

**DBHS Practice Protocol**

**Child and Adolescent Service Intensity Instrument (CASII)**



**Developed by the  
Arizona Department of Health Services  
Division of Behavioral Health Services**

**Effective: 4/1/08  
Last Revised: 5/7/08**

**NOTE:**

**This DBHS Practice Protocol has required implementation elements. Providers are required to implement the identified Service Expectations, as clearly identified in this document.**

**Title**

Child and Adolescent Service Intensity Instrument (CASII)

**Goal (What Do We Want to Achieve Through the Use of this Protocol?)**

To establish a protocol for the effective use and administration of the Child and Adolescent Service Intensity Instrument (CASII) in Arizona, as part of the Child and Family Team Practice, in an effort to:

1. Provide guidance for assignment of case managers in a consistent manner on a statewide basis
2. Clarify how Child and Family Team practice varies based upon complexity of need
3. Facilitate more consistent evaluation practices across T/RBHAs and providers

**Target Audience**

This Protocol is specifically targeted to T/RBHA and their subcontracted network and provider agency behavioral health staff who participate in the assessment and service planning processes and are responsible for the implementation and use of the CASII tool with all children and adolescents between the ages of 6 through 17.

**Target Population(s)**

All children and adolescents between the ages of 6 through 17, enrolled in the Tribal and Regional Behavioral Health Authority (T/RBHA) system.

**Attachments**

[Attachment A: Arizona's Child & Adolescent Service Intensity Instrument Scoring Sheet](#)

**Definitions**

[Child and Family Team \(CFT\)](#)

[Family](#)

[Guardian](#)

[Natural Support](#)

**Background**

ADHS is committed to the Arizona Vision, which states, *"In collaboration with the child and family and others, Arizona will provide accessible behavioral health services designed to aid children to achieve success in school, live with their families, avoid delinquency, and become stable and productive adults. Services will be tailored to the child and family and provided in the most appropriate setting, in a timely fashion and in accordance with best practices, while respecting the child's and family's cultural heritage"*.

Child and Family Team practice is based on the Arizona Vision and the [12 Arizona Principles](#):

1. Collaboration with the child and family
2. Functional outcomes
3. Collaboration with others
4. Accessible services
5. Best practices
6. Most appropriate setting

7. Timeliness
8. Services tailored to the child and family
9. Stability
10. Respect for the child and family's unique cultural heritage
11. Independence
12. Connection to natural supports

ADHS has embarked on several transformation initiatives to improve the behavioral health service delivery system for children and adolescents in Arizona. One of the initiatives was the establishment of dedicated case managers for children and adolescents with complex needs. For children/adolescents with complex needs, it is important to use an assessment process designed to identify level of complexity and to ensure that the need for case managers is identified on a uniform basis. The function of the CASII is to assist with coordinating resources based on the child's identified level of service intensity.

### **Procedures**

The Child and Family Team (CFT) plays the central role in decision making. CFT's are expected to use the CASII to inform case manager assignment for children/adolescents with complex needs. The CASII is not to be used to determine eligibility for specific levels of care, types of services, or particular service models (see [ADHS/DBHS Provider Manual Section 3.14 Securing Services and Prior Authorization](#)).

Below are the essential implementation procedures:

- 1) The CASII shall be completed by the behavioral health service provider, who is trained in the use of the tool, in collaboration with the child/adolescent and family, and other members of the CFT. The CASII must be conducted in a manner which is strengths-based, family friendly, culturally sensitive, and clinically sound and supervised. The CASII shall be completed within the initial 45 day assessment period (see [PM Section 3.9 Intake, Assessment, and Service Planning](#)) and every six months thereafter. It can also be used anytime a CFT feels updated information would benefit service planning. A final CASII should be completed as part of the disenrollment process from behavioral health services for the child/adolescent (see [PM Section 3.8 Outreach, Engagement, Re-engagement, Closure, and Re-enrollment](#)).

The CASII suggests level of service intensity based on the following dimensions:

- I. Risk of Harm
- II. Functional Status
- III. Co-Occurrence of Conditions
- IV. Recovery Environment
  - A. Environmental Stress
  - B. Environmental Support
- V. Resiliency and/or Response to Services
- VI. Involvement in Services
  - A. Child/Adolescent
  - B. Parent and/or Primary Caretaker

See [Attachment A: Arizona's Child & Adolescent Service Intensity Instrument Scoring Sheet](#).

**Service Expectation: The CASII shall be completed by the behavioral health service provider, who is trained in the use of the tool, in collaboration with the child/adolescent and family, and other members of the Child and Family Team. The CASII must be conducted in a manner that is strength-based, family friendly, culturally sensitive, and clinically sound and supervised. All T/RBHA and Service Providers shall complete the CASII as part of the**

**initial 45 day assessment period and every six months thereafter. A final CASII shall be completed as part of the disenrollment process from behavioral health services for the child/adolescent. The Level of Service Intensity and date of CASII administration shall be entered into the Client Information System and a copy of the CASII Scoring Sheet shall be included in the person's clinical record.**

- 2) Since children and families present with diverse needs, CFT practices will vary depending on the unique needs of the child/adolescent and their family. Despite these differences, CFT practice must still include the nine essential CFT activities and reflect the 12 Arizona Principles (see the [Child and Family Team Practice Protocol](#)).

The tables below describe how the CFT practice may be implemented for children and families with varying needs and service intensity levels. While the CASII suggests a level of service intensity, the CFT identifies the specific services and supports that will best meet the identified needs. Service planning should always be individualized, family driven, culturally competent and flexible. Children are resilient and families are adaptable and strong, therefore, as their needs vary over time, service intensity will adjust to correspond with these changes.

CASII Levels of Intensity	Implementation Guidelines <sup>1</sup> for Child and Family Team Practice 9 Essential Activities of Effective CFT Practice
Level 0 And Level 1	<ol style="list-style-type: none"> <li>1. <u>Engagement of the Child and Family</u>- focused on acknowledging the demonstrated strengths of the family to exercise independence and judgment.</li> <li>2. <u>Immediate Crisis Stabilization</u>- The need for immediate crisis stabilization is not present or the presenting situation, once resolved, leads to relative stability. The child/family have adequate community resources/informal supports which address their needs before they become a crisis.</li> <li>3. <u>Strengths, Needs, &amp; Culture Discovery</u>- should be maintained and updated as needed during the course of services. Current and potential informal and community supports are explored and identified. These supports may be currently utilized or may not be needed. The child and family's Vision for the Future is identified.</li> <li>4. <u>CFT Formation</u>- The behavioral health service provider (i.e. clinician or medical behavioral health professional) explores CFT formation with the child and family by asking them who they would like or would find helpful participating on their CFT. The family may have an established and available network of natural supports and may not want anyone else on the team, but the CFT formation process should be addressed and documented. The size of the team may be much smaller than one whose needs are more complex. However, the CFT should still function in accordance with the 12 Arizona Principles.</li> <li>5. <u>Behavioral Health Service Plan Development</u>- will likely reflect fewer overall needs with objectives focused on maintaining stability.</li> <li>6. <u>Crisis and Safety Planning</u>- At this level of intensity crisis plans may not be needed, but would assist with identifying what could go wrong and hinder a successful implementation of the service plan. The CFT should develop a specific plan to address these identified issues. The plan should include specific interventions and response strategies to support the child/family during a crisis situation. In addition the plan should identify steps to prevent crisis situations from occurring or establish safety criteria.</li> <li>7. <u>Behavioral Health Service Planning Implementation</u> – Implementation will focus on coordination of service delivery with natural supports that are being utilized by the child and family within his/her community to ensure ongoing stability.</li> <li>8. <u>Tracking &amp; Adapting</u>- Regular review of a child's status is expected. Tracking should be incorporated into regular meetings. Because only one service provider may be involved with the child/family (i.e. clinician or medical</li> </ol>

<sup>1</sup> It should be emphasized; this matrix of intensity is a guide for a differential response and is not intended to be prescriptive, all inclusive, or determinant.

	behavioral health professional) monitoring should be less time consuming and require less coordination. 9. <u>Transition Planning</u> - Children having a low complexity of needs are more likely to be maintaining stability or have greater ability to handle transitions. Appropriate transition activities may focus more on typical transition to adulthood (i.e. educational and vocational guidance, employment, adult relationships, etc.) rather than transition to the adult behavioral health system.
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CASII Levels of Intensity	Implementation Guidelines <sup>2</sup> for Child and Family Team Practice 9 Essential Activities of Effective CFT Practice
Level 2 And Level 3	<ol style="list-style-type: none"> <li>1. <u>Engagement of the Child and Family</u>- focused on acknowledging the demonstrated strengths of the family to exercise independence and judgment. A thorough understanding of the family dynamics, strengths, needs and culture is necessary to help the family achieve its goals, prevent an escalation of needs and involves additional persons critical for understanding the child and family's current situation who may then become part of an integrated support system.</li> <li>2. <u>Immediate Crisis Stabilization</u>- concerns at intake may require prompt intervention, yet are not of the nature that require immediate crisis stabilization or extensive support services. Often, the need for crisis stabilization can be circumvented with the timely formation of a Child and Family Team.</li> <li>3. <u>Strengths, Needs, &amp; Culture Discovery</u>- Informal and community supports may be readily identified, but not utilized or may be running low on energy due to the stress of the situation. The SNCD should result in a document of clearly identified strengths, needs, and culture of the family, which is shared with CFT members, and updated as needed. The child and family's Vision for the Future is identified.</li> <li>4. <u>CFT Formation</u>- The child and family are asked who they would like to have on their CFT. The child and family can identify CFT members, but may need assistance with getting them engaged. Other agencies may be involved and should be encouraged to participate. Providers of support and rehabilitation services may also be needed to support the child and family. Family support (i.e. family support partner or peer to peer support) may or may not be needed to promote family voice.</li> <li>5. <u>Behavioral Health Service Plan Development</u>- will include goals, tasks, and assignments that address multiple concerns in more than one setting which can include limited or minimal involvement with other agencies. The services needed may be more easily identified and described, and also include natural supports. Objectives are often set with shorter timelines so progress can be checked frequently and timely changes implemented when needed.</li> <li>6. <u>Crisis and Safety Planning</u>- At this level of intensity crisis plans may not be needed, but would assist with identifying what could go wrong and hinder a successful implementation of the service plan. The CFT should develop a specific plan to address these identified issues. The plan should include specific interventions and response strategies to support the child/family during a crisis situation. In addition the plan should identify steps to prevent crisis situations from occurring or establish safety criteria to support the child's stability in the community.</li> <li>7. <u>Behavioral Health Service Planning Implementation</u> - may require closer monitoring of Service Plan implementation to ensure all identified services are secured and implemented which may require coordination of delivery between behavioral health and other agency services and how these work with the child's natural supports in all settings.</li> <li>8. <u>Tracking &amp; Adapting</u>- Regular review of a child's status is expected. Also regular checks/progress meetings are necessary so service levels are adjusted when indicated and alternative approaches implemented. Typically, the CFT is not large and can be brought together quite easily every month or six weeks to ensure progress is being made.</li> <li>9. <u>Transition Planning</u>- Adolescents may or may not require transition into the adult behavioral health system. When determined as a priority by the CFT, planning should also be considered for other life transitions that may occur.</li> </ol>

<sup>2</sup> It should be emphasized; this matrix of intensity is a guide for a differential response and is not intended to be prescriptive, all inclusive, or determinant.

CASII Levels of Intensity	Implementation Guidelines <sup>3</sup> for Child and Family Team Practice 9 Essential Activities of Effective CFT Practice
Level 4 Level 5 And Level 6	<ol style="list-style-type: none"> <li>1. <u>Engagement of the Child and Family</u>- focused on acknowledging the demonstrated strengths of the family to exercise independence and judgment. Engagement may be more successful when time is provided to understand the family dynamics, identify potential informal and community supports, and to reconnect or rebuild supports that may have been helpful in the past. The behavioral health service provider should also ensure additional participants of the CFT, identified by the family are engaged in this process. This may include family members, friends and other participating partner agencies such as Child Protective Services (CPS), Division of Developmental Disabilities (DDD), juvenile justice (ADJC/AOC) and education (ADE).</li> <li>2. <u>Immediate Crisis Stabilization</u>- The child and family present at intake with immediate safety concerns requiring a crisis stabilization plan and implementation of crisis intervention services.</li> <li>3. <u>Strengths, Needs, &amp; Culture Discovery</u>- focus is needed to obtain a clear understanding of the family's story. Current, potential, informal and community supports are explored and more thoroughly identified. The SNCD should clearly identify child and family strengths, specific needs, and cultural influences/preferences as well as the family's Vision for the Future. Frequent updating of the SNCD may be necessary as CFT interactions increase and lead to the identification of additional needs and/or developing strengths. The SNCD develops into a document which clearly identifies the strengths, needs, and culture of the child and family, is shared with CFT members, and updated as needed.</li> <li>4. <u>CFT Formation</u>- Children/adolescents identified at these levels of intensity should have a designated case manager<sup>4</sup> to coordinate services and activities of the Child and Family Team. The behavioral health service provider assists the child and family with identifying CFT participants, explains the activities of CFT practice and engages participants' involvement. Clinical consultation and specialized behavioral expertise may be necessary to advise the CFT. Representatives from multiple systems (CPS, ADJC/AOC, DDD, ADE, etc) are often involved and require additional coordination for input and discussion. Direct Service staff are typically involved in providing support and rehabilitation services and should be included on the CFT. Family support resources (i.e. family support partner or peer to peer support) may be of assistance by helping the child/family to have a voice in the CFT practice.</li> <li>5. <u>Behavioral Health Service Plan Development</u>- The service plan will typically be more involved and inclusive of other stakeholder priorities. The service plan may include more clinical consultation/involvement and support and rehabilitation providers. There will be a greater focus on developing natural supports. Service planning should include things that get the child/adolescent involved with activities in the community.</li> <li>6. <u>Crisis and Safety Planning</u>- Crisis planning is required for these children/adolescents. It is critical to identify crisis or safety issues that could affect the child or family's stability. The plan should include a thorough functional assessment, specific interventions, and response strategies that support the child/family during a crisis situation, prevent crisis situations from occurring, or establish safety criteria. Crisis Planning should include other involved agency representatives. The CFT should review the Plan frequently to ensure it sufficiently meets the needs of the child and family, especially following a crisis situation. The Plan may require daily 24 hour responsiveness. Based on the identified needs of the child/adolescent, a safety plan may be necessary.</li> <li>7. <u>Behavioral Health Service Planning Implementation</u> - more time is spent ensuring services are well-coordinated and implemented in a timely manner in response to the Service Plan. Service Plans may include the provision of support and rehabilitation services.</li> <li>8. <u>Tracking &amp; Adapting</u>- Regular review of a child's status is expected. Frequent CFT meetings may need to closely monitor progress and determine whether strategies are working. Increased coordination may be needed because</li> </ol>

<sup>3</sup> It should be emphasized; this matrix of intensity is a guide for a differential response and is not intended to be prescriptive, all inclusive, or determinant.

<sup>4</sup> Caseload sizes should remain small with a goal of a 1:15 ratio, for high intensity needs.

there are likely to be many tasks to monitor and more people involved in implementing the plan. The CFT should evaluate the effectiveness of the plan's interventions and strategies and make changes whenever the service plan is not working.

9. Transition Planning- For adolescents, the transition into the adult behavioral health system will likely be necessary. The adolescent may also have more difficulty handling transitions in general. These transitions may include changes in caretakers, schools, service providers/ support workers, and living environments. The adolescent may not be well prepared to transition into adulthood and may need considerable assistance with learning needed skills. Successful transition into the adult behavioral health system should be addressed in the service plan and an SMI eligibility evaluation completed if necessary. (see [Practice Protocol Transition to Adulthood](#))

**Service Expectation: The CASII recommends the Level of Service Intensity while the Child and Family Team identifies the services and supports to best meet the identified needs. The CASII is not to be used to determine eligibility for specific levels of care, types of services, or particular service models. Children/adolescents identified at CASII levels 4, 5, and 6 of service intensity, should have a designated case manager to coordinate services and activities of Child and Family Team practice. Crisis and/or safety planning is required at these levels of service intensity.**

### **Training and Supervision Expectations**

This Practice Protocol applies to T/RBHAs and their subcontracted network and provider agencies for all behavioral health staff who participate in the assessment and service planning processes and are responsible for the implementation and use of the CASII tool with all children and adolescents between the ages of 6 through 17. Behavioral health agency staff must participate in DBHS designated Child and Adolescent Service Intensity Instrument (CASII) training, education, and technical assistance (see [PM Section 9.1 Training Requirements](#)). This 6-8 hour training must be completed prior to the administration of the CASII.

Only persons who have attended a two-day training containing a “teach back” method are authorized to train the CASII through the American Academy of Child and Adolescent Psychiatry (AACAP). These “master trainers” can then train other staff on the use and implementation of the CASII, as well as train new trainers by having them participate in two, one-day training sessions that include a “teach back” component.

Each T/RBHA shall establish their own process for ensuring that all agency staff responsible for implementing and supervising the use of the CASII understands the required service expectations and whenever this Practice Protocol is updated or revised ensures that their subcontracted network and provider agencies are notified and required staff are retrained as necessary on the changes. Each T/RBHA is required to provide documentation, upon request from ADHS, demonstrating that all required network and provider agency staff have been trained on the service expectations and guidance contained in this Protocol.

In alignment with [A.A.C. R9-20-205. Clinical Supervision](#), requirements, the supervision for implementation of this Protocol is to be incorporated into other supervision processes which the T/RBHA and their subcontracted network and provider agencies have in place for direct care clinical staff.

### **Anticipated Outcomes and How they will be Measured**

Anticipated outcomes include:

- Increased statewide practice in accordance with the 12 Arizona Principles;

- Improved engagement and collaboration in service planning between children, families, community providers and other child serving agencies;
- Improved identification and incorporation of strengths and cultural preferences into planning processes;
- Coordinated planning for seamless transitions between child-serving agencies and when transitioning to the adult behavioral health system

Outcomes will be measured through the use of one or more of the following:

- Consumer/family satisfaction surveys
- T/RBHA reviews of CFT practice
- Random audits completed by ADHS/DBHS
  - Administrative Reviews (chart reviews)
  - Monitoring and Oversight Department audits (chart reviews)
  - Morbidity/Mortality reviews

### **How will Fidelity be Monitored?**

For children/adolescents identified at CASII service intensity levels 4, 5, and 6, the Wraparound Fidelity Assessment System (WFAS) will be the method for conducting fidelity measurement for the purpose of practice improvement. WFAS instruments to be used for this purpose include; the Wraparound Fidelity Index, v. 4 (WFI-4), the Team Observation Measure (TOM), and the Documentation of Wraparound Process (DWP). A modified fidelity method is under development for children with less complex needs.

## Child and Adolescent Service Intensity Instrument (CASII) Desktop Guide

### Service Expectations:

- The CASII shall be completed by the behavioral health service provider, who is trained in the use of the tool, in collaboration with the child/adolescent and family, and other members of the CFT.
- The CASII must be conducted in a manner that is strength-based, family friendly, culturally sensitive, and clinically sound and supervised.
- All T/RBHA and Service Providers shall complete the CASII as part of the initial 45 day assessment period and every six months thereafter. A final CASII shall be completed as part of the disenrollment process from behavioral health services for the child/adolescent.
- The Level of Service Intensity and date of CASII administration shall be entered into the Client Information System and a copy of the CASII Scoring Sheet shall be included in the person's clinical record.
- The CASII recommends the level of service intensity while the CFT identifies the services and supports to best meet the identified needs.
- The CASII is not to be used to determine eligibility for specific levels of care, types of services, or particular service models.
- Children/adolescents identified at CASII levels 4, 5, and 6 of service intensity should have a designated case manager to coordinate services and activities of CFT practice. Crisis and/or safety planning is required at these levels of service intensity.

### ❖ Key elements to remember about this best practice:

- The CASII is to be used as general guidance for CFT's to plan for the amount of coordination and service planning a child/adolescent and family may need.
- There are nine essential activities that create effective CFT practice: Engagement, Immediate Crisis Stabilization, Strengths, Needs and Culture Discovery, CFT Formation, Service Plan Development, Service Plan Implementation, Ongoing Crisis and Safety Planning, Tracking and Adapting, and Transition.
- Since children and families present with diverse needs for behavioral health services CFT practices will vary depending on the unique needs of the child/adolescent and their family. Despite these differences, the CFT practice will still include the nine primary CFT activities and reflect the 12 Arizona Principles.

### ❖ Benefits of using this best practice:

- Provides guidance for assignment of case managers in a consistent manner on a statewide basis.
- Clarifies how CFT practice varies based upon complexity of need.
- Facilitates more consistent evaluation practices across T/RBHAs and providers.