Child and Adolescent Service Intensity Instrument (CASII)
Frequently Asked Questions

1. Q: What is the REAL purpose behind the CASII and what is the motivation behind its implementation?

A: The purpose and motivation behind the implementation of the CASII is to utilize objective, quantifiable criteria for determination of service intensity in providing guidance for assignment of case managers to children identified with “high or complex needs” in a consistent manner on a statewide basis. The use of this tool will also provide data to Child & Family Teams (CFTs) to better inform service planning that is individualized to each child and family’s needs.

2. Q: Post assessment, what does the number signify?

A: The composite score directly correlates to a level of service intensity that describes a graded continuum of treatment responses. At each level of service intensity, the CASII User’s Manual provides examples to illustrate a broad range of programming options that allow for variations in practice patterns and resources among communities, as well as with different agencies within the system of care. The level of service intensity criteria provides general recommendations that can be used across a variety of care environments and are met in numerous ways by whomever can best provide the support or intervention (i.e. provider, informal support, community program).

3. Q: How does the CASII dovetail with the System of Care, Arizona Vision and 12 Principles?

A: The use of the CASII supports the goal of implementing a children’s statewide service delivery system in accordance with the Arizona 12 Principles and Child & Family Team practice as contained in the Arizona Department of Health Services (ADHS) and the Arizona Healthcare Cost Containment System (AHCCCS) Medicaid Children’s System of Care Plan. The CASII helps identify in a quantifiable manner those children who have complex behavioral health needs and will need a dedicated case manager. This data has assisted ADHS with establishing case manager expansion goals in conjunction with each Tribal and Regional Behavioral Health Authority (T/RBHA) for every Geographic Service Area. Additionally, based on each child’s score, the CASII describes the service intensity of care needed rather than placement, so that “services will be tailored to the child & family, provided in the most appropriate setting, in a timely fashion and in accordance with best practices while respecting the child & family’s cultural heritage” (Arizona Vision). The CASII then becomes another tool that can be utilized by CFTs to identify strengths and needs and then implement the services and supports to meet those needs.
4. Q: What angle can we take to engage staff to find this as a useful/practical tool (both in the training itself and post training for implementation)?

A: The CASII is a useful tool because it translates information from the child, family and other CFT members into a number that reflects service intensity and can quantify clinical data. The tool is non-diagnostically driven and looks at each child’s condition to identify who presents with high/complex needs requiring the assignment of a case manager. The process of using the tool to evaluate a child’s situation can help focus attention on interventions that target specific areas when a team is feeling stuck or overwhelmed. The CASII is a system that is flexible and adaptable, describes an array of services and level of service intensity rather than a specific treatment setting or program.

5. Q: Will there be data fields in the Client Information System (CIS) for the CASII data?

A: The level of service intensity and the date of the CASII shall be entered into the Client Information System.

6. Q: What are the requirements for completion of the CASII?

A: The following guidelines for CASII completion are outlined in the ADHS/DBHS Practice Protocol Child and Family Team Practice and the collection of the data requirements are outlined in the Demographic and Outcome Data Set User Guide (DUG):

- All T/RBHA and Service Providers shall complete the CASII as part of the initial assessment, at a minimum of every six months thereafter, and at the time of an Episode of Care End from behavioral health services.

The use of the CASII is also done at any time when the CFT believes a review is needed more frequently to reflect any significant internal or environmental changes in the child’s life.

7. Q: Is there a timeframe for implementing a modified CASII for the birth to six population?

A: The CASII has undergone validity studies for use with persons age 6-18. Currently ADHS has focused on implementing the use of this tool with all Medicaid eligible children and adolescents between the age of 6 through 17 enrolled in the T/RBHA system. The American Academy of Child and Adolescent Psychiatry (AACAP) has published the Early Childhood Service Intensity Instrument (ECSII) for use with children age birth to five. T/RBHAs and service providers may choose to utilize the ECSII; however, ADHS is not mandating the use of this instrument.

8. Q: How do agencies determine what type of 24-hour psychiatric monitoring is warranted?
A: Refer to the CASII User’s Manual pages 46-47 and review the description for Level Five: Non-Secure, 24-hour services with psychiatric monitoring in the first paragraph, as well as #1. Clinical Services which outlines the types of therapeutic services including the psychiatric monitoring. Review these same sections for Level Six: Secure, 24-hour services with psychiatric management and Clinical Services on pages 48-49.

Use of the CASII helps agencies determine how a child ranks on six dimensions. The dimensions that produce higher scores which may have more weight for the need for 24-hour psychiatric monitoring or management could include Dimension I. Risk of Harm, II. Functional Status and III. Co-Occurrence of Conditions: Developmental, Medical, Substance Use and Psychiatric. The type of psychiatric monitoring/management is as varied as the child’s needs. For example, a child who is depressed and shows this through lethargic behavior, non-involvement with family members and friends, excessive sleeping and poor appetite who has talked about wanting to die but has no plan. This child’s psychiatric oversight could include weekly appointments for monitoring of symptoms and medication management with additional daily phone contact by medical personnel (i.e. Physician Assistant, Nurse Practitioner, RN) with the caregiver and child for closer monitoring if the child has adequate supervision in his/her home or community setting.

The determination of what psychiatric monitoring is needed to ensure that each child’s unique health and safety needs are met during situations where a child’s symptoms or behavior become unsafe for the child, his/her family or community is made by the CFT. It is the expectation of ADHS that the CFT members with clinical experience provide guidance and that documentation supports the decisions and recommendations of the team.

9. Q: When a caretaker is a foster parent and the biological parents are also involved in the service planning, who is rated in Dimension VI?

A: Rate the biological parents in this situation because they are involved in the service planning process and likely have contact with the professionals involved. If the biological parents are distantly involved, this may be shown by the rating for this domain which will prompt the CFT to implement more intensive engagement activities with the parents.

If a child has recently been placed with a foster parent, rating the foster parent separately from the biological parent may provide the behavioral health provider with information on where support may be needed to assist with the foster parent’s successful involvement in service planning processes and collaborative relationships for the length of time the child/adolescent remains in his/her care.

Refer to page 35 in the CASII User’s Manual for the description of “parent and/or primary care taker involvement in services.”
10. Q: In the training for the CASII, it states that “crisis planning may not be necessary for children with low needs.” Currently all children are required to have a crisis plan. Which process should the behavioral health service provider follow?

A: Per the ADHS/DBHS Practice Protocol Child and Family Team Practice Service Expectations: “When identified as a need, the behavioral health service provider facilitates crisis planning when there are identified risks and/or safety concerns that threaten the stability of a child in his/her community setting. A Crisis Plan is required for all children identified at CASII service intensity levels 3, 4, 5 or 6.”

11. Q: What if our CASII trainers leave the agency’s employment?

A: Behavioral health agencies are encouraged to support interested staff in becoming “master trainers” to ensure there is an ongoing pool of qualified trainers 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.

12. Q: Are “master trainers” of the CASII required to be certified by the American Academy of Child and Adolescent Psychiatry (AACAP) and what are the certification criteria?

A: There are no specific certification criteria required for “master trainers” of the CASII by AACAP. In order to be considered “certified” or “authorized” to train the CASII a person will have completed a two-day training containing a “teach back” method that then authorizes them to train other staff on using and implementing the tool or allows them to train new “master trainers” by having those individuals participate in two, one-day training sessions that include a “teach back” component.