PRACTITIONER'S GUIDEBOOK

Best Practices in Assessment for the Kansas Serious Emotional Disturbance Waiver

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Kansas Department for Aging and Disability Services

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SECTION 1: BACKGROUND OF THIS GUIDE

Purpose. The Kansas Serious Emotional Disturbance (SED) Waiver Best Practices Guide for Assessment was developed to share best practices in assessment for Kansas children and families. Additionally, this guide was developed to support community mental health centers (CMHCs) in conducting accurate and equitable SED Waiver eligibility processes. CMHCs can supplement their initial staff CAFAS training and CAFAS booster training with this guide, as it accounts for specific challenges or concerns that are unique to Kansas and Kansas' SED Waiver eligibility process.

The Guide is organized as follows:

- Brief introduction to the CAFAS and PECFAS;
- Developer identified CAFAS/PECFAS administration guidelines;
- Summary of the common challenges observed regarding the CAFAS administration in Kansas and accompanying best practice recommendations; and
- General best practices for conducting child and family assessments in mental health contexts.

This guide closes with an example case vignette and decision flow charts for some of the CAFAS domains.

Context. This Guide was developed within the context of a contract between Kansas Department of Aging and Disability Services (KDADS) and The University of Kansas School of Social Welfare (KU). For this contract, KU conducted a third-party review of one component (CAFAS assessment) of the clinical eligibility criteria for the SED Waiver. KU staff conducted observations to determine matches in CAFAS/PECAFS scores between clinician and KU researcher-completed CAFAS/PECFAS scores (i.e. KU staff observed CAFAS/PECFAS interviews to provide the state of Kansas with rater/scorer reliability information).

From 2018 to 2021, KU staff observed over 230 clinical interviews and CAFAS assessments at 23 mental health centers in Kansas as part of the third-party review contract. Throughout this time, numerous clinicians with various educational backgrounds and levels of practice experience completed the CAFAS or PECAS with children and families experiencing a variety of mental health concerns. During the early phases of this project, it became apparent to KU staff that each CMHC and clinician has their own method for administering the CAFAS/PECFAS. As such, KU staff began to maintain detailed notes regarding successful assessment methods and assessment methods that could yield more accurate and positive outcomes for the determination of SED Waiver eligibility for children, adolescents, and families. To consistently collect this information, an interview information form was created, and included items about if the client was present, if all domains were discussed, the structure of the interview, and any other information that the observer wanted to note. The form was completed after each interview. KU staff compiled these observations, along with recommendations for using the CAFAS, into a single comprehensive guide that clinicians and CMHC leadership across the state can access and utilize.

SECTION 2: CAFAS AND PECFAS OVERVIEW

Community mental health centers often use the Child and Adolescent Functional Assessment Scale (CAFAS) (Hodges & Wong, 1996) to assess a child or adolescent's functional impairment (Bates, 2001; Winters, Collett, & Meyers, 2005). The CAFAS includes multiple subscales that identify impairment in eight different domains: (1) School; (2) Home; (3) Community (also delinquency); (4) Behavior Towards Others; (5) Moods/Emotions; (6) Self-harming Behaviors; (7) Substance Use; and (8) Thinking (rationality of thoughts). The CAFAS is completed by a qualified mental health professional, and responses are obtained through a standard clinical interview with a child or adolescent, as well as additional informants such as caregivers, significant others, teachers, etc. A total score is generated, based on clinician endorsement of specific domain items, as well as subscale scores, where higher scores indicate more severe impairment. Table 1 details each CAFAS domain and provides brief behavioral descriptions.

In addition to the eight domains used to rate youth's behaviors, there are two additional domains designed to assess the youth's environment as it relates to caregiver resources. These two caregiver resource domains are (1) material needs and (2) family/social support. While completion of the two caregiver resources domains is not required to determine youth impairment level, completion of these domains allows raters to determine if the youth's needs are greater than the caregiver's available resources. The

Table 1. CAFAS domains and descriptions

Domain	Behavioral Description
School/Work	Ability to function satisfactorily in group educational environments
Home	Extent to which youth observes reasonable rules and performs age-appropriate tasks
Community	Respects rights of others and their property and conformity to laws
Behavior Towards Others	Appropriateness of youth's daily behavior toward others, including adults and peers
Moods and Emotions	Modulation of the youth's emotional life
Self-harmful Behaviors	Extent to which youth can cope without resorting to self-harmful behaviors or verbalizations
Substance Use	Youth's substance use and the extent to which it is maladaptive, inappropriate, or disruptive to normal functioning
Thinking	Ability of youth to use rational thought processes

CAFAS is intended for youth between the ages of 6 and 16 (Murphy, Pagano, Ramirez, Anaya, Nowlin, & Jellinek, 1999); it should not be utilized with younger children. In response to the need to understand functional impairment in young children, the developers of the CAFAS developed the Pre-School and Early Childhood Functional Assessment Scale (PECFAS). The PECFAS is designed for children aged 3 to 7. It intentionally overlaps with the CAFAS-targeted age range in case of developmental or cognitive delays. The PECFAS is modeled after the CAFAS and includes seven child domains and two additional scales that can be used to assess the child's environment (Hodges, 1994). The PECFAS scores individual child functioning using the same CAFAS domains, except for the substance abuse domain. Table 2 contains the PECFAS domains and a brief behavioral description for each domain.

Table 2. PECFAS domains and descriptions

Domain	Behavioral Description
School/Daycare	Ability to function satisfactorily in group educational environment
Home	Extent to which youth observes reasonable rules and performs age-appropriate tasks
Community	Respects rights of others and their property and conformity to laws
Behavior Towards Others	Appropriateness of youth's daily behavior toward others, including adults and peers
Moods and Emotions	Modulation of the youth's emotional life
Self-harmful Behaviors	Extent to which youth can cope without resorting to self-harmful behaviors or verbalizations
Thinking	Ability of youth to use rational thought processes

CAFAS Prior Research. The CAFAS, originally developed in the 1980s, has demonstrated both concurrent and predictive validity. Regarding concurrent validity, prior research has demonstrated the CAFAS has the capabilities to differentiate between various clinical levels of care for adolescents and risk factors for children and families. (Hodges & Wong, 1996; Hodges, Doucette-Gates, & Liao, 1999; Manteuffel, Stephens, & Santiago, 2002; Walrath, Mandell, Liao, Holden, DeCarolis, Santiago, & Leaf, 2001).

Regarding predictive validity, prior studies have demonstrated that the CAFAS successfully predicts juvenile justice involvement, re-institutionalization rates of children and youth at a residential center, cost of services, and more restrictive care settings (Doucette, Hodges, & Laio, 1998; Hodges, Doucette-Gates, & Kim, 2000; Hodges & Wong, 1997; Doucette, Hodges, & Laio, 1998; Hodges & Kim, 2000; Quist & Matshazi, 2000).

Training Recommendations.

Though training for the CAFAS can be done on an independent basis at any given time, CAFAS developers suggest conducting "booster" or recertification training annually or every two years to ensure there is no rater drift. CAFAS training for various classifications of staff within the same organization is recommended as such training promotes cohesion among staff and provides an opportunity for staff members to discuss and have input into program goals and objectives. CAFAS developers also recommend that recertification or booster training occur, particularly for more experienced clinicians, as these clinicians can become desensitized to impairment behaviors (Hodges 2012a; Hodges, 2012b). For example, if a clinician frequently works with youth engaged in delinquency, the clinician may rate some severe delinquent behaviors as not as severe as other clinicians, thus causing a drift in scoring/rating.

SECTION 3: CAFAS AND PECFAS ADMINISTRATION GUIDELINES

To ensure the CAFAS is administered equitably across Kansas, it is important to maintain consistent procedures. The following sections highlight key points for consistent and effective CAFAS/PECFAS assessment as outlined by the CAFAS developers and manual.

Interview Recommendations. The following are suggestions regarding the interview approach for the CAFAS (Hodges, 2012b):

- Get sufficiently detailed information to permit accurate ratings for all CAFAS domains.
- Administration should be consistent over time (i.e., use same procedures for repeated assessment and for all assessments with youth).
- A semi-structured interview, such as the CAFAS Parent Report, can be particularly useful in some settings.
- It is best to involve multiple informants (e.g., youth, caregiver, school, juvenile justice). As noted by Hodges (2012a), some domains more easily lend themselves to youth report, such as self-harm behaviors or substance use. See Table 3 for all domains where it is recommended a clinician also get a youth's perspective.
- The CAFAS checklist can be a helpful tool.

Ensuring Integrity of the CAFAS. In Kansas, the scores generated from the CAFAS are vitally important, as they ultimately determine a youth's clinical eligibility for SED Waiver services. As such, it is essential that CAFAS information and scoring be accurate. The following are suggestions regarding the integrity of data collection (Hodges, 2012b):

- Item endorsements determine the subscale score; clinicians do not assign a score. For example, if a clinician thinks the youth is severely impaired regarding behaviors at school, they should not simply indicate 'severe impairment'. Rather, a youth should be exhibiting one of the behaviors in the 'severe impairment' domain.
- Keep a record of the item endorsements in the youth's clinical record with the signature of the rater. Consider the CAFAS to be part of the youth's case/clinical/medical record.
- Collect information at the item level. It is important to note which item a clinician is endorsing, particularly if reviewing or comparing scores between raters.
- Concerns about the implementation and use of CAFAS ratings need to be addressed so that ratings can be professional and not driven by other system, environmental, or organizational factors. The youth's behaviors or impairment level should dictate scores.

General Scoring Guidelines. The domain and total scores of the CAFAS are critical, as these scores are used to determine the level of services a youth/family can receive. As such, the following are specific guidelines for scoring the CAFAS as recommended by Hodges (2012a):

- Start at the most severe category.
- Work your way down the column, indicating which items the youth's behavior are most like.

- Once you have reached the bottom of a column, if you have marked items in that column, you may move on to the next domain; if no items were marked, then you may move on to the next column. For example, if you start in the severe column for School domain and get to item 010 (dropped out school and holds no job) and do not believe the youth met criteria for any of the items in the severe column (or the exception item), then you move onto the moderate column and proceed downwards.
- Do not skip a subscale/domain; every sub-scale/domain should be rated to get a clear understanding of the youth's functioning.
- Scores should reflect what is known to be true about the youth's behavior at that time.
- The youth's most severe behavior during the given time period should be rated.
- Be culturally sensitive to the youth's family and beliefs.
- Do not assume scores because the youth has already been in services.
- Each domain should be scored on its own (i.e., do not infer a problem exists because of another).
- Each domain contains an exception item. If the youth's behavior does not meet a specific item listed, an exception (with an explanation) can be used.

SECTION 4: BEST PRACTICES IN CAFAS ADMINISTRATION: KANSAS OBSERVATIONS

From 2018 to 2021, KU staff observed over 230 clinical interviews and CAFAS assessments at 23 mental health centers in Kansas. Throughout this time, numerous clinicians with various educational backgrounds and practice experience completed the CAFAS, or PECAS, with children and families experiencing a variety of mental health concerns. The recommendations below focus primarily on the CAFAS as the majority of observed assessments were of the CAFAS. If a recommendation applies to the PECFAS, this is specifically noted. During this time, KU staff maintained detailed notes, using a standard post-interview information form, regarding successful assessment practices and assessment practices that could be modified to yield more positive outcomes for children, adolescents, and families. The following sections summarize the main observations of KU staff by noting commonly observed challenges and then providing recommendations for addressing each of these challenges.

Identified Assessment Challenges & Recommended Practices: General CAFAS Administration. The following section details common challenges in overall CAFAS administration, per KU staff observations, and provides recommended practices for addressing these assessment challenges.

Presence of Case Managers/Waiver Facilitators

Assessment Challenge. Often, families receiving an SED Waiver eligibility assessment are already service recipients at the CMHC. As such, other team members may already have a rapport with the youth and have knowledge about the child's situation. However, the identified assessor must still complete the full assessment, though it can be lengthy and might have incomplete information.

Recommended Practice. Though not common place, some mental health centers/clinicians have asked additional members of the treatment team to be present during the CAFAS/PECFAS administration if the youth has been an existing client. For example, some clinicians have the case manager, or the Waiver facilitator, be present during the caregiver/youth interview. By having these additional members present, the qualified mental health professional can get more detailed information about the youth and their behavior. Additionally, these individuals offer additional support for the family during the interview. Additional treatment team members being present can be particularly helpful for the clinician in completing specific domains, such as the School domain, as the case manager has frequent contact with the youth's teachers or other school personnel, and at times, actually observes the youth at school.

While some clinicians have asked additional treatment team members to be present to assist with

the administration of the CAFAS, other clinicians have additional treatment team members present to assist in redirecting the youth during uncomfortable moments during the interview. For example, the Self-harm domain can cause youth to become uncomfortable or experience stress during the clinical interview due to the nature of the questions being posed. As such, some clinicians have a case manager or other treatment team member sit with the youth and practice previously learned coping skills, during the interview. This practice seems to help the youth continue in the interview.

Interview Approach: Multiple Informants

Assessment Challenge. KU staff noted various clinical interview approaches conducted by CMHC clinicians, such as the mixed informant approach while gathering information pertaining to the youth's behavior. Specifically, most clinicians will use a mixture of youth statements and caregiver statements to obtain a subscale score. While the CAFAS developers indicate clinicians should use a variety or all sources of information to determine scores, KU staff noted that clinicians will often use youth statements to score certain domains, and caregiver statements for others, thus, failing to use multiple informants on each subscale domain or getting caregiver perspectives for all domains. For example, KU staff observed situations where only the caregiver was asked questions regarding seven of the eight domains (School, Home, Community, Behavior Towards Others, Moods/Emotions, Self-harm, and Thinking). Then the clinician only sought input from the youth regarding one domain (Substance Use). In this situation, the clinician did use multiple informants, but only for one domain.

Recommended Practice. Ideally, the clinician should use multiple sources of information to get a true understanding of the youth's impairment level for each domain. Caregivers should be asked about all domains, but there are some domains where it is also recommended to get youth input as caregivers may be poorly informed. Table 3 identifies which domains clinicians should also seek youth statements/input. For these domains, it is suggested that these questions be asked in-person, or directly to the youth by the clinician. For the Substance Use domain, it is best to ask the caregiver and the youth seperately.

Table 3. CAFAS Domains and Primary Informant

Caregiver/Adult Informant	Youth Informant
School	Community
Home	Moods/Emotions
Behavior Towards Others	Self-harmful
Thinking	Substance Use

Interview Approach: Conversational Style

Assessment Challenge. Another frequent approach KU staff observed involves the clinician reading the specific items on each of the CAFAS subscales, then having a caregiver endorse or decline that item. For example, rather than engaging in a more general conversation regarding school, the clinician will begin at the severe level for the School domain and read item 001 (out of school or job due to behavior that occurred at school or on the job during the rating period, asked to leave or refuses to attend). If the parent endorses that item, the clinician then moves on to the Home domain. If the parent declines that item, the clinician then reads item 002 (expelled or equivalent from school due to behavior, multiple suspensions, removed from community school placed in an alternative school) and will continue to go through each individual item until the caregiver endorses a specific item.

Recommended Practice. An alternative to this approach involves the clinician engaging in a conversation with the caregiver and youth. Some clinicians have the caregiver describe the youth's present situation for each of the domains and then the clinician selects the item they think fits best. Similarly, some clinicians select one item they think fits, then asks the caregiver their thoughts. This process continues until an agreement is reached regarding which item most appropriately aligns with the youth's current behavior.

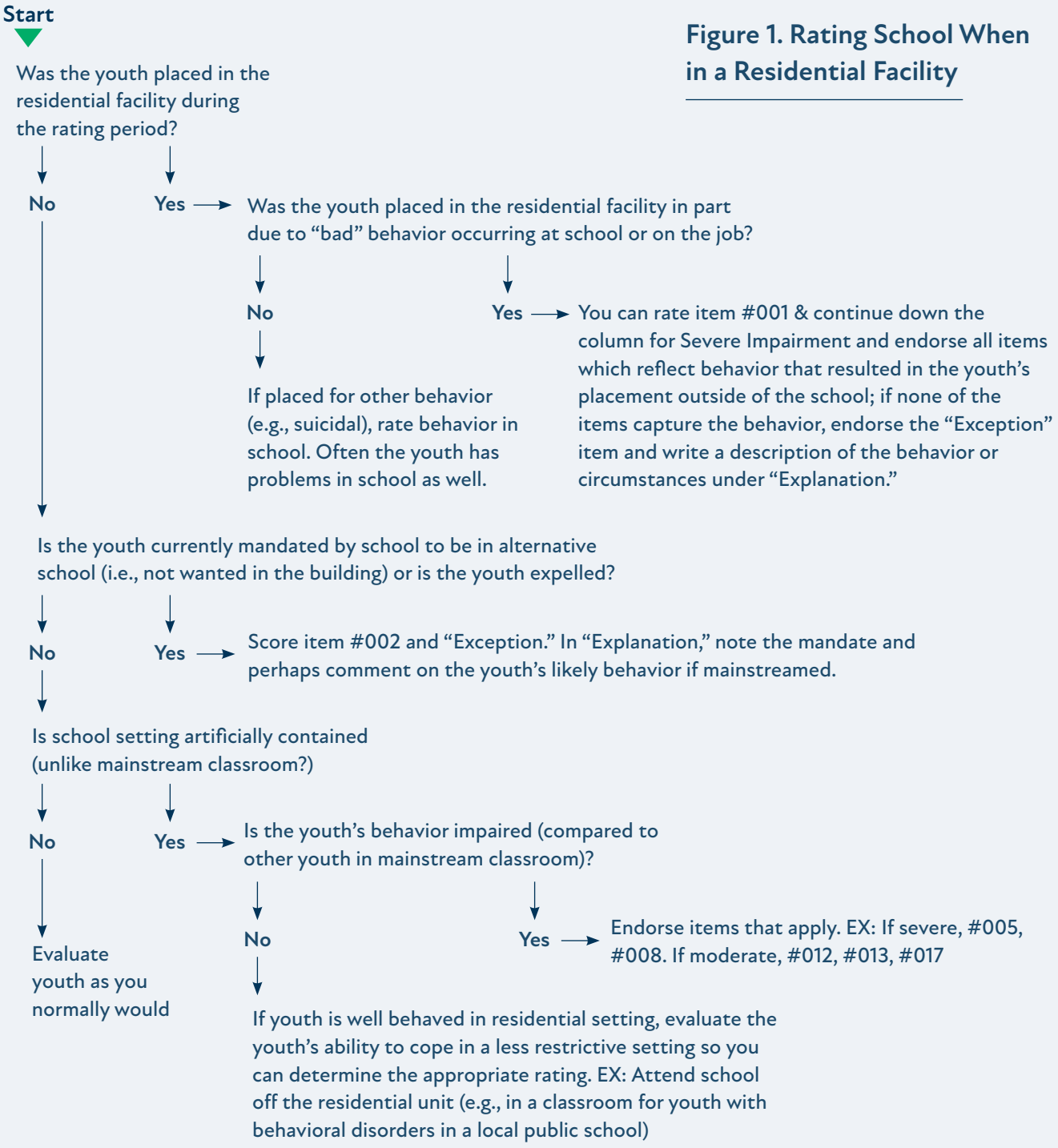
PRTF Discharges

Assessment Challenge. A frequent situation clinicians at CMHCs encounter is determining clinical eligibility for the SED Waiver for youth discharging from a Psychiatric Residential Treatment Facility (PRTF). It is often difficult to determine impairment level for youth discharging from the PRTF for multiple reasons. First, the caregiver, who is most often the one providing information to determine CAFAS scores, has limited exposure to the youth during their PRTF stay. Some domains, such as School, become particularly challenging to determine impairment level while the youth is in the PRTF. Furthermore, the youth may experience significant improvement while at the PRTF, however, concerns remain regarding their behavior when returning to their home setting. In other words, the youth has apparently improved, however, the residential facility does not have sufficient means for gradually "stepping down" the youth to a less restrictive setting.

Recommended Practice. Given that these challenges are not unique to Kansas, the CAFAS developers

have created guidelines for administering the CAFAS when youth are placed in residential care. While the CAFAS developers have established guidelines to assist in determining impairment for youth discharging from residential facilities (see Figure 1), it is still important to note that these are often complex issues, and each assessment must consider the unique situation.

Figure 1. Rating School When in a Residential Facility



Source: Adapted from Hodges (2012a).

Time Reference

Assessment Challenge. KU staff noted challenges as they pertain to the time reference for rating behavior. Some clinicians do not explicitly state the time period they are rating; as such, some behaviors being described by caregivers may be dated and it can be unclear if those behaviors are current problems. Some clinicians use various time periods throughout the same interview (e.g., some domains are rated on a six-month interval while other domains are rated on a three-month interval in the same interview). Overall, there is variance throughout Kansas on what time period should be used (i.e., some mental health centers use six months while others use three months).

Recommended Practice. To successfully score the CAFAS, a time reference point must be made clear at the beginning of the clinical interview. The CAFAS is intended to rate the youth's impairment level over the course of a specified time-period. The CAFAS manual states that the time-period being examined for CAFAS should be explicitly identified by the scoring agency or by the mental health authority responsible for service eligibility.

Identified Assessment Challenges & Recommended Practices: CAFAS Domains. The following section reviews common challenges *within each domain* of the CAFAS, as observed in CAFAS assessments conducted at Kansas CMHCs, and provides relevant recommended assessment practices for addressing the challenges.

School/Work: Grades/Attendance/Behavior

The School/Work domain assesses the youth's performance in their school/work setting and is primarily concerned with these specific areas: grades, attendance, and behavior. The CAFAS School/Work domain measures the youth's impairment relative to the extent to which the youth can carry out typical age-appropriate expectations at school or work.

Assessment Challenge. A common challenge KU staff observed regarding scoring the School/Work domain centers on Scoring school during the summer months or scoring school when the youth has recently discharged from a Psychiatric Residential Treatment Facility (PRTF).

Recommended Practice. Per CAFAS scoring guidelines, clinicians scoring this domain should rate for the most recent time-period the youth was in school (if administering the CAFAS during the summer

months). Also, the CAFAS scoring guidelines provide additional clarification for scoring School/Work if the youth has been in residential treatment. Per the guidelines, the clinician should probe to determine the youth's functioning while in a group educational setting.

Home: Safety/Compliance/Runaway Behavior

The Home domain ascertains the youth's willingness to observe reasonable rules and perform age-appropriate tasks within the home and family environment.

Assessment Challenge. A common challenge observed by KU staff regarding the scoring of the Home domain, pertains to when the youth has been in a PRTF. As the youth has been out of the home, it becomes difficult to determine the level of impairment when placed back into the home. A PRTF represents an artificial and typically more structured home environment. As such, when the youth is returning home, it could be viewed as the youth "stepping down" levels in terms of restrictive treatment settings. As indicated previously, youth discharging from residential settings often have complex and challenging circumstances, and as such, there is no one correct solution.

Recommended Practice. For the Home domain, CAFAS developers have indicated that if the youth has been in a PRTF for more than three months, the clinician should endorse the item(s) that represent the youth's behavior while in the PRTF. An example would be of a youth who has been in a PRT for four months and then is discharged to their home. In this situation when the clinician asks the caregiver about their behavior in the home setting, the clinician should refer to the behavior of the youth while at the PRTF. The terms "home" and "household members" should be thought of in the context of "PRTF" and other peers or persons in the youth's PRTF unit.

Community: Obeys Laws/Respects Property/Refrains from Offensive Acts

The Community domain primarily involves items referencing the youth's legal situation. The Community domain is focused on if the youth obeys laws and abstains from illegal acts. Table 4 details the specific areas of information the Community domain evaluates.

Table 4. Behaviors to Probe for in the Community Domain

Expectation for Youth in the Community	
Obeys Laws	Respects the property of others or public property
Respects Property	Respects property of others or public property
Refrains from particularly offensive acts	Refrains from: physical aggression; sexual misconduct/ mistrust; fire-setting (even in the home)

Assessment Challenge. A common challenge regarding this domain involves the clinician probing for items unrelated to what the Community domain involves such as temper tantrums.

Recommended Practice. If behaviors not scored in this domain are brought up, consider how this information may be utilized in scoring other domains. For example, while the youth's temper-tantrum behavior at the grocery store may be important and could possibly inform other domains; temper-tantrum behaviors are not measured in this scale. Rather, if the temper tantrum led to defacing property, legal charges, etc., then it would qualify for this domain. This is a domain in which caregiver and youth input should be sought.

Behavior Towards Others: Free of Unusually Offensive Behaviors/ Interactions Free of Negative Troublesome Behaviors/ Judgment

Regarding the Behavior Towards Others domain, the intent is to assess patterns of behavior that are social or interpersonal in nature. An important aspect of this domain is to account for the youth's developmental level, as comparisons for scoring need to be made regarding age-appropriate behaviors.

Assessment Challenge. In this scale, sibling arguments are often brought up by the caregiver or parent. Additionally, fighting in general is often identified. However, at times, the severity of the fighting behavior is unclear.

Recommended Practice. Sibling arguments should be viewed and rated within the context of typical sibling relationships (i.e., given that it is common for siblings to fight, score if youth's fighting with sibling is dangerous or harmful). In regard to understanding the context and severity of fighting, Hodges (2012a) recommends assessing for the following if the youth is engaging in fighting behaviors:

- Was the incident considered serious enough that it was reported to police or referral made for services (e.g., mental health, juvenile justice, etc.)?
- Was there a weapon or other instruments (e.g., broken bottle) used?
- Was there a difference in size or age (i.e., one youth could have easily been hurt by the other)?
- Was the initiation of the fight mostly mutual?
- Did the fight break up on its own or was intervention needed?
- Was anyone hurt?
- Was anyone genuinely scared as a result?

Self-harm: No Self-Harmful Behaviors

For the Self-harm domain, clinicians should be assessing for whether the youth is engaged in self-harm behaviors, including self-harmful thoughts and desires. An additional area for clinicians to assess is whether the youth can cope with stressful situations without resorting to self-harmful behaviors or verbalizations. Often, youth have these desires or engage in these types of behaviors without the knowledge of the caregiver. As such, clinicians should discuss this domain with youth, as well as their caregivers.

Assessment Challenge. KU staff have noted this domain can cause discomfort for youth who are present during the initial clinical eligibility interview. Additionally, throughout numerous observations, KU staff have noted some clinicians inquire about the youth's self-harming behaviors by stating "Are we self-harming?" Using "we" language when asking about youth behaviors appears to trivialize the behavior, can confuse the youth, and at times is not age-appropriate, as most of the youth being interviewed are in the adolescent phase.

Recommended Practice. Clinicians should talk with the caregiver and the youth separately about self-harmful behaviors. KU staff have also noted that this domain seems to be scored more easily when clinicians have a firm grasp of the youth's historical behaviors as it relates to self-harm. An efficient way to score this domain would be for the clinician to have a preconceived idea of the item they are leaning towards endorsing, then reviewing that specific item with the youth and caregiver. Finally, it is always best to directly ask the youth if they are engaged in self-harm behaviors.

Substance Use: No Negative Effects or Risk Taking/Frequency/Amount of Usage

The CAFAS Substance Use domain refers to a youth's usage of alcohol and drugs. Specifically, the Substance Use domain is assessing for the amount and frequency, in which a youth uses substances and if their use has negative implications for their functioning. Substance use is often done without a caregiver's knowledge or consent. As such and as indicated in Table 3, clinicians should also discuss this domain with the youth. Like the Self-harm domain, it could be helpful to ask the youth and caregiver about these behaviors separately.

Assessment Challenge. A common challenge KU staff have observed when clinicians are assessing a youth's substance use behaviors involves vaping. Vaping tobacco and vaping marijuana are more recent behaviors that were not common during the development of the original CAFAS. As such, there are no items that specifically pertain to vaping.

Recommended Practice. When scoring this section, it is important to remember the key aspect to probe for is whether the youth's substance use is leading to maladaptive or disruptive behaviors. Substance use among adolescents is illegal, but not uncommon. As such, it is important for clinicians to identify the level of use and whether it is negatively impacting the youth's daily functioning.

For a more accurate depiction of the youth's substance use behaviors, clinicians should begin to ask questions regarding vaping, type of vape, and how often they vape and then endorse the item most closely related to the youth's vaping behavior. The vaping trend has reversed decades-long efforts to reduce nicotine use in adolescents, and an increased number of adolescents are reporting vaping behaviors. As such, this behavior is important information to capture. If the youth reports vaping tobacco/nicotine, these behaviors are best noted in the School, Home, or Community domains, as Hodges (2012a) suggests scoring tobacco-related behaviors in those domains. If the youth is engaged in vaping marijuana, then an item in the substance use domain should be endorsed.

Thinking: Communications/Perceptions/Cognitions/Orientation & Memory

The final domain of the CAFAS, is the Thinking domain. The Thinking domain is unlike the other seven domains. At the beginning of each level of impairment in this domain, there is a statement which gives an overview of the extent of impairment observed at that level (severe, moderate, mild, none). Underneath the overview statements in each impairment column, there are the traditional individual

behavioral items. Per Hodges (2012a), the clinician should read over the statement at the beginning of each impairment level and determine which level the youth's thinking behaviors are most like. After that determination, the clinician should then determine which behavioral item to endorse. A key component to scoring this item is that the youth's behavior must meet criteria for the overview **and** the specific behavioral item.

Assessment Challenge. KU staff have noted that the overview statements for the impairment levels are often not discussed. Rather, just the behavior items are discussed. Additionally, KU staff have noted this domain is often only thought of as assessing for psychotic like behaviors (i.e., auditory or visual hallucinations).

Recommended Practice. To better assess this area, Hodges (2012a) provides the following definitions for terms included in this domain:

- Echolalia: repeating words of others in a meaningless fashion
- Flight of ideas: a nearly continuous flow of accelerate speech with changes from topic to topic
- Incoherence: lack of logical or meaningful connection between words, phrases, sentences; excessive use of incomplete sentences, excessive irrelevancies, or abrupt change sin subject matter; idiosyncratic word usage; distorted grammar
- Loosening of associations: characterized by ideas that shift from one subject to another; ideas may be unrelated or only obliquely related to the first without speaker showing any awareness that the topics are unconnected
- Hallucinations: sensory perceptions that occur without external stimulation of the relevant sensory organ; hallucinating typically involves an experience of hearing or seeing things that are not there
- Depersonalization: Alteration in the perception or experience of oneself so that one feels as if one is an outside observer of oneself (e.g., feels like one is in a dream)
- Derealization: Alteration in the perception or experience of the external world so that it seems strange or unusual (e.g., people seem mechanical)
- Delusions: false personal beliefs based on incorrect conclusions about external reality
- Obsessions: recurrent persistent ideas thoughts impulses or images that are experienced at least initially as intrusive and senseless; for example, having repeated impulses to kill a loved one, early obsessions caused marked distress or time consuming and significantly interfere with the person's normal routine functioning at school or work or usual social activities

- Compulsions: repetitive behaviors that the person feels driven to perform in response to an obsession
- Suspicions: must be a distortion of reality, unfounded given the youth's current circumstances or the youth shows a consistent bias of being suspicious that negatively affects relationships
- Magical thinking: the belief that thoughts words or actions can cause or prevent an outcome in some way that defies the normal laws of cause and effect
- Disassociation: the disruption into usually integrated functions of consciousness, memory, identity, or perception of environment

There are some disorders that youth experience that may result in behaviors that should be scored in the Thinking domain. Table 5 contains these disorders. However, as Hodges (2012a) notes, just because a youth has a disorder listed, does not mean they will necessarily have behaviors needing scored.

Table 5. Common Disorders and Thinking Impairment

Disorder	Functions that may be impaired
Autism	Communications; Orientation
Schizophrenia	Communications; Perceptions; Cognitive; Orientation
Brief Psychotic Disorder	Communications; Perceptions; Cognitions
Schizophreniform	Communications; Perceptions; Cognitions
Schizoaffective	Perceptions; Cognitions
Schizotypal	Communications; Perceptions; Cognitions
Manic Episode	Communications; Mood/Congruent Delusions
Anorexia	Cognitions; Body dysmorphic
Obsessive-Compulsive Disorder	Cognitions; Compulsions
Post-Traumatic Stress Disorder	Cognitions; Perceptions

SECTION 5: BEST PRACTICES IN OVERALL ASSESSMENT

In addition to the CAFAS specific best practices, the following sections provide best practice recommendations for two areas that are critical for any type of assessment, virtual approaches and equity.

Virtual Assessments. Since the COVID-19 pandemic began, virtual and tele-heath practices have expanded significantly in children's mental health, including for assessment for eligibility for SED Waiver services in Kansas. For the third-party review contract, the majority of assessments observations in 2020 and all assessment observations in 2021 occurred virtually due to the COVID pandemic.

As tele-health has grown, increasing resources are being provided to ensure effective tele-health practices. Some resources where more detailed information can be accessed are below.

Telehealth Resources

- Heartland Telehealth Resource Center, led by researchers at the KU Medical Center Telemedicine & Telehealth Department, offers telehealth insights that assist with telehealth implementation and utilization.

- Interprofessional Framework for Telebehavioral Health Competencies which covers: 1) Clinical Evaluation and Care, with subdomains addressing Cultural Competence and Diversity, Documentation and Administrative Procedures; 2) Virtual Environment & Telepresence; 3) Technology; 4) Legal & Regulatory Issues; 5) Evidence-Based & Ethical Practice, with a subdomain addressing Social Media; 6) Mobile Health and Apps and 7) Tele practice Development. These seven domains are categorized into 51 tele behavioral objectives, grouped according to level of expertise (Novice, Proficient and Authority). Each of these tele behavioral objectives more specifically identifies discrete areas of knowledge, skills and/or attitudes to be expected of a professional functioning at a defined level. This organizational structure provides the framework for 149 individual tele behavioral practices (Maheu, Drude, Hertlein, Lipschutz, Wall & Hilty, 2018).

- The Guide "Telehealth for the Treatment of Serious Mental Illness and Substance Use Disorders" developed by the Substance Abuse and Mental

Health Services Administration (Telehealth for the Treatment of Serious Mental Illness and Substance Use Disorders | SAMHSA Publications and Digital Products).

- A Practical Guide to Video Mental Health Consultation which provides a practical summary of points to review for a successful tele-behavioral health visit developed by Mental Health Online.

Insights from the tele behavioral health literature as well as the KU third-party review observations are combined to inform an approach to the SED Waiver eligibility assessments which are conducted remotely. These steps for this approach are outlined below.

Identify appropriateness for a virtual visit. Family and youth comfort level is the first determinant. Permission is needed. If they are not comfortable, another plan should be made for conducting the visit.

The next determinant is provider understanding of technology to conduct the visit. Can the provider explain to the participants how to use the technology? Does the provider have the capacity to assist participants in to using the technology?

Be prepared for a professional meeting. Show professional intent and present the same way as if the meeting is in person. Set up a space that is professional. Minimize background visuals. Have good lighting. Try LED Daylight bulbs if possible. Lamps in front can help to create crisp lighting.

Have a short description available about what platform you will be using and give technology requirements for a successful meeting. For instance:

> *"I will be sending you a Zoom link to join a meeting. Please try to have a computer you can join from. For Mac users, you can download the software here. For Microsoft users, you can download the software here. If you have questions about how to do this, please contact me and I will help you gain access so that we can have a successful meeting. Please think about a good location to have this meeting. We will be discussing confidential information. For this reason, it is a good idea to have a private space and to stay in one location until the end of the meeting. A smart phone will work, but a computer with a video camera is ideal for this interview."*

Prepare participants. Prepare caregiver on how the interview will be conducted. An example of how to do so follows:

> *"This interview will take about 30 minutes. We will be covering 8 areas of functioning today. I will need to document the highest level of need to determine waiver eligibility. For this reason, I'll be asking about the more significant behaviors or concerns. Once I document the most severe concern in each area, I'll move on. Please know that I am aware that you and your youth and have many strengths. I do not want to create any discomfort but some of the stuff we talk about might create discomfort. For this reason, your youth can leave the zoom room to take a break if they need to or we can cover uncomfortable details at a different time."*

Professional conduct during the virtual meeting. Introduce all participants in the call. Make sure everyone can hear. Be prepared to trouble shoot if sound is not working. Know your technology. If trouble shooting is needed, be aware of how your face looks while you assist. The benefit to telehealth is you can see your face while you work. Use this as a strategy to practice holding a welcoming, calm face while you navigate a small problem. You are the emotion regulating force in the virtual room. Youth, and possibly caregivers, who are present may already feel uncomfortable participating. A calm welcoming face will minimize the stress created by technology glitches and set the stage for stress that will need to be navigated when asking about functioning across the domains.

Be aware that virtual face-to-face interactions are not the same as face-to-face in-person interactions. For example, with in-person interactions, we can look away or look down when addressing uncomfortable content or feeling nervous. To assist in facilitating a comfortable environment, clinicians can lean in when youth or guardians are expressing difficult things. Head tilts and nods show listening and understanding. If typing while interviewing, be aware of facial expressions. It may be useful to write notes instead so that you can look away from the computer while recording content that is needed for scoring. In many situations, this is the first time the family and youth are having contact with the CMHC, an engaging professional experience will help. If you have to pause and write something, explain what you are doing. For example:

> *"I am going to look away and write that down. I want to be sure I get the details right."*

Please notice youth discomfort (hoodie over the head, slouched in chair) and offer a break or check in with them. Offer them choices when possible, and always offer for youth to leave the room.

Attend to dynamics if youth and parents get agitated – offer support. For example,

> *"Thank you so much for telling me the truth. Remember what we are talking about helps document the need for support that will help your family or youth."*

Make strengths-based relational statements when you notice youth and parent are communicating well. "You two really know each other, I can tell he cares what you think and that you

are paying attention." Take every opportunity to notice pro-social behavior and abilities. For example, if youth is not using substances or has not no contact with law enforcement, point this out as a strength, especially if they have complicated behaviors at school or with peers.

Ensuring Equity in Assessment and Service Eligibility Determination. Ensuring an equitable and culturally-responsive CAFAS assessment and experience is imperative so that all children and families receive an accurate, unbiased assessment and have access to the services they need. Additionally, ensuring equitable practices in CAFAS administration, within the context of SED eligibility determination, is essential, as prior research has documented disparities as they relate to the over representation of minority youth identified as SED (Mark & Buck, 2006). Furthermore, communities of color have been historically disadvantaged by systemic and structural barriers (i.e. mental health care access). These barriers can significantly impact and shape the experiences and life trajectories of children, youth, and families (Andrews, Parekh, & Peckoo, 2019).

The use of a racial equity lens has been recommended in multiple service arenas, including child welfare, juvenile justice, and education. Recently, researchers at the National Institute for Learning Outcomes Assessment (NILOA) developed equity-minded assessment recommendations for educators examining outcome achievement for students (Montenegro & Jankowski, 2020). While these recommendations were developed within the context of educational assessment practices, the suggestions are applicable and can be taken into consideration for the administration of the CAFAS assessment when determining SED Waiver eligibility. The sidebar box below includes these recommendations as well as others we have identified.

Recommendations for Ensuring Equity in Assessment & Service Eligibility Determination.

At the Individual Level

- Ask about and validate **experiences of stigma and discrimination** (on basis of mental health, race, ethnicity sexual orientation, gender identity, and other relevant factors)
- Use a **trauma-informed** assessment approach
- Use **evidence-based assessment** tools that have been tested with diverse groups
- **Check biases** and ask reflective questions throughout the

assessment process to address assumptions and positions of privilege*

- Use **multiple sources of evidence** appropriate for the youth being assessed and assessment effort*
- Include **youth perspectives** and take action based on perspectives*
- Increase **transparency** in assessment results and actions taken*

At the Organizational Level

- Provide staff with **training about equitable practices** in assessment and service
- Hire staff with **lived experiences** and staff from **underserved or marginalized communities** to conduct assessments and provide services
- Ensure collected data and information can be **meaningfully disaggregated and critiqued.***
- Make **evidence-based changes** that address issues of equity that are context-specific*

At the Systems Level

- Develop **equity-related targets** for the services
- Ensure **clear and consistent definitions and requirements** for assessment and service eligibility across the system
- Ensure **adequate support, resources, and trainings** for agencies within the system

* Montenegro & Jankowski, 2020

Case Context

Carter has been referred by the foster care agency after recent hospital stay of 10 days. When admitted, he was using a lighter to burn skin and wanting to "go to sleep and not wake up." Carter was placed in foster care 5 days before admission to the hospital when his father was charged with possession with intent to sell an illegal substance. Carter fought nonstop with foster siblings when they got in his space. He would punch and throw things (lamp and shoes).

Carter has no relatives close as his mother passed way at age two in a car accident, Carter was in the car. Since age 2, he has had nightmares and "sleep issues."

Carter is coming to the foster care agency with his case manager and joining the mental health center by Zoom today to complete a CAFAS for SED Waiver Eligibility. The clinician has sent a link and instructions for joining Zoom. Carter, Case Manager, and the Assessing Clinician (Ted) have all joined the Zoom call.

Case Interview

Ted: Good morning! Thanks for joining the call today! (Ted then reviews introduction paperwork.)

Ted: (Looking away from computer.) I am just typing these details so I am sure I get them right for our reports.

Ted: (Talking to Carter) Ok let me explain how this interview works, and you can ask any questions of me before we get started or anytime really. Deal? The purpose of this

interview is to understand how you have been doing in specific areas in the last 3 months. Specifically, I want to know how you are doing in school or work/training, the place you were living, how it's going getting along with others, how your moods are, how your thoughts are, how you are doing in the community when you go out and about. Finally, I need to understand if the way you are thinking ever leads to thoughts of wanting to hurt yourself or someone else. The reason I want to know these things is that we have additional community-based services that may be useful to help decrease these symptoms and help you feel more comfortable in your daily life. My hope is to help you feel comfortable but sometimes talking about these things can be uncomfortable, if at any point you need a break or don't feel like answering something, it's ok. . I also want you to know that I am going to be asking you about some things as well as your case managers. Do you have any questions for me?

Carter: (shakes head no)

Ted: This interview should only take us about 20-30 minutes. I am going to ask you questions about what has been going on in the last 3 months [provide date]. I'll start with the behaviors that lead to severe impairment first.

Ted: From reading the background information, it sounds like Carter was out of school two months ago due an incident in the bathroom. (Looks for agreement from everyone; this is all Ted says and scores item 001 on the School/Work domain as the background information states that Carter was suspended for vaping THC in the restroom at school.)

Ted: This meets criteria for severe impairment because he was out of school during the last 3 months. (Ted does not go over detail at this time about the incident as it is not needed to score the CAFAS for Clinical Eligibility.)

Ted: (Ted moves on to the Home Domain and immediately scores a 041 on Severe Impairment as youth was placed in Hospital.) The waiver is intended to prevent future hospitalizations and connect you with helpers to decrease the chances you will go back into the hospital, so I am going to mark severe impairment in this next domain, Home,

because you were in the hospital. (Ted selects 041 under severe impairment.)

Ted: Does anyone have concerns regarding any legal charges pending for the incident that happened at school or anything else in the last 3 months?

Carter: At school, I would sell pods in the bathroom. So many people do it. I just got caught.

Ted: Ok, I see, and understand it takes two when you deal. Are you on probation for this?

Carter: I have court sometime and have to meet with an ISP (Intensive Supervision Provider) every week right now. I don't get it, my Dad sold stuff for years and he makes more than all of you!

Ted: (Ted notices the tone change in the room and decides to interrupt negativity with a strengths-based relational statement. Scores Community as a 066 and moves on.) I bet you and your Dad are pretty close and you love him very much. It must be hard to be away from him. Did you need a break for a drink or to use the restroom? Some of this stuff can be hard to talk about.

Carter: (nods) Let's get this over with!

Ted: You got it. It's nice you can speak your mind. Any behaviors that anyone has observed that are bizarre or odd.

Everyone in meeting: (shakes heads no)

Ted: Has Carter been aggressive or dangerous with anyone?

Everyone in meeting: (shakes heads no)

Ted: Any sexually assaultive behaviors towards others?

Everyone in meeting: (shakes heads no)

Carter: No, but I have been assaulted!

Ted: I am sorry to hear this, what happened? Do you want to talk about it?

Carter: No, it happened in the hospital! I reported it to staff! They didn't do anything!

Ted: That makes you angry and anger is protective and a good thing to have. I would be happy to make sure you get some specific support around this assault.

Carter: Really, I want to be done with this!

Ted: I hear you and I appreciate your honesty. I'm moving on. Do you like animals, ever deliberately hurt them?

Carter: (loudly) No way! I love animals! I want a dog! Who would hurt an animal?

Ted: (Takes the opportunity to notice strengths and preferences.) I apologize, it's cool you want a dog. What do you want to get?

Carter: I want a rescue. I don't care what kind of dog it is.

Ted: (speaking to case worker) Can you tell me anything about how things go with peers in the hospital or at school?

Case worker: Carter will stand up for himself quickly and aggressively by pushing if feeling threatened.

Ted: Does this happen frequently?

Case worker: (nods) Yeah, at least one or two times a week there's some kind of fight where

Carter is.

Carter: Yea, I'll throw the first punch if I am disrespected.

Ted: (Ted decides to score 093 in Behavior Towards Others due to the frequency of fighting.) Carter, you know how to take care of yourself and want to be respected, that's a good thing. You deserve respect for sure. Do you think that your emotional responses are extreme or excessive?

Carter: No! If someone is disrespecting, I'm gonna stand up!

Ted: (Ted decides to score 116 on Moods due to background information received about non-stop fighting and the reactivity he is seeing in the assessment.) I am moving to this next section and I need to understand any self-harmful behaviors. I know why you went to the hospital. Have you attempted to take your life?

Carter: No.

Ted: That's good news, thanks for letting me ask you that and responding. Have you been in situations where you are aware of the danger and done something anyway, where you could get hurt?

Carter: Well, I burn myself.

Ted: OK, when this happens do you have intent to end your life?

Carter: No, I just want to stop the pain and feel something else.

Ted: Ok, I have heard that before and you are not alone in feeling that. Do you wish you were not here or talk about not being here?

Carter: Sometimes I wish it would just stop, but no I would never kill myself." Ted, "How often

are you burning yourself?

Carter: Daily, that's why I am wearing a sweatshirt today, I don't want anyone to see my arms.

Ted: (decides to score a 146 as the self-harm is persistent but not life threatening.) Well you know what I think? We have some folks here that can help you with that. Thanks for being honest with me. I'm gonna ask you a little more about vaping and substance use. Would you say that you are pre-occupied with using or getting access to any substances?

Case manager: Yes, I believe he is.

Carter: I use a about 1 Cart of THC a week.

Ted: Is that in the morning and all throughout the day?

Carter: Yeah.

Ted: Anything else?

Carter: Well, I didn't have my battery in the hospital. I don't see what the big deal is with it. Delta 8 is legal you know.

Ted: Yeah, things are changing fast. Are there other substance you use, like alcohol?

Carter: Occasionally, but nah.

Ted: Ok I am going to say lifestyle centers on acquiring and using THC.

Carter: Well, all my friends are like me and we have fun together so I really don't see why it's a problem.

Ted: (Ted senses defensiveness so decides to stick with 154 on Substance Use. Makes a statement to decrease negativity and change the subject.) I hear ya, we are about done here, let's get this finished here. I appreciate your time today! Are there times when your thoughts feel disconnected or it's just very hard to communicate what you are thinking?

Carter: Well yeah! I am pissed that all this &@&!$ went down in my life! My Dad's in Jail, my Mom is gone! I live with strangers!

Ted: You have been through so much. I am trying to understand if your thoughts are delusional or if you hear or see things that are not there!

Carter: No! No way! I dream about the car accident, but I don't see my mom or anything like that! I have dark ass dreams sometimes.

Ted: Do you lose track of time or where you are?

Carter: No

Ted: Anybody notice if communication is disorganized and that this leads to occasional difficulty in communications or interactions with others?

Everyone in meeting: (shakes heads no)

Case worker: I feel like communication is a strength for Carter.

Ted: Oh nice! Yes, I agree, he is direct and honest, and very capable in expressing himself. Any thoughts that just stick in there and you can't let them go?

Carter: I think about my mom a lot on her Birthday and the anniversary of her death. I can't

really participate in things on those days.

Ted: (Ted decides to score a 194. As thoughts prevent Carter from participating in normal activities at twice a year and one of his triggers happened within three month behavior rating window.) Ok, we are done with the assessment. My assessment scores determine that Carter is eligible for Waiver Services.

End of Interview

SECTION 7: REFERENCES

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APPENDIX: DECISION FLOW CHARTS FOR SELECT CAFAS DOMAINS

The Appendix provides quick reference decision flow charts for two CAFAS domains which seem to be the most challenging or confusing to complete, the Self-harmful Behavior domain and the Thinking domain.

This section is intentionally left blank. Printable flow charts begin on the next page.

Self-Harmful Behavior Domain

Start

Severe Impairment

Q: Does the child have intentional self-destructive behaviors that have, or could, result in serious self-injury or self-harm? (e.g., suicide attempt with desire to die, self starvation) [142]

Q: Does the child have seemingly non-intentional self-destructive behaviors that have, or could likely, result in serious self-injury and the child is aware of the danger? (e.g., runs out in path of a car, opens car door in moving vehicle) [143]

Q: Does the child have a clear plan to hurt self or desire to die? [144]

No to All Items
Move on to Moderate Impairment in this subscale.

Yes to One or More Items
Move on to the next subscale.

Moderate Impairment

Q: Does the child have non-accidental self-harm, mutilation, or injury which is not life-threatening but not trivial? (e.g., suicidal gestures or behavior without intent to die, superficial razor cuts) [146]

Q: Does the child talk or repeatedly think about harming self, killing self, or wanting to die? [147]

No to All Items
Move on to Mild Impairment in this subscale.

Yes to One or More Items
Move on to the next subscale.

Mild Impairment

Q: Does the child have repeated non-accidental behavior suggesting self-harm, yet the behavior is very unlikely to cause serious injury? (e.g., repeatedly pinching self or scratching skin with dull objects) [149]

No to All Items
Select 151 or 152 on the CAFAS, then move to the next subscale

Yes to Item
Move on to the next subscale.

Remember to look at strengths.

- No self-destructive actions
- Does not knowingly engage in dangerous behavior
- Seeks help if experiences self-destructive urges
- No self-destructive talk
- Uses coping strategies other than self-harm
- Uses appropriate outlets
- Respects their own body
- Avoids being sexually exploited
- Maintains adequate weight without supervision
- Others....

Start

Severe Impairment

Q: Is communication impossible or extremely difficult to understand with child due to incoherent thought or language (e.g., loosening of associations, flight of ideas) [182]

Q: Is the child's speech or nonverbal behavior extremely odd AND is non communicative? (e.g., echolalia idiosyncratic language) [183]

Q: Does the child have strange or bizarre behavior due to frequent and/or disruptive delusions or hallucinations? Is the child unable to distinguish fantasy from reality? [184]

Q: Does the child have short-term memory loss/disorientation to time or space most of the time? [185]

No to All Items
Move on to Moderate Impairment in this subscale.

Yes to One or More Items
Move on to the next subscale.

Moderate and Mild subscales on the next page

★ For Severe Impairment...

Child must be **unable** to attend a normal school classroom, does not have normal friendships, and cannot interact adequately in the community for this domain in the Severe Impairment category.

Remember to look at strengths.

- Tries to control inappropriate thoughts, feelings, and impulses
- Despite communication difficulties, tries to relate to others
- Understands that thoughts cannot directly cause events to happen
- Has good understanding of personal circumstances
- Can express self adequately and clearly
- Can communicate need to others
- Talks to others at an age-appropriate level
- Fantasies are "within normal limits" for age
- Can envision long-term goals
- Hygiene is appropriate for age
- Can learn from experiences
- Other...

Moderate Impairment

Q: Does the child have challenges with communication to the point it doesn't "flow," is irrelevant, or disorganized? (i.e., more than other children of similar age) [187]

Q: Does the child have frequent distortion of thinking? (e.g., obsessions, suspicions) [188]

Q: Does the child have intermittent hallucinations that interfere with normal functioning? [189]

Q: Has the child had frequently marked confusion or evidence of short-term memory loss? [190]

Q: Does the child have preoccupying cognitions or fantasies with bizarre, odd, or gross themes? [191]

No to All Items
Move on to Mild Impairment in this subscale.

Yes to One or More Items
Move on to the next subscale.

★ For Moderate Impairment...

Child must have **frequent** difficulty in communication or behavior **OR** specialized setting or supervision needed for the Moderate category of this domain.

Mild Impairment

Q: Does the child have eccentric or odd speech (e.g., impoverished, digressive, vague) [193]

Q: Does the child have thought distortions? (e.g., obsessions, suspicions) [194]

Q: Expression of odd beliefs or, if child is older than eight years old, magical thinking? [195]

Q: Has the child experienced unusual perceptual experiences not qualifying as pathological hallucinations? [196]

No to All Items
Select 198 or 199 on CAFAS and move to next subscale

Yes to One or More Items
Move on to the next subscale.

★ For Mild Impairment...

Child must have **occasional** difficulty in communication, in behavior, or in interactions with others in the Mild category of this domain.