepts limited age-appropriate responsibility for behavior.
- d- Passively cooperates in treatment planning and treatment.

3 - Incompletely Engaged

- a- Ambivalent, avoidant, or distrustful relationship with clinicians and other care providers.
- b- Acknowledges existence of problem, but resists accepting even limited age-appropriate responsibility for development, perpetuation, or consequences of the problem.
- c- Minimizes or rationalizes distressing behaviors and consequences.
- d- Unable to accept others' definition of the problem and its consequences.
- e- Frequently misses or is late for treatment appointments and/or is not invested in treatment, including medication and homework assignments.

4 - Non-Collaborative

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

5 - Unengaged

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

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

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

1 - Optimal

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

2 - Constructive

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

3 - Incompletely Engaged

- a- Inconsistent and/or avoidant relationship with clinicians and other care providers despite competent attempts at engagement.
- b- Defines problem, but has difficulty creating a shared definition of development, perpetuation, or consequences of the problem.
- c- Unable to collaborate in development of treatment plan.
- d- Unable to participate consistently in treatment, with inconsistent follow-through.

4 - Non-Collaborative

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

5 - Unengaged

- a- No awareness of problem.
- b- Not physically available.
- c- Refuses to accept child or adolescent, or other family members’ need to change.
- d- Actively avoidant of and unable to form relationship with clinician or other care provider, in context of significant cognitive difficulties, psychosis, intoxication, or major mental illness or impairment.