QUICK REFERENCE

Print-Friendly Best Practices and User Flowcharts for Kansas Serious Emotional Disturbance Waiver

October 2021

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HOW TO USE THIS QUICK REFERENCE

Purpose. This Quick Reference Guide was developed to provide clinicians with easy-to-access recommendations and decision guides for common challenges in CAFAS/PECFAS assessment. The first section of the guide summarizes common challenges in overall CAFAS administration, and the second section reviews common challenges within each domain. Both sections include recommended assessment practices for addressing each challenge. The Guide concludes with quick reference decision flow charts for two CAFAS domains, which clinicians often find most challenging or confusing to complete, the Self-harmful Behavior domain and the Thinking domain.

Printing Instructions. This document is intended to be printed for quick reference. Print from Adobe Reader for the best printing results. Select the **"Booklet"** option under "Page Size and Handling." Under "Booklet Subset," select "both sides" with the binding on the "left." **Under "Orientation," select "portrait."** If you do not select "portrait," the booklet will print incorrectly. Once printed, fold along the dashed line in the center of this guide.

To print only the flow charts on pages 20 through 23, type "20-23" under "Pages to Print." Under the "Size" options, select "Custom Scale: 100%." It is not recommended that you print the flow charts double-sided.

Funding Acknowledgment. This guide was developed as part of a contract with the Kansas Department of Aging and Disability Services and the funding source was Kansas Medicaid.

CLINICIAN NOTES

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.

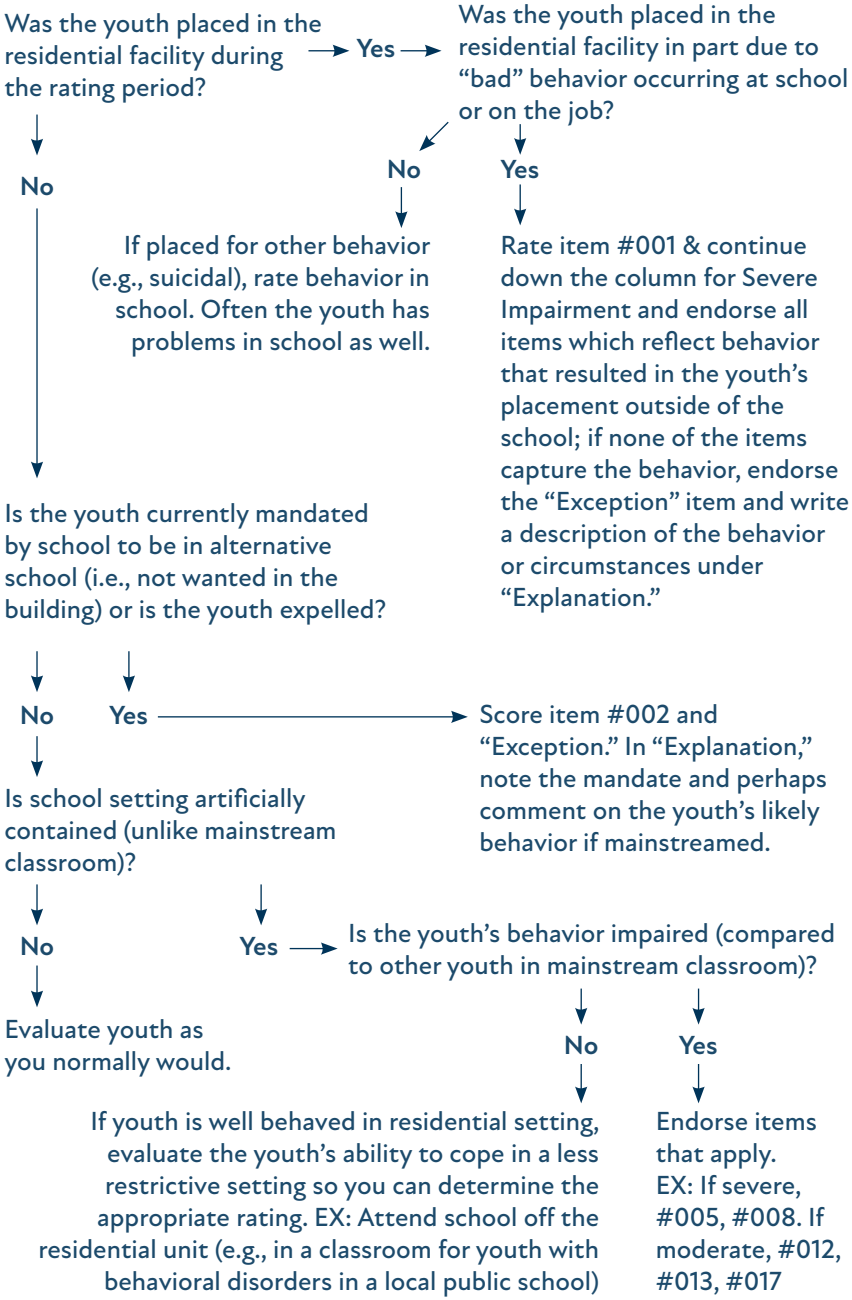
PRTF Discharges

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 on the following page), 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.

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/Free of Negative Troublesome Behaviors and 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 ask questions regarding vaping, type of vape, and how often they vape. 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 endorse an item in the Substance Use domain.

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

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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....

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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.

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