
CHILD AND ADOLESCENT SCREENING INVENTORY
FOR RESIDENTIAL CARE
(CASI)[™]

JOHN DOE

DOB: 09/18/1990

AGE 14

ID OR SOCIAL SECURITY NUMBER: 123-45-6789

Date of Report: 01/10/2005

www.casisystem.com

E-mail: info@casisystem.com

Copyright © 2003-2005 Psychological Assessment Systems, Inc. and Paul A. Sunseri, Psy.D.
All rights reserved.

USE OF THE CASI INTERPRETIVE REPORT

The CASI provides computer generated quantitative data and narrative statements for children and adolescents referred for treatment in residential care facilities. The scale scores and interpretive hypotheses contained in this report are empirically derived and statistically based. For a complete description of the development of the CASI and its psychometric properties, please refer to the accompanying *User's Guide & Technical Manual for the Child and Adolescent Screening Inventory for Residential Care*. Although the CASI was developed to be used as an assessment tool to help guide placement and treatment decisions, final decisions should be made after a careful consideration of all available information about a particular child and not based solely on the data provided in this report. Finally, information contained in the CASI report should be considered confidential.

DEMOGRAPHIC INFORMATION AND PLACEMENT HISTORY

This 14-year-old Caucasian male has been referred for placement by his county department of social services. Former placements include two foster homes. This would be his first placement into a residential care facility.

FAMILY FUNCTIONING INDEX

The level of family functioning is highly associated with treatment outcome and placement stability. Children whose families function at a low level are significantly at risk for premature discharge. Children from low functioning families tend to exhibit more serious behavior problems during treatment, are less likely to reduce the severity of behavior problems as a result of treatment, and are less likely to be discharged to lower levels of care following treatment. Treatment outcomes and behavioral improvements are better with children whose families function at intermediate levels and best when families function at high levels. Unless the relationship between a child and his or her family is such that contact is clearly harmful, effective family therapy and consistent family involvement should be part of every treatment plan with the goal of improving the family's level of functioning and ultimately the child's treatment outcome.

The Family Functioning Index generated by CASI is an average of scores (0 = low, 1 = intermediate, and 2 = high) among six separate categories. The scores among the six categories are added together and then divided by six to produce a Family Functioning Index that ranges from 0 - 2. Based on the information obtained on this adolescent, his **Family Functioning Index = 0.33**, which places his family at the **LOW FUNCTIONING LEVEL**. Please see Appendix A for the actual scores for this adolescent, which can serve as the basis for a family therapy treatment plan.

RELEVANT BEHAVIOR

The following information assesses this client's behavioral functioning in comparison to other children and adolescents in residential treatment within the following five domains: Aggression, Noncompliance, Other Externalizing/Conduct Problems, Sexualized Behavior, Self-Harm, and a Total Problem Score. A graph of these five domains appears on the following page. Scores within each domain are reported as T-scores (Mean = 50, Standard Deviation = 10). For example, a client who obtains a T-score of 50 on the Noncompliance scale would fall within the average range for someone receiving treatment in residential care, i.e., he or she is no more (but no less) noncompliant than the average adolescent in treatment. Differences of one standard deviation or more above the mean ($T > 60$) or one or more standard deviations below the mean ($T < 40$) would represent a difference that is statistically meaningful. Higher T-scores, therefore, indicate more serious behavior problems and lower T-scores less serious.

AGGRESSION. This adolescent obtained a T-score of 60 on this scale, placing him at the 82nd percentile when compared to other boys in residential treatment. He is significantly more likely to have problems in this area relative to other boys his same age in treatment.

NONCOMPLIANCE. This adolescent obtained a T-score of 66 on this scale, placing him at the 94th percentile when compared to other boys in residential treatment. He is significantly more likely to have problems in this area relative to other boys his same age in treatment.

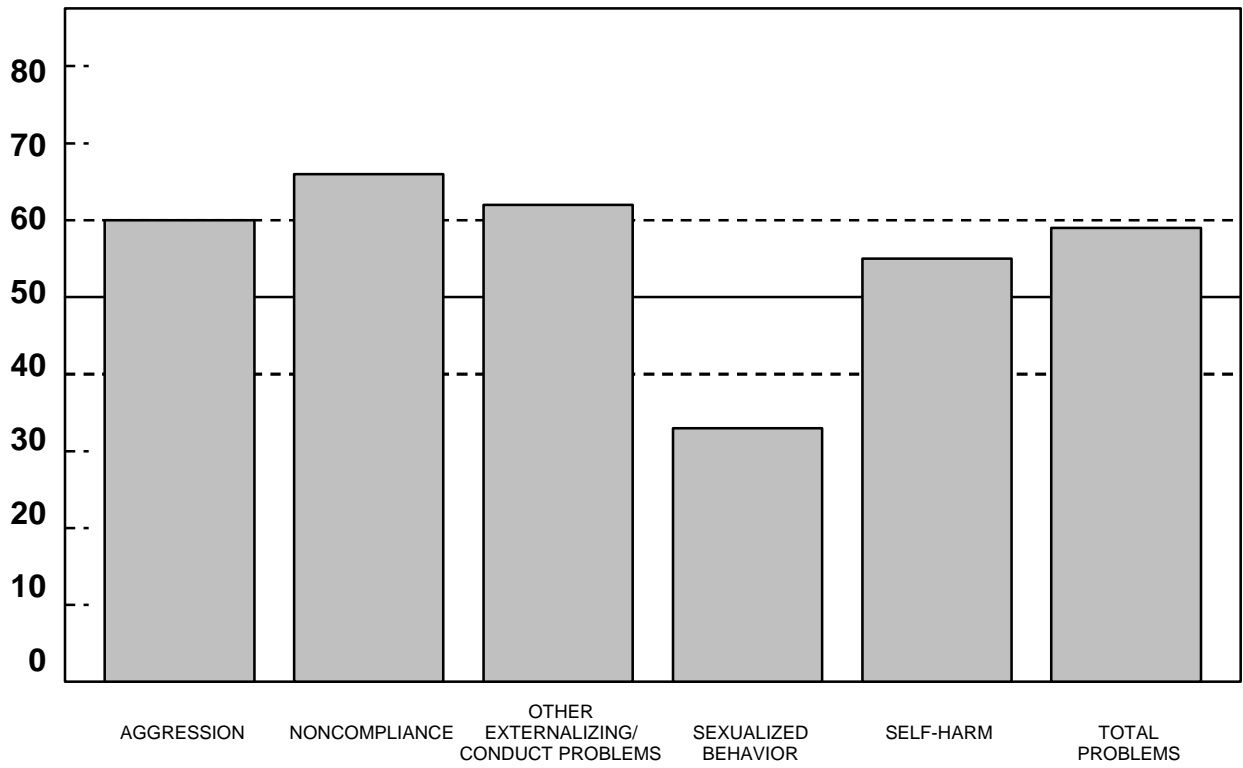
OTHER EXTERNALIZING/CONDUCT PROBLEMS. This adolescent obtained a T-score of 62 on this scale, placing him at the 87th percentile when compared to other boys in residential treatment. He is significantly more likely to have problems in this area relative to other boys his same age in treatment.

SEXUALIZED BEHAVIOR. This adolescent obtained a T-score of 33 on this scale, placing him at the 5th percentile when compared to other boys in residential treatment. He is significantly less likely to have problems in this area relative to other boys his same age in treatment.

SELF-HARM. This adolescent obtained a T-score of 55 on this scale, placing him at the 60th percentile when compared to other boys in residential treatment. His scores in this problem area fall within the high average range relative to other boys his same age in treatment.

TOTAL PROBLEM SCORE. This adolescent obtained a T-score of 59 on this scale, placing him at the 81st percentile when compared to other boys in residential treatment. His total problem behaviors overall are in the high average range relative to other adolescents in residential treatment.

CASI SCALES PROFILE



T-SCORE:	60	66	62	33	55	59
PERCENTILE:	82	94	87	5	60	81

SERIOUS TREATMENT-INTERFERING BEHAVIORS

This section describes the relative probability of this client engaging in behaviors that significantly interfere with successful treatment and a placement stability. The probabilities of the presence or absence of the behaviors described in this section are calculated on what is known historically about this client's behavior as these behaviors have been empirically shown to be stable over time and across situations. Additionally, even if these behaviors have not been demonstrated in the past, predictive statements can also be made based on relative elevations on the associated Behavioral Scales. It is important to note that although the following statements are empirically derived and statistically based, it is not possible to predict behavior with complete accuracy and therefore should be considered behavioral hypotheses rather than absolute certainties.

PSYCHIATRIC HOSPITALIZATION. Chronic or even periodic hospitalization can disrupt the course of treatment and increase the probability of multiple placements in residential care. This adolescent's history suggests that it is **LESS LIKELY** that he will require psychiatric hospitalization during this placement. Historical data show that he has not required hospitalization in the past. The probability of being hospitalized in this placement is decreased significantly as a result of a negative history for hospitalization in the past. *It is important to note, however, that this client obtained an elevated T-score on the Self-Harm scale, which places him at risk for engaging in behaviors that often precipitate hospitalization.*

THE NEED FOR PHYSICAL RESTRAINT/SECLUSION. Children and adolescents in residential treatment who behave in ways that precipitate the use of physical restraints and/or seclusion are at risk for placement instability. This adolescent's history suggests that it is **MORE LIKELY** that he may require this type of intervention during this placement. Historical data show that he required the use of this type of intervention in the past. The majority of children and adolescents with a history of the need for physical restraints or seclusions in the past also require their use in the next placement. The likelihood of this client requiring restraint or seclusion is increased further as he has required this type of intervention relatively recently (within the last year). The frequency of requiring restraints or seclusions for this adolescent has been once or twice per month on average. There is a strong association between how often a child or adolescent has required restraints or seclusions in previous settings and how often he or she will require them in the current setting. Therefore, one might expect to see these interventions used again about this often in the residential setting until this problem is effectively treated.

RUNAWAY. Treatment can be seriously disrupted if a client runs away from a residential care facility. Additionally, attempts to run away potentially expose the child to life-threatening situations. Running away is the single largest contributor to clients being discharged from treatment prematurely and experiencing multiple placements. This adolescent's history suggests that it is **MORE LIKELY** that he may attempt to run away from this residential placement.

Historical data show that he has run away in the past and he has done so relatively recently (within the last year). Children and adolescents with a history of running away are significantly more likely to run away from the current residential treatment facility. The probability of this adolescent running away in his next facility is increased further as the historical data show that he ran away on more than one occasion (he has run away at least four times). There is a strong association between how often a child or adolescent has run away from other settings and how frequently he or she is likely to run away in the current setting. This problem is further compounded as the type of runaway he exhibited in the past is especially difficult to manage and resistant to treatment. Historical data show that in the past when he ran away, on at least one occasion he remained on the run for many days or longer. The type of runaway in the past is associated with the type of runaway in the next setting, so if this adolescent were to run away from this next facility, he may again remain on the run for long periods of time until this problem is effectively treated.

DEGREE OF RISK FOR PLACEMENT DISRUPTION

Based on the available information, among the possible risk levels of Low, Moderate, and High, the degree of risk for this adolescent with respect to multiple residential placements is **High**. This conclusion is reached for the following reasons. The level of family functioning for this client is low, which is a significant risk factor for placement instability. Additionally, this adolescent has a history of requiring the use of physical restraint or seclusion and running away and he is more likely to have behavior problems in the areas of Aggression, Noncompliance, and Other Externalizing/Conduct Problems. These problems, coupled with the low level of family functioning, place this client at risk for placement disruption and multiple placements, especially in lower level, less intensive residential programs.

(NOTE TO THE READER OF THIS SAMPLE REPORT. Users of the CASI have the option of replacing the Degree of Risk for Placement Disruption section of the report with a specific Level of Care Recommendation. Some users prefer the option of identifying a specific level of care in which the client is likely to be the most stable and the least likely to experience a premature termination.

TREATMENT RECOMMENDATIONS:

(NOTE TO THE READER: The Treatment Recommendations section of the report is optional and may be omitted at the user's discretion.

The following treatment recommendations are based on areas of potential concern identified by the CASI report. If these areas are attended to effectively, the probability of this adolescent being stable in placement will increase. Each of the problems listed below requires clinical attention and should become a part of the client's initial treatment plan. Any evidence-based treatments identified in the literature will be referenced as well and should be implemented whenever possible.

Resistance to Treatment

This adolescent does not appear to be agreeable to treatment and is resistant. Research has shown that clients who are resistant to treatment have poorer outcomes than clients who are not resistant. It would be helpful in the case of this adolescent to employ strategies designed to increase his motivation and level of commitment as soon as possible. Motivational Interviewing (Miller & Rollnick, 1991) and some of the commitment strategies used in Dialectical Behavior Therapy (Linehan, 1993) would probably be very helpful in decreasing resistance.

Linehan, M.M. (1993). *Cognitive-behavioral treatment of borderline personality disorder*. New York: Guilford Press.

Miller, W.R., & Rollnick, S. (1991). *Motivational interviewing*. New York: Guilford.

Family Functioning and Involvement

Unless all efforts have been attempted and family contact is clearly detrimental or otherwise harmful for this adolescent, immediate, concerted efforts should be made to increase this family's level of functioning. The low level of functioning in this case poses the single biggest risk factor for this adolescent and its importance in terms of treatment outcome cannot be overstated. Improving the functional abilities of available caretakers will very likely increase the probability of a stable placement and a successful treatment outcome and decrease the probability of premature termination. A structured, well-planned treatment approach should be adopted right away for this family that includes regular family therapy with the explicit goal of improving functionality. Obtaining a commitment to attend family therapy prior to placement can often be very helpful with respect to increasing the likelihood of attendance. Several good, evidenced-based family treatments have been identified in the literature. Although originally developed for other settings, several treatments explicitly target improving functionality and therefore would be very useful in this case, such as Functional Family Therapy (FFT; Alexander, Pugh, Parsons, & Sexton, 2000), Multidimensional Family Therapy (MDFT; Hogue, Liddle, Becker, & Johnson-Leckrone, 2002), and Multisystemic Therapy (MST; Henggeler, 2001). An experienced, culturally competent therapist is a must for this family. Often, simply making regular and genuine overtures to family members and adopting a nonjudgmental approach can induce even the most reluctant parents to make substantial changes. A residential care facility with this type of approach would be best suited to this particular adolescent's family situation. The location of the residential treatment facility should be given due consideration as proximity to home is associated with family contact and home visits. Children and adolescents who are placed within 30 miles of their parents' home are significantly more likely to have regular family contact and go on home visits than children placed 60 miles away or farther. This is especially likely to be true if this adolescent's family lacks reliable transportation, the means to afford travel, or a work schedule that makes regular contact difficult (as is often the case with low functioning families). If these factors are present, a facility close to home would be optimal.

Alexander, J.F., Pugh, C., Parsons, B.V., & Sexton, T.L. (2000). Functional family therapy. In D.S. Elliott (Ed.), *Blueprints for violence prevention (Book 3)*. Center for the Study and Prevention of Violence, Institute of Behavioral Science, University of Colorado.

Henggeler, S.W. (2001). Multisystemic therapy. In D.S. Elliott (Ed.), *Blueprints for violence prevention (Book 6)*. Center for the Study and Prevention of Violence, Institute of Behavioral Science, University of Colorado.

Hogue, A. T., Liddle, H. A., Becker, D. & Johnson-Leckrone, J. (2002). Family-based prevention counseling for high risk young adolescents: Immediate outcomes. *Journal of Community Psychology*, 30(1), 1-22.

Psychiatric Hospitalization and Self-Harm

WARNING: This client's score on the Self-Harm scale is significantly elevated, which suggests that he may be at increased risk for self-harm and suicidal behaviors. Adequate supervision is essential. Although it was determined that psychiatric hospitalization is less likely for this client, he engages in behaviors that place him at risk for hospitalization during placement. Should hospitalization occur, it would then become an important component of this adolescent's treatment plan to offset the need for subsequent hospitalizations. Often it is helpful to form a good working relationship with a nearby hospital in order to develop a coordinated treatment plan. For clients who are hospitalized repeatedly, it is especially helpful (if possible) to choose the same hospital in each instance as it generally becomes easier with time to construct a coordinated treatment approach. A cognitive-behavior technique with the best empirical support for reducing both self-harm behavior and hospitalization is Dialectical Behavior Therapy (Linehan, 1993).

Linehan, M.M. (1993). *Cognitive-behavioral treatment of borderline personality disorder*. New York: Guilford Press.

The Need for Physical Restraint/Seclusion

An immediate treatment plan should be implemented to reduce or even ideally eliminate the need for very serious intervention. This is especially true for older adolescents and/or physically large clients as this behavior poses a significant threat to the physical safety of staff members. Several evidenced-based treatments are available for anger management, such as Anger Control Training (Feindler & Guttman, 1994) and Anger Coping Program (Lochman, Whidby, & Fitzgerald, 2000). In general, successful treatment of aggression and anger control problems involves helping the client identify emotional triggers, environmental events, and bodily sensations that precipitate impulsive/aggressive behaviors in conjunction with teaching self-managed de-escalation techniques. Short-term behavioral contracting, although probably less effective in the long run, may be helpful early in treatment to increase this client's motivation to reduce aggressive behavior.

Feindler, E.L., & Guttman, J. (1994). Cognitive-behavioral anger control training. In C.W. LeCroy (Ed.), *Handbook of child and adolescent treatment manuals*. (pp. 170-199). New York: The Free Press.

Lochman, J.E., Whidby, J.M., & Fitzgerald, D.P. (2000). Cognitive-behavioral assessment and treatment with aggressive children. In P. Kendall (Ed.), *Child & adolescent therapy: Cognitive-behavioral procedures* (pp. 31-87). New York: The Guilford Press.

Running Away

This potential behavior poses the biggest risk factor for this adolescent in terms of the potential for multiple placements. A treatment plan should be firmly in place as soon as the client arrives (or preferably even before he arrives) to address this problem. NOTE: This client *should not* be housed in close proximity to other clients who also exhibit runaway behavior as this will almost certainly worsen the problem (especially not as roommates and ideally not even in the same house, cottage, unit, etc. if possible). Clients tend to be at their greatest risk for running away early in treatment. Approximately 60% of clients who terminate treatment by running away do so within 90 days after placement, so one simply should not wait to intervene in this area. This adolescent may struggle with urges to leave the facility, especially during stressful periods or following negative exchanges with peers, staff, or family members. Obtaining an early verbal commitment to treatment and identifying contingencies (rewards and consequences, both long-and short-term) are essential. Various cognitive-behavior techniques may be helpful in tracking urges to run away, such as keeping a daily diary card in which the client rates the strength of his urges to leave treatment. Periodic check-ins by staff, especially during periods of stress may be helpful (e.g., “My guess is you’re having thoughts of running away right now.”) Here again, short-term behavioral contracting may be somewhat helpful initially, but will probably be in itself insufficient to adequately treat this behavior. A more effective long-term course would be to foster attachments to both staff and prosocial peers and teach the client behavioral skills to resist his urges to leave treatment impulsively. Although it is common to hear anecdotal reports that support placing clients who chronically run away into facilities that are distant from their home communities, research does not support this practice as the rate of termination is no better and possibly worse.

END OF REPORT

APPENDIX A: FAMILY FUNCTIONING SCORES

The following scores were obtained to calculate the **Family Functioning Score**. Items endorsed for this family, which can serve as the basis for an initial family therapy treatment plan, are shown below in italicized bold type.

Problem Solving:

- 2 Able to negotiate, express opinions
- 1 Some difficulty in communication & problem solving
- 0 *Minimal problem solving, little compromise***

Dealing with Stress/Conflict:

- 2 Talks over problems, effective handling of stress
- 1 Major conflict ignored, able to resolve minor differences
- 0 *Domestic violence, substance abuse, harmful to safety/health***

Parental and Family Conflict:

- 2 No significant family discord
- 1 *Moderate discord, frequent arguments, threats of separation***
- 0 Serious discord, violence, separations

Parental Social Supports:

- 2 Available support from immediate family and friends
- 1 *Only one or two family members or friends available***
- 0 Caregiver isolated or reliant only on professional help

Parenting Skills and Physical Discipline:

- 2 No use of physical discipline
- 1 Physical discipline used; but not excessive or abuse
- 0 *Excessive use of physical discipline***

Involvement in Case Planning:

- 2 Fully and actively involved
 - 1 Minimally involved
 - 0 *Resistive to agency contact***
-

**APPENDIX B:
BEHAVIORAL SCORES**

The following behavioral scores were obtained on this client. Under each scale, the specific behavioral items are shown. Missing or unavailable scores are indicated as such. The severity of each behavior item was endorsed according the following key:

0 = not true 1 = somewhat or sometimes true 2 = very true or often true

<u>Scale Name</u>	<u>Behavioral Item</u>	<u>Score</u>
Aggression	curses at others	2
	quick temper or temper tantrums	2
	damages property	2
	strikes adults	2
	strikes peers	1
Noncompliance	overreacts	2
	argues	2
	impulsive	2
	stubborn	2
	doesn't handle being told no by adults	2
	challenges authority	2
	noncompliant	2
	poor hygiene	1
Other Externalizing/ Conduct Problems	secretive	2
	seeks out negative peers	2
	does not accept criticism	2
	lies	2
	shows no remorse	2
	steals	2
	uses substances	2
	teases other children	1
	doesn't show empathy	1
	manipulative	1
	avoids school	1

APPENDIX B (Continued)
BEHAVIORAL SCORES

0 = not true 1 = somewhat or sometimes true 2 = very true or often true

<u>Scale Name</u>	<u>Behavioral Item</u>	<u>Score</u>
Sexualized Behavior	promiscuous	1
	engages in sex play	0
	inserts objects into rectum or vagina	0
	exposes self to others	0
	sexually aggressive/provocative	0
Self Harm	burns self	2
	suicidal thoughts	2
	swallows nonfood items or overdoses	2
	sad or unhappy	1
	bangs own head	0
	picks at skin or sores	0
	cuts self	0
	bites self	0
	pulls out own hair or eyelashes	0
strikes self	0	
