Training on the Assessment for Safe and Appropriate Placement:

Using the Massachusetts Child and Adolescent Assessment Protocol: PSB

(M-CAAP: PSB)

PART TWO

November 2022

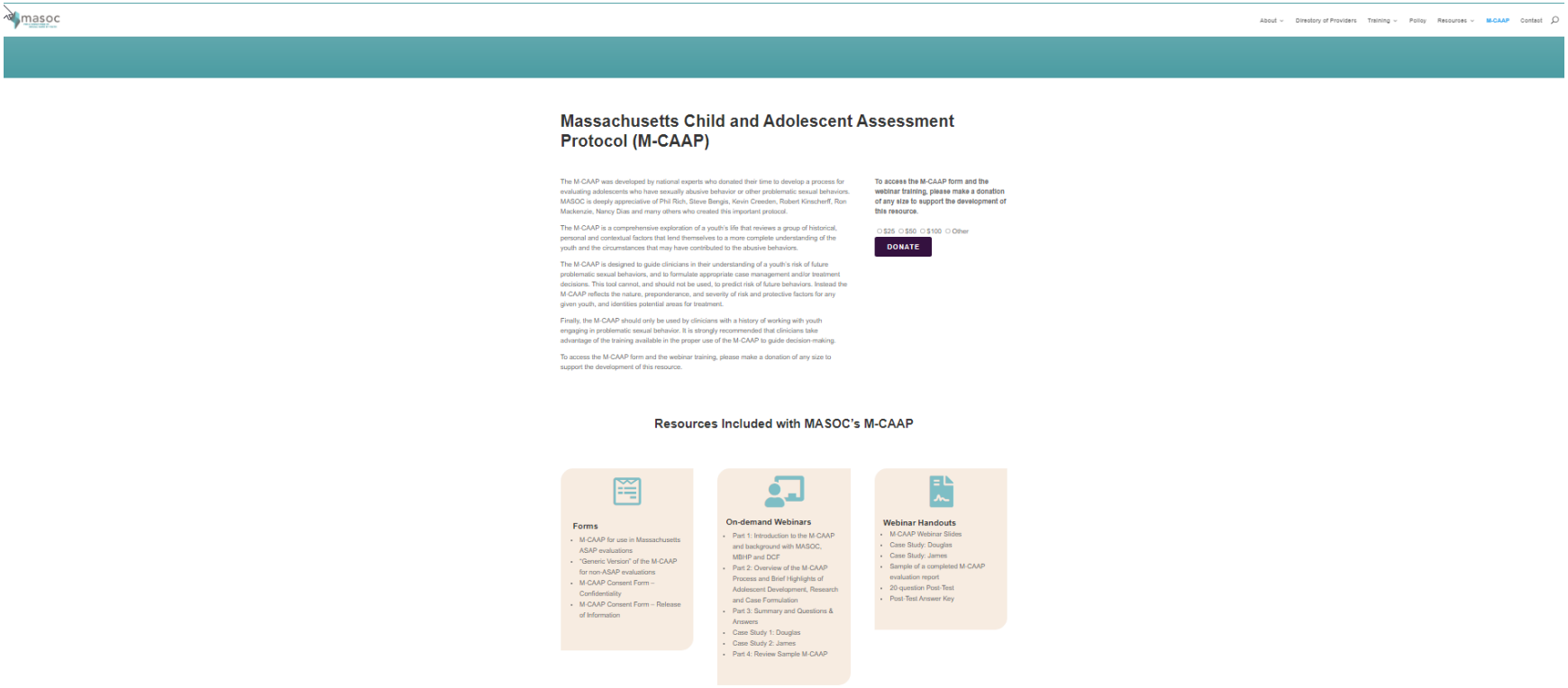
Kevin Creeden
Robert Kinscherff
Phil Rich

The Interactive M-CAAP

Phil

The Interactive M-CAAP

- The M-CAAP is available for download as an interactive Microsoft Word document.
  - https://masoc.net/m-caap



The Interactive M-CAAP

- The “boilerplate” text is locked and cannot be changed or modified by users.
- However, each item and checklist has an interactive open text box, which allows for entry using all word processing features.
- The interactive M-CAAP also has instructions for the evaluator throughout the protocol, which can be seen by evaluators on their computer screens but will not print out or appear in the printed evaluation report.

The Interactive M-CAAP

- However… instructions are in “hidden text.
- They must be switched on in order to be visible to the evaluator.

The evaluation is being conducted for the Department of Children and Families for purposes of safe and appropriate case management and treatment planning. It is not being prepared with the intention of using it in a legal proceeding. However, DCF may choose to introduce it in legal proceedings involving the care and protection of the young person and/or may be required to release it in response to a court order or other legal process in other legal proceedings.

The young person and their legal guardian have signed a statement attesting that they have been informed of the nature and purpose of the evaluation, that DCF is the identified client for purposes of the evaluation and will be receiving a report and recommendations and limits upon confidentiality and privilege, including potential uses of the evaluation in legal proceedings. They attest that they have been given an opportunity to ask questions or express concerns regarding the evaluation. Signing of this statement also attests that the legal guardian authorizes the evaluation to proceed (informed consent) and that the young person has received a developmentally appropriate explanation of the evaluation.

INSTRUCTION TO THE EVALUATOR *(this instruction will not appear on printed report)*
For Massachusetts ASAP use M-CAAP prescribed notification of confidentiality/purpose of evaluation forms only. For others, forms serve as a guide.

I. EXPLANATORY, DEMOGRAPHIC, AND DESCRIPTIVE INFORMATION

A. Identifying Information and Reason for Evaluation

INSTRUCTION TO THE EVALUATOR *(this instruction will not appear on printed report)*
- This section is intended to provide a brief overview only, with details provided in the report that follows:
  - Name, age, living situation, school grade, IQ and special education services
  - Brief psychosocial circumstances that help describe the young person
  - Behavioral and other psychosocial history in brief, if relevant
  - Other brief descriptive information that help frame the evaluation and evaluation circumstances
- Reason for evaluation. Briefly describe….
  - Reason for the M-CAAP, as described in the referral material available at the time the evaluation was requested by DCF
  - Brief summary/description of the problematic sexual behavior, to be described in detail later in the report
  - Do not include name of alleged/substantiated victim, unless an immediate relative, such as a sibling. Use first initial only, or variant of first initial if there is more than one identified victim with the same initial.

B. Informants to the Evaluation

INSTRUCTION TO THE EVALUATOR *(this instruction will not appear on printed report)*
- List informants, including roles and relationships.
- Identify informants contacted, but not reached.

Comment, if necessary:

C. Documents Reviewed for this Evaluation

INSTRUCTION TO THE EVALUATOR *(this instruction will not appear on printed report)*
- List all records reviewed, type and date of records, and author of reports.
- Identify records requested, but not received or reviewed.

Comment, if necessary:

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I. EXPLANATORY, DEMOGRAPHIC, AND DESCRIPTIVE INFORMATION

A. Identifying Information and Reason for Evaluation

B. Informants to the Evaluation

Comment, if necessary:

C. Documents Reviewed for this Evaluation

Comment, if necessary:

D. Legal Status

E. Sexual Offender Registry

II. PRESENTATION AND RESPONSE TO THE ASSESSMENT PROCESS

A. Mental Status Exam (MSE)

1. Appearance and Behavior	Within normal/expected limits Assess age appropriate dress, grooming, physical appearance, facial expression; motor behaviors such as slow, restless, agitated; attitude; and unusual mannerisms, tics, etc. *Comment if unusual or necessary:*
2. Speech	Within normal/expected limits Assess volume, rate, rhythm, spontaneity, impairments, word-finding problems, pressure, etc. *Comment if unusual or necessary:*
3. Mood and Affect	Within normal/expected limits Assess subjective state of predominant emotional feeling, including range of emotions, flatness, blunted, normal, labile, and inappropriateness of affect to content. Note eating or sleeping problems. *Comment if unusual or necessary:*
4. Stream of Thought	Within normal/expected limits Assess rate of thoughts, as slow or fast, and content as coherent, tangential, loose, or flight of ideas. *Comment if unusual or necessary:*
5. Thought Content	Within normal/expected limits Assess for worry, preoccupation, fears, phobias, obsessions, compulsions, ideas of reference, persecutory or other delusions, grandiosity, jealousy, and somatization, auditory, visual, or other hallucinations. *Comment if unusual or necessary:*
6. Orientation and Concentration	Within normal/expected limits Assess for orientation to person, place, and time, attention skills, and distractibility. Assess ability to do serial 7's or 3's, basic arithmetic skills, and spelling, such as spelling words backwards.

The Interactive M-CAAP

Assessment for Safe and Appropriate Placement: Sexual Behavior
Child/Adolescent Assessment Protocol (M-CAAP)

Name:
Gender:
Date of Birth: Age:
Current Residence:
Legal Address:
Height: Weight:
Race/Ethnicity: Religious Affiliation:
Primary Language:
School Grade: IQ (full scale):
School Name and Location:
State Agency Lead Agency, if relevant:
State or Private Insurance Name and Number:
Other Identifying Information:
Date of Report: Evaluation Date(s):
Evaluator and Credential:

Open text fields

Purpose of the MA SOC Child/Adolescent Assessment Protocol

The M-CAAP is the format used to complete the Assessment for Safe and Appropriate Placement (ASAP) evaluation for the Massachusetts' Department of Children and Families. The M-CAAP evaluates concerns for continued sexually abusive behavior or other problematic sexual behaviors, if current circumstances remain unchanged. However, concerns about risk for continued sexually problematic behavior are not based upon any single factor or group of factors. Instead, prognosis is based upon a thorough review of not only the history of sexually problematic behavior, but also personal and contextual factors that lend themselves to a more complete understanding of the youth and the circumstances that led, contributed to, or in some other way influenced, the problem sexual behavior.

The assessment is comprehensive and reviews multiple details of the youth's life, providing a basis for understanding risk and forming case management and/or treatment decisions. However, an assessment regarding concern for continued sexually problematic behavior is not a statement of certainty that a youth will or will not engage in further problematic sexual behavior. Instead, the assessment reflects the nature, preponderance, and severity of risk and protective factors for any given youth, and also clearly identifies areas in need of treatment. An assessment of risk factors therefore partially reflects target areas for continued treatment and supervision, aimed at reducing or limiting risk for further sexually problematic behavior. The M-CAAP additionally assesses areas or circumstances in the youth's life that elevate risk for sexually problematic behavior, as well as protective factors and circumstances that may mitigate or reduce the risk for further sexually problematic behavior.

Locked Boilerplate Text

Informed Consent
Both the youth and legal guardian signed an Informed Consent form attesting to their agreement to participate in the evaluation. HIPAA compliant consent for Release of Information forms were signed by the youth's legal guardian prior to the evaluator contacting, speaking to, or seeking information from anyone outside of the state agency or other referral source.

Statement of Informed Consent/Assent and Limits of Confidentiality
The youth and the youth's legal guardian were informed that the referral agency is the client for purposes of this evaluation. Information reported to, or discovered by the evaluator will be used by the evaluator to provide a report and recommendations to the referral agency. The youth and others may decline to participate in the evaluation, decline to respond to particular questions, or end an interview with the evaluator at any time, but any information shared with the evaluator is not private, confidential, or privileged since it may be used if relevant for the report and recommendations to the referral agency. The report will become part of the referral agency record of the youth and/or family, and there may be circumstances when it might be accessible under state law such as in the event the youth should ever become the subject of civil commitment proceedings due to convictions for sexual offenses.

The Interactive M-CAAP

The youth and the youth's legal guardian were informed that the evaluator is a mandated reporter for purposes of reporting known or suspected neglect or abuse of a child under age 18, a disabled person, an elder aged 60 years or older, or other circumstances triggering a mandated report or a duty to warn/protect should a person pose a risk of significant harm to themselves or others.

The evaluation is being conducted for the referral agency for purposes of safe and appropriate case management and treatment planning. It is not being prepared with the intention of using it in a legal proceeding. However, the referral agency may choose to introduce it in legal proceedings involving the care and protection of the youth and/or may be required to release it in response to a court order or other legal process in other legal proceedings.

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A. Informants to the Evaluation

- ☐

Open text fields

B. Documents Reviewed for this Evaluation

- ☐

C. Brief Reason for Evaluation

☐

Open text fields

D. Legal Guardianship and Custody

☐

E. Legal Status

☐

F. State Agency Involvement

☐

G. Sexual Offender Registry

☐

II. PRESENTATION AND RESPONSE TO THE ASSESSMENT PROCESS

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3. Mood and Affect	☐ Within normal/expected limits

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D. Legal Guardianship and Custody

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M-CAAP
Consent Forms

- Two consent forms will be required for the M-CAAP, and are also available for download.
  1. Consent/Assent: Psychosocial Evaluation
  2. Authorization and Consent for Release of Information

Case Studies

Case Study 1

DOUGLAS

From: C. Latham & R. Kinscherff. *A Developmental Perspective on the Meaning of Problematic Sexual Behavior in Children and Adolescents.* NEARI Press, 2012.

Robert

Case History: Douglas

- Douglas is the only child of Gina and Joe, born without complications after an uneventful pregnancy. Joe died when Doug was two and Doug has no memory of him. Gina suffers from physical and psychiatric disabilities which have limited her ability to care for Doug, and has been very ambivalent about parenting him since his birth.
- CPCS was first involved when Doug was two due to chronic physical and verbal abuse, and twice in foster care at ages two and three when Gina was hospitalized.
- He was socially isolated from family and peers as he entered elementary school, and missed many days of school as Gina was preoccupied and limited by her own disabilities.
- He was psychiatrically hospitalized at age 7 after threatening to kill himself and setting two fires at home.
- He disclosed physical and verbal abuse by him mother, was discharged to a foster home, but was then returned to his mother with additional supports in place.

Case History

- Doug was repeatedly sexually abused by an adult neighbor between ages 5 -7 by an adult neighbor. He became aggressive, threatening, and displayed regressed and disorganized behavior.
- The abuse was not disclosed and so no connection was drawn between the abuse and the onset of Doug's troubled behavior.
- Despite the supports, Doug was defiant to his mother and engaged in what in retrospect seems to have been sexual-abuse reactive play with younger children.
- He was placed at age 8 in a short-term stabilization unit where he was easily emotionally dysregulated and sexualized (which were seen as reactions to trauma).
- He was discharged to foster care and was with several foster families over three years until returned to his mother at age 11.
- He was placed with his grandparents a few weeks later; his mother did not keep approved visits or phone calls – at least in part because of an apparently delusional belief that her own father had abused her and was now abusing Douglas.

Case History

- Douglas' mother shared this belief with him, along with other beliefs (imminence of the end of the world).
- Douglas was confused and terrified by these beliefs, caught in emotional extremes between idealizing her and the life he hoped to have with her and anger when she didn't follow-through with visits and calls.
- At age 12, Doug sexually abused his then 5-year old cousin. This prompted outpatient treatment for that incident and other previous problematic sexual behavior.
- Despite this treatment, Doug remained defiant, aggressive, moody and irritable, and prone to lying. He had great difficulty with peers. His historically good academic performance and school behavior began to deteriorate and he was suspended after assaulting a peer he believed had taunted him.
- He began to show sexualized behavior at school, including intense unwanted sexual interest in a few female peers and telling stories about his claimed sexual exploits.

Case History

- At age 14, his mother attempted to enlist him in a suicide pact. Her parental rights were subsequently terminated, and Doug entered his seventh foster placement. He was then placed in his current residential treatment center after disclosing willing participation in unprotected sex with an older adolescent he met in the community.
- Doug has never required physical management and he was apparently cooperative with treatment although seen as “manipulative” and focused upon how others perceived him.
- In response to seeming progress in treatment, he was moved to a cottage with greater community access just after his 16th birthday. Within days, he had initiated a 10 month period of efforts to have sexual contact with every other cottage resident – all of whom where apparently willing.
- When this was eventually discovered and staff attempted to restrict his activities and increase supervision, Doug persisted in making sexual gestures and comments to his peers.

Case History

- Doug realized as he approached his 18th birthday that he had no place to go and filed for continued voluntary services through CPCS through age 21.
- His treatment team and CPCS case worker are skeptical about his interest in treatment even as he faces possible homelessness.

Assessments and Diagnoses

- **Past Assessments**: Average IQ, average academic achievement. Age 13: Chronically overwhelmed by stress, few coping resources, little tolerance for ambiguity. Age 15: Anxiously seeks reassurance from others but questions the genuineness of supports, intense separation fears from those he finds supportive, depressed-submissive in relationships.

- **Past Diagnoses**: Depression, Anxiety, PTSD (age 5); Conduct Disorder (age 13); ADHD, combined type (age 14); Reactive Attachment Disorder, Dysthymic Disorder, Anxiety Disorder, Histrionic and Dependent personality traits (age 15).

Sexual History

- Sexual History: Repeated sexual abuse by male neighbor (ages 5 – 7); Multiple episodes of mutual fondling/oral sex with peers and younger children (ages 7 – 10), including sexual contact with one peer continuing 8 years and occurring at knifepoint towards the end (ages 7 – 16); forcible sexual abuse of 5 year-old female (age 11); grooming younger male neighbor (age 13); intense interest in homosexual pornography (ages 13 -15); unprotected sex with older adolescent whom he had just met in community (age 15); multiple sexual encounters with peers in RTC and continuing despite increased staff supervision (age 16-17).
- Sex variously used for pleasure, self-soothing, revenge, and as he grew older, to facilitate friendships and sense of emotional closeness. At age 18, no specific sexual attraction to younger or prepubescent children, intense interest in pornography is focused on peer-aged or young adult individuals engaged in consenting sex (not children, rape, or sadomasochistic).

Case Study 1: Questions/Discussion

- What have been drivers of Douglas' PSB at each point?
- What functions have been served by his PSB at each point?
- What context and victim characteristics are most salient at each point?
- How has his developmental trajectory and life circumstances contributed to PSB at each point?
- What is his risk profile by the end of the case? Context? Most likely to be target or victim of PSB? Other?
- What interventions at what intensity and duration? Targets for intervention?

Case Study 2

JAMES

Phil

Case History

- James is 14.
- Prior IQ testing indicated borderline IQ, but this is possibly an under-estimate, driven by a significant reading difficulty, poor self-esteem that influenced testing, and difficulties in the learning environment in general.
- James' intellectual functioning more likely falls into the average or low-average range.
- He has shown great progress in his educational performance during the time he has been in his current placement at a secure residential treatment center, where he was admitted 20 months ago.
- James' reading level has increased from 1st grade to 10th grade, with much of the improvement occurring within a one-year period.
- He was formerly embarrassed by his reading and writing difficulties, sometimes significantly behaviorally acting out in school in order to avoid reading, and especially out loud.

Case History

- James has exhibited increasing behavioral difficulties since age 8, including two arrests since age 10.
- The first was at age 11 after shooting an older peer in the leg with a realistic looking pellet gun.
- James made the older peer kneel while pointing the gun at his eye, following the older boy's bullying of James' younger brother.
- James shot the older boy twice in the leg as the boy ran away, as well as another teenage girl in the area.
- He was again arrested at age 12, following his rape of a 63-year-old hearing disabled woman in her home, while threatening to hit her with a hammer if she did not comply.
- He was not identified, but returned to the home one week later, he later claimed looking for part-time work. This led to his arrest.
- He had previously done some chores for the woman's elderly mother, which is how he knew the home.
- James took his younger brother with him when he returned.

Case History

- Prior to this, James' behaviors had consistently escalated in non-compliance, verbal threats, and physical aggression aimed at peers and teachers.
- This included severe bullying of several girls in his school, who were afraid of him.
- Since age 8 escalating behavioral problems include multiple school suspensions and disciplines, expulsion from three schools, including alternative schools for students with emotional and behavioral difficulties.
- He was frequently truant from school, had no same age friends, and spent much time with a gang-like group of peers, several years older than James.
- Following his second arrest, James has been in secure treatment for 20 months, his placement at the time of the evaluation.

Case History

- James reports feeling “deeply bad” about his sexual offense, although does not easily show emotions and appears somewhat flat, and his level of empathy has been questioned by his caseworker, probation officer, and other treatment providers.
- He generally appears somewhat emotionless, with a history of difficulty understanding or expressing feelings other than anger.
- However, James’ anger now seems to be well managed by him and not experienced as frequently.
- Although close to his family, and especially his younger brother, James reports formerly not caring very much for people, but describes himself now caring more about and for others.
- There is a history of instability in the family, with multiple moves over the years.
- He moved at least 11 times prior to age 12 and has never lived in the same home for more than two years.
- Additionally, he attended at least eight different schools prior to age 12.

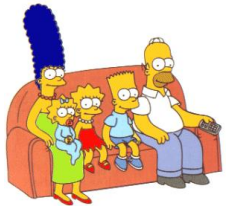
Case History

- Even though his mother and brother have been constants in James' life, many other adults, and especially other family members, have come in and out of James' living environment.
- James has no history of therapeutic or mental health treatment prior to his first arrest and subsequent placement with a state agency.
- Throughout his 20 months in secure treatment, James has been respectful, manageable, and cooperative.
- He is described by all providers as cooperative, quiet, shy, and likeable, and has shown increasing progress in participation, attitude, engagement in treatment, and personal growth.

Case History

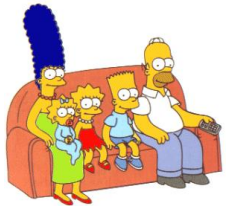
- However, all providers believe that much of James' growth and development can be attributed to the secure treatment environment, and that he requires a rich and supportive environment to maintain growth.
- He continues to be described as not highly empathic and difficult to build a strong relationship with, but now more connected and prosocial.
- Describe growth, James continues to lack skills in self-expression and self-reflection and the capacity to explain what he has learned in treatment.
- However, all providers note clear and positive changes in his presentation and engagement, with moderate growth.
- Nevertheless, there is also uncertainty about the depth of change in James, and the possibility that gains reflect the strength of his current environment rather than being internalized, and the potential for a return to problematic behaviors upon return to the community.

Family History



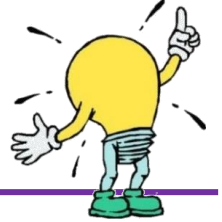
- James is the oldest of two children born to his parents.
- His mother was 16 when she gave birth to James and his father was 19.
- She gave birth to his younger brother 18 months later.
- Although living together on-and-off as a couple for several years, James' parents were never married, and neither has since married.
- His parents have been disengaged and lacking follow through, noted throughout James' educational and medical treatment records.
- James' mother describes his father as a good father who cares about his children, although he does not give child support money despite being court-ordered.
- She also describes his father as "juvenile," unreliable, a "punk," and a poor role model for their children.
- Nevertheless, she also describes him as her best support, and wishes they could again be a couple.

Family History



- James' younger brother, age 13, has also experienced significant behavioral difficulties, and continues to do so.
- He began getting into trouble around age 10, including in school, and he has been suspended from school, and has few friends, often spending time alone at home. He seems to be on a similar trajectory as James.

Psychological Insights



- Psychological testing points toward a dominating form of conduct disorder, fitting with James' prior behavioral and attitudinal presentation, although not with his current presentation.
- It suggests a significant tendency for impulsivity and acting out, as well as "isolation mechanism."
- This is a psychological process that allows forceful behavior without experiencing the emotions or experiences of the other person, or "cold blooded" behavior.
- Testing also highlights impulsiveness and resentful attitudes, and James' self-image as assertive, bold, "hard-boiled," and masculine, hiding a deep insecurity about his self-worth.
- It describes him as capable of an impulsive willingness to engage in risky behaviors, acting without fear despite potential harm to self or others, and lacking in sentimentality, tenderness, and inner conflict, or feelings of shame or guilt.
- Overall, he is described as unempathic.

Case Formulation

- We want to know, as best as we can, what drives James' sexually harmful behavior, and how might we best treat that problem.
- We want to understand, not only what happened but, perhaps of more importance, why James engaged in sexually harmful behavior.

Case Formulation

- Case formulation – our ability to theorize the causes and development of and explanation for the behavior.

  "A hypothesis about the causes, precipitants, and maintaining influences of a person's psychological, interpersonal and behavioral problems."

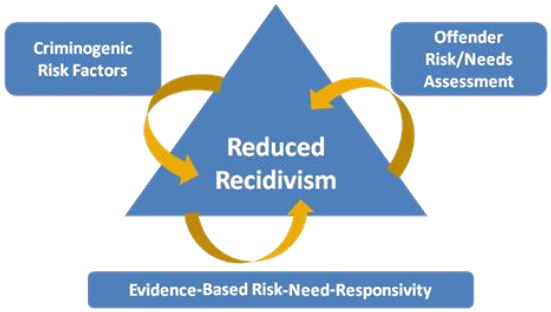
  - Eells, 2007

- Formulation provides a clinical theory about the case and its dynamics.
- It sets the pace for the individualized assessment and treatment of each client.

Case Formulation

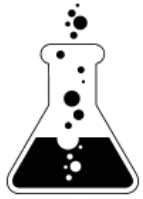
- Formulation implies the ability to recognize, add up, and put together the pieces.
- It is the case formulation that allows the assessment to embrace the ideas implicit in the risk, need, and responsivity model…

  … and the risk factors that must be recognized and addressed for each individual if treatment is to be individualized and geared towards the needs of each individual.



Seven Elements of Case Formulation

- A quality case formulation...
  1. Is consistent with theory that describes and helps explain human behavior
  2. Identifies facts relevant to the individual case
  3. Is based upon reliable and good quality information
  4. Provides sufficient information by which to produce a detailed and meaningful description of the case
  5. Is easy to understand, and free from unnecessary details, propositions, and assumptions
  6. Ties together information about the past, present, and future of the case – *diachronicity*
  7. Points to strategies that will be effective in managing and treating problem behavior.



- Hart et al., 2011; McMurran et al., 2012

The Five P's of Case Formulation

- The formulation is based on case information that is adequate in terms of both quantity and quality.
- It identifies, describes, and connects the five P's:

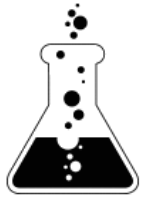
  Problem… what are we trying to understand? (James' behavior)

  Precipitating factors… what triggered the problem?

  Perpetuating factors… What maintains the presenting problem?

  Predisposing factors… what makes James vulnerable to the problem?

  Protective factors… what might buffer against a recurrence?



Case Study 2: Questions/Discussion

- In thinking about safe and appropriate placement, how much do changes in the past 20 months count?
- How do changes reflect "permanent" change?
- How do apparent changes balance against the insights of psychological testing?
- Should James remain in secure treatment or has his growth readied him for a lower level of care and supervision?
- What factors, historical and current, most drive James' behaviors, including his sexually abusive behavior?
- What factors most need to be addressed/treated in order to both reduce risk and increase prosocial strengths and behaviors?
- Was his sexually abusive behavior related to his general behavioral difficulties?
- What are the most appropriate/relevant targets for treatment?

Case Study 3

Alex

Kevin

Case History: Alex

- Identifying Information
  - 17-year-old male
  - 8th grade
  - Full scale IQ: 84 (VCI=87; PRI=113; WMI=80; PSI=56)
  - current placement: residential treatment
  - previously lived with biological mother and older sister
  - **Sexually inappropriate behavior**: open masturbation in family living room
  - **Other concerning behaviors:** self-harm (head banging, punching himself in the face); threatening and aggressive behavior (generally when in an argument or conflict with adults); elopement from prior programs; suicidal statements

Current Family Constellation

- Mother (age 45) originally from Puerto Rico. Spanish speaking
- Sister (25): just moved out of the home; reportedly doing well
- Father: died in an accident just after Alex's birth.
- Step-siblings: reportedly several from many other relationships that father had engaged in. Alex has no contact. All reside either in Puerto Rico or Dominican Republic

Family History

- No reported history of abuse or neglect.
- Mother and sister very religious
- Mother works full-time
- Sister and mother converse in Spanish. Alex understands some Spanish but does not speak Spanish

Developmental History

- Early developmental delays
  - Did not walk independently until age 3
  - Did not speak in full sentences until age 5
  - Rarely interacted with other children
  - Avoided eye contact

- Has received special education services since kindergarten

- Diagnosed with Autism at age 4
- Current diagnoses: Autism, Schizoaffective Disorder; ADHD

Presentation

- In prior programs it was reported that Alex would often stand up and sing “showtunes” unprompted.
- Very verbal, easily distracted, can become perseverative
- Upon first meeting stated that he was gender fluid and polyamorous
- Alex noted that he had several ”alters” (other personalities) and would like to be called Aubrey

Presentation

- During our initial interviews when asked a question, he would sometimes blink his eyes rapidly and ask me to repeat it. This stopped after our second interview.

- He stated that his problems were caused by his mother's religiosity and her unwillingness to accept his sexual identity

Sexual History

- No reported history of sexual abuse
- First sexual information received in middle school health class
- Reports that he started masturbating at age 16
- Limited exposure to online pornography
- Only “sexual experience” was kissing a girl who was with him in a prior program

Sexual History

- Stated that he has “vivid” memories of dressing up in women’s clothing when he was a child, putting on make-up, and lipstick

- Would like the opportunity to wear women’s clothing currently and does not understand why there cannot be sexual relationships with other students placed at the program

- When asked about his sexual relationships in the future he identified 2 females and 2 males that he has had crushes on and wishes they could all share an apartment and have a sexual relationship with each other

Strengths

- Invested in school but struggles to maintain organization and attention
- Has some positive peer relationships
- Mother is engaged in treatment and views Alex positively, but their relationship is conflicted
- Has positive (but unrealistic) outlook for the future
- Can be viewed as either “charming” or “manipulative”
- Currently his behavior is generally stable

Risks

- Can be impulsive and argumentative when expectations are not met by the adults in his environment
- Judgement and poor problem-solving place him at risk for being manipulated and victimized by others
- Questions regarding ongoing mental health stability and whether he would follow-through with medication and treatment if he lived in a less structured environment
- Takes little responsibility for his own behavior. Tends to blame conflicts or difficulties on others.

Needs

- Requires support in structuring his day
- Transitional assistance into adulthood
- Requires vocational education and likely a “job coach” at least initially
- Facilitation of pro-social activities to promote and expand interests and allow the development of relationships with peers.
- Individual treatment (sex education; social skills; self-regulation; adaptive problem-solving)
- Support in helping him explore sexuality in a safe manner
- Family treatment

Case Study 3: Questions/Discussion

- What other information would you want before determining services?
- What type of placement options might be appropriate?
- What other considerations would have to be taken into account?
- What services would you prioritize with this client?

M-CAAP Training Wrap-Up: Question-and-Answer

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- MBHP Qualifications Document:

  https://www.masspartnership.com/pdf/PerfSpec-ASAP.pdf

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Massachusetts Child and Adolescent Assessment Protocol

References

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