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

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

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.

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

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

Note: A rating of serious risk of harm requires care at level 5 (non-secure, 24-hour services with psychiatric monitoring), independent of other dimensions.

5. EXTREME RISK OF HARM
a. Current suicidal or homicidal behavior or such intentions with a plan and available means to carry out this behavior;
   i. Without expressed ambivalence or significant barriers to doing so, or
   ii. With a history of serious past attempts that are not of a chronic, impulsive, or consistent nature, or
   iii. In presence of command hallucinations or delusions that threaten to override usual impulse control.

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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.

Note: A rating of extreme risk of harm requires care at level 6 (secure, 24-hour services with psychiatric management), independent of other dimensions.

DIMENSION II. FUNCTIONAL STATUS

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

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/control of bodily functions.

   b. No more than transient impairment in functioning following exposure to an identifiable stressor with consistent and normative vegetative status.

2. MILD FUNCTIONAL IMPAIRMENT

   a. Evidence of minor deterioration, or episodic failure to achieve expected levels of functioning, in relationships with peers, adults, and/or family (e.g., defiance, provocative behavior, lying/cheating/not sharing, or avoidance/lack of follow through); school behavior and/or academic achievement (difficulty turning in homework, occasional attendance problems), or biologic functions (feeding or elimination problems) but with adequate functioning in at least some areas and/or ability to respond to redirection/intervention.

   b. Sporadic episodes during which some aspects of self-care/hygiene/control of bodily functions are compromised.

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

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

Note: A rating of serious functional impairment requires care at level 5 (non-secure, 24-hour services with psychiatric monitoring), independent of other dimensions.

5. SEVERE FUNCTIONAL IMPAIRMENT
   a. Extreme deterioration in interactions with peers, adults, and/or family that may include chaotic communication or assaultive behaviors with little or no provocation, minimal control over impulses that may result in abusive behaviors.
   b. Complete withdrawal from all social interactions.
   c. Complete neglect of and inability to attend to self-care/hygiene/control of biological functions with associated impairment in physical status.
   d. Extreme disruption in vegetative function causing serious compromise of health and well being.

CALOCUS Instrument 15
e. Nearly complete inability to maintain any appropriate school behavior and/or academic achievement given age and developmental level.

Note: A rating of severe functional impairment requires care at level 6 (secure, 24-hour services with psychiatric management), independent of other dimensions. The only exception to this is if the sum of IVA & IV B = 2, indicating both a minimally stressful and a highly supportive recovering environment.

DIMENSION III. CO-MORBIDITY: DEVELOPMENTAL, MEDICAL, SUBSTANCE USE, AND PSYCHIATRIC

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

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

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

2. MINOR CO-MORBIDITY
   a. Minimal developmental delay or disorder is present that has no impact on the presenting problem and for which the child or adolescent has achieved satisfactory adaptation and/or compensation.
   b. Self-limited medical problems are present that are not immediately threatening or debilitating and that have no impact on the presenting problem and are not affected by it.
   c. Occasional, self-limited episodes of substance use are present that show no pattern of escalation, with no indication of adverse effect on functioning or the presenting problem.
   d. Transient, occasional, stress-related psychiatric symptoms are present that have no discernable impact on the presenting problem.
3. SIGNIFICANT CO-MORBIDITY
   a. Developmental disability is present that may adversely affect the presenting problem, and/or may require significant augmentation or alteration of treatment for the presenting problem or co-morbid condition, or adversely affects the presenting problem.
   b. Medical conditions are present requiring significant medical monitoring (e.g., diabetes or asthma).
   c. Medical conditions are present that may adversely affect, or be adversely affected by, the presenting problem.
   d. Substance abuse is present, with significant adverse effect on functioning and the presenting problem.
   e. Recent substance use that has significant impact on the presenting problem and that has been arrested due to use of a highly structured or protected setting or through other external means.
   f. Psychiatric signs and symptoms are present and persist in the absence of stress, are moderately debilitating, and adversely affect the presenting problem.

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

Note: A rating of major co-morbidity requires care at a level of 5 (non-secure, 24-hours services with psychiatric monitoring), independent of other dimensions. The only exception to this is if the sum of IVA & IV B = 2, indicating both a minimally stressful and a highly supportive recovering environment.

5. SEVERE CO-MORBIDITY
   a. Significant medical condition is present that is poorly controlled and/or potentially life threatening in the absence of close medical management (e.g., severe alcohol withdrawal, uncontrolled diabetes mellitus, complicated pregnancy, severe liver disease, debilitating cardiovascular disease).
   b. Medical condition acutely or chronically worsens or is worsened by the presenting
problem.

c. Substance dependence is present, with inability to control use, intense withdrawal symptoms and extreme negative impact on the presenting disorder.

d. Developmental disorder is present that seriously complicates, or is seriously compromised by, the presenting disorder.

e. Acute or severe psychiatric symptoms are present that seriously impair functioning, and/or prevent voluntary participation in treatment for the presenting problem, or otherwise prevent recovery from the presenting problem.

Note: A rating of severe co-morbidity requires care at level 6 (secure, 24-hour services with psychiatric management), independent of other dimensions.

**DIMENSION IV. RECOVERY ENVIRONMENT**

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

**Environmental Stress**

1. **MINIMALLY STRESSFUL ENVIRONMENT**

   a. Absence of significant or enduring difficulties in environment and life circumstances are stable.

   b. Absence of recent transitions or losses of consequence (e.g., no change in school, residence, or marital status of parents, or no birth/death of family member).

   c. Material needs are met without significant cause for concern that they may diminish in the near future, with no significant threats to safety or health.
d. Living environment is conducive to normative growth, development, and recovery.
e. Role expectations are normative and congruent with child or adolescent's age, capacities
and/or developmental level.

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

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

4. HIGHLY STRESSFUL ENVIRONMENT
a. Serious disruption of family or social milieu due to illness, death, divorce, or separation of
parent and child or adolescent; severe conflict; torment and/or physical/sexual abuse or
maltreatment.
b. Threat of severe disruption in life circumstances, including threat of imminent incarceration,
lack of permanent residence, or immersion in alien and hostile culture.
c. Inability to meet needs for physical and/or material well-being.
d. Exposure to endangering, criminal activities in family and/or neighborhood.
e. Difficulty avoiding substance use and its effects.
5. EXTREMELY STRESSFUL ENVIRONMENT
a. Traumatic or enduring and highly disturbing circumstances, such as 1) violence, sexual abuse or illegal activity in the home or community, 2) the child or adolescent is witness to or a victim of a natural disaster, 3) the sudden or unexpected death of a loved one, 4) unexpected or unwanted pregnancy.
b. Political or racial persecution, immigration, social isolation, language barriers, and/or illegal alien status.
c. Incarceration, foster home placement or re-placement, inadequate residence, and/or extreme poverty or constant threat of such.
d. Severe pain, injury, or disability, or imminent threat of death due to severe illness or injury.

Environmental Support

1. HIGHLY SUPPORTIVE ENVIRONMENT
a. Family and ordinary community resources are adequate to address child’s developmental and material needs.
b. Continuity of active, engaged primary care takers, with a warm, caring relationship with at least one primary care taker.

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

3. LIMITED SUPPORT IN ENVIRONMENT
a. Family has limited ability to respond appropriately to child’s developmental needs and/or problems, or is ambivalent toward meeting these needs or addressing these problems.
b. Community resources only partially compensate for unmet material and emotional needs and/or child or adolescent has limited or inconsistent access to network.
c. Family or primary care-takers demonstrate only partial ability to make necessary changes during treatment.
4. MINIMALLY SUPPORTIVE ENVIRONMENT
   a. Family or primary care taker is seriously limited in ability to provide for the child’s
developmental, material, and emotional needs.
   b. Few community supports and/or serious limitations in access to sources of support so that
material, health, and/or emotional needs are mostly unmet.
   c. Family and other primary care takers display limited ability to participate in treatment and/or
service plan (e.g., unwilling, inaccessible, cultural dissonance).

5. NO SUPPORT IN THE ENVIRONMENT
   a. Family and/or other primary care takers are completely unable to meet the child’s
developmental, material, and/or emotional needs.
   b. Community has deteriorated so that it is unsafe and/or hostile to the needs of children and
adolescents for education, recreation, constructive peer relations, and mentoring from
unrelated adults.
   c. Lack of liaison and cooperation between child-servicing agencies.
   d. Inability of family or other primary care takers to make changes or participate in treatment.
   e. Lack of even minimal attachment to benevolent other, or multiple attachments to abusive,
violet, and/or threatening others.

DIMENSION V. RESILIENCY AND TREATMENT HISTORY

This dimension records that a child or adolescent’s ability to self-correct when there are disruptions
in the environment. This includes the ability to use the environment as well as the child/adolescent’s
own internal resources. This judgment can be made by considering how well the child or adolescent
has responded to the treatment in the past, but consideration should also be given to responses to
stressor and life changes.

For children/adolescents who have faced major life changes and respond adaptively, the score will be
low. For children/adolescents who are sensitive to minor changes such as schedule disruptions, the
score will be higher. Most children in the autistic spectrum struggle with particular sensitivities that
leave then much less flexible to manage the minor bumps of life.

With regard to treatment, children may respond well to some treatment situations and poorly to
others. The treatment response in some cases may not be related to level of intensity, but rather to the
characteristics, attractiveness, and/or cultural competency of the treatment provided. However,
children and adolescents rarely have long histories of prior treatment upon which to evaluate
resiliency, thus responses to stressors and life changes with no professional involvement should be
considered as well.
Most recent experiences in treatment or care take precedence over more remote experiences in determining the score. For younger children who may not have extensive involvement in any treatment, responses to developmental challenges without professional involvement may be as indicative of resiliency as treatment history.

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

1. FULL RESILIENCY AND/OR RESPONSE TO TREATMENT
   a. Child has demonstrated significant and consistent capacity to maintain development in the face of normal challenges, or to readily resume normal development following extraordinary challenges.
   b. Prior experience indicates that efforts in most types of treatment have been helpful in controlling the presenting problem in a relatively short period of time.
   c. There has been successful management of extended recovery with few and limited periods of relapse even in unstructured environments or without frequent treatment.
   d. Able to transition successfully and accept changes in routing without support; optimal flexibility.

2. SIGNIFICANT RESILIENCY AND/OR RESPONSE TO TREATMENT
   a. Child demonstrated average ability to deal with stressors and maintain developmental progress.
   b. Previous experience in treatment has been successful in controlling symptoms but more lengthy treatment is required.
   c. Significant ability to manage recovery has been demonstrated for extended periods, but has required structured settings or ongoing care and/or peer support.
   d. Recovery has been managed for short periods of time with limited support or structure.
   e. Able to transition successfully and accept changes in routine with minimal support.

3. MODERATE OR EQUIVOCAL RESILIENCY AND/OR RESPONSE TO TREATMENT
   a. Child has demonstrated an inconsistent or equivocal capacity to deal with stressors and maintain normal development.
   b. Previous experience in treatment at low level of intensity has not been successful in relief of symptoms or optimal control of symptoms.
   c. Recovery has been maintained for moderate periods of time, but only with strong professional or peer support or in structured settings.
   d. Has demonstrated limited ability to follow through with treatment recommendations.
e. Developmental pressures and life changes have created temporary stress.
f. Able to transition successfully and accept change in routine most of the time with a moderate intensity of support.

4. POOR RESILIENCY AND/OR RESPONSE TO TREATMENT

a. Child has demonstrated frequent evidence of innate vulnerability under stress and difficulty resuming progress toward expected developmental level.
b. Previous treatment has not achieved complete remission of symptoms or optimal control of symptoms even with intensive and/or repeated exposure to treatment.
c. Attempts to maintain whatever gains that can be attained in intensive treatment have limited success, even for limited time periods or in structured settings.
d. Developmental pressures and life changes have created episodes of turmoil or sustained distress.
e. Transitions with 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 this treatment exposure.
d. Developmental pressures and life changes have created sustained turmoil and/or developmental regression.
e. Unable to transition or accept changes in routine successfully despite intensive support.

DIMENSION VI. TREATMENT ACCEPTANCE AND ENGAGEMENT

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

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

**Child or adolescent acceptance and engagement**

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 treatment, to define the presenting problems, to accept his or her role in the development and perpetuation of the primary problem, and to accept his or her role in the treatment planning and treatment process, and to actively cooperate in treatment.

1. **OPTIMAL**
   a. Quickly forms a trusting and respectful positive therapeutic relationship with clinicians and other care providers.
   b. Able to define problem(s) and accepts others’ definition of the problem(s), and consequences.
   c. Accepts age-appropriate responsibility for behavior that causes and/or exacerbates primary problem.
   d. Actively participates in treatment planning and cooperates with treatment.

2. **CONSTRUCTIVE**
   a. Able to develop a trusting, positive relationship with clinicians and other care providers.
   b. Unable to define the problem, but accepts others’ definition of the problem and its consequences.
   c. Accepts limited age-appropriate responsibility for behavior.

3. **OBSTRUCTIVE**
   a. Ambivalent, avoidant, or distrustful relationship with clinicians and other care providers.
   b. Acknowledges existence of problem, but resists accepting even limited age-appropriate responsibility for development, perpetuation, or consequences of the problem.
   c. Minimizes or rationalizes problem behaviors and consequences.
   d. Unable to accept others’ definition of the problem and its consequences.
   e. Frequently misses or is late for treatment appointments and/or is noncompliant with treatment, including medication and homework assignments.
4. ADVERSARIAL  
   a. Actively hostile relationship with clinicians and other care providers.  
   b. Accepts no age-appropriate responsibility role in development, perpetuation, or consequences of the problem.  

5. INACCESSIBLE  
   a. Unable to form therapeutic working relationship with clinicians or other care providers due to severe withdrawal, psychosis, or other profound disturbance in relatedness.  
   b. Unaware of problem or its consequences.  
   c. Unable to communicate with clinician due to severe cognitive delay or speech/language impairment.

Parent and/or primary care taker acceptance and engagement
The parent and/or primary care taker sub-scale measures the ability of the parents or other primary care taker to form a positive therapeutic relationship, to engage with the clinician in defining the presenting problem, to explore their role as it impacts on the primary problem, and to take an active role in the treatment planning 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 problem.  
   c. Sensitive and aware of the child or adolescent’s problems and how they can contribute to their child’s recovery.  
   d. Active and enthusiastic in participating in assessment and treatment.

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

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

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

5. INACCESSIBLE
   a. No awareness of problem.
b. Not physically available.
c. Refuses to accept child or adolescent, or other family members’ need to change.
d. Unable to form relationship with clinician or other care provider due to significant cognitive difficulties, psychosis, intoxication, or major mental illness or impairment.