Community Mental Health Authority
of Clinton, Eaton, and Ingham Counties (MI)

(**Group Two:** Existing Standardized Protocols)

- **Local Level**: Implementing CAFAS Within an Individualized Approach to Care

Overview

Clinton Eaton Ingham (CEI) is a community mental health center that operates as a capitated local management entity for the delivery of child/adolescent behavioral health care in three counties in the Lansing, Michigan area. CEI both manages and provides care for children in the Lansing catchment area and their families. Perhaps more than any other local management entity (LME) in Michigan, CEI has incorporated the State's mandated use of the CAFAS into its ongoing, day-to-day assessment, service planning and treatment outcome monitoring activities.

CEI administers the CAFAS at intake, again within the first month of service provision, at 4-6 months, and annually for children who remain in care more than a year. This is far more than is required by the State, which mandates administration of the CAFAS at intake and exit. CEI uses the tool to triage youngsters into appropriate levels of care, i.e., outpatient versus the package of services known as home-based (which include in-home services, therapeutic case management, and crisis services).

Background

CEI has used the CAFAS since the state mandated its use in 1998. Initially, there was resistance among CEI clinicians to using it because CAFAS was viewed as "problem-oriented" whereas the culture at CEI is "solution-focused." CEI leadership made a decision to integrate use of the CAFAS systemically, that is, not to train just one "CAFAS expert" as some of the other LMEs were doing, but to incorporate the CAFAS into everyday practice by training all of its clinicians (using a "train-the-trainers" approach) and revamping agency forms so that CAFAS requirements were embedded into day-to-day documentation. In this way, use of the CAFAS did not require additional paperwork but could become part of everyday practice. CEI stakeholders indicated that it took about a year to a year and a half to incorporate use of the CAFAS into the CEI culture and that, currently, there is a 97% compliance rate with use of the tool. CEI stakeholders also noted that while there was an initial perception that the CAFAS was problem-oriented, clinicians in time came to see the tool as very functional and now use it as, in effect, a "common language" within the agency. Similar to Michigan State-level stakeholders, CEI interviewees expressed a desire to get their counterparts in the child welfare system and within the courts to use the CAFAS to broaden this common language across child-serving systems and create better placement decisions.

Individualized, Culturally Competent Family Focus

CEI as an agency is committed to partnering with families and was in the forefront of flagging some of the issues with the CAFAS initially that led to strengthening the caregiver subscales of the CAFAS. CEI currently is piloting an additional caregiver scale to accompany the CAFAS, which assesses parenting skills (i.e., the Advance Child Management Skills Scale for Caregivers, Hodges, 2002).

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CEI stakeholders believe that, initially, it can be difficult to administer the CAFAS with families with multiple problems who are in serious crisis, which characterizes many of the families with whom CEI works. However, CEI's experience is that families become receptive over time as they see improvements in CAFAS scores, which become a kind of tangible benchmark for progress. CEI stakeholders also emphasized that the CAFAS makes treatment decision more transparent for families because decisions are tied to functional status across many domains that are understandable and important to families, such as school functioning. It is not, in the words of one CEI stakeholder, "mystical" or absorbed with diagnostic jargon, and it allows families to "see their own progress." CEI stakeholders believe that use of the CAFAS supports their overall aim to help families become more self-reliant.

CEI stakeholders indicated that use of the CAFAS allows them to report actual data to families and to the larger community on progress made. It reportedly has helped to take their work out of the anecdotal realm and gives both families and the community measurable results.

CEI stakeholders also feel that their use of the CAFAS supports what has long been an individualized approach to care at the agency, at the same time it reduces subjectivity in the assessment and treatment planning process. CEI clinicians use the CAFAS as a guide within an individualized approach to care. In addition, CEI reportedly provides a fairly broad range of services and treatment interventions and, as a result, is able to craft "finely tuned" care plans.

About 10% of the population in Lansing is comprised of racial and ethnic minority families, and the area also encompasses both urban and rural populations. CEI stakeholders did not identify any particular issues related to use of the CAFAS with respect to racial and ethnic minority children.

Fidelity and Oversight

Because they are implementing a continuum of care, more than one clinician typically is involved in a child's care at CEI. Thus, the agency has a built-in inter-rater reliability system with respect to use of the CAFAS.

CEI described the State's "oversight" role as more supportive than regulatory. CEI stakeholders have found the State and its evaluator to be highly responsive to issues raised by the agency both with respect to the CAFAS instrument itself and regarding assistance in analyzing data on different subgroups of children served. For example, feedback contributed by CEI reportedly led to changes in the language of the CAFAS to be more strengths-based, and, as noted earlier, CEI is piloting the extended caregiver guidelines.

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Experience To Date

To date, CEI reportedly has used the CAFAS primarily at the service planning level; however, it is very interested in using it more at a systemic level but lacks the management information system (MIS) capacity at present. It finds the data generated by the State and its evaluator to be very helpful in understanding macro (i.e., population level) issues and would like to be able to do more of that kind of data analysis within the agency if resources were available.

CEI stakeholders pointed out that they very much are serving children with the most serious disorders (as the State intends) and that the CAFAS allows them to document that; the average total CAFAS score of children served by CEI at intake is 130 (compared to an average statewide total score of 80). CEI has adopted a solution-focused treatment approach and does not believe it is helpful to families for the agency to "hang onto" children indefinitely. In general, they consider a total CAFAS score of 70-80 to be sufficient for discharge, for example. As noted earlier, the CAFAS has removed much of the subjectivity around when a child should be discharged (and discharge could be to a step-down service). CEI stakeholders also noted that use of the CAFAS supports moving children more readily out of service so that more children can get in. As a result, the agency does not have waiting lists, and stakeholders noted that families can always return for services if needed.

CEI has worked closely with the State and its university evaluator to identify weaknesses in the CAFAS, such as in the caregiver scales noted earlier, and is assisting in piloting a new parent management skills scale. CEI also works with the State and its evaluator to analyze subgroups of children and youth it serves to identify areas needing more targeted interventions. For example, they found that youth with delinquent behaviors made improvements while often their families did not so the agency began to look at targeted interventions they could do with the families of these youth. As a result, CEI reportedly is having better results with delinquent youth than LMEs statewide.

CEI stakeholders also reported that one subgroup of children with whom they are finding that the CAFAS is not the best tool to identify strengths and weaknesses is those with developmental disabilities.

CEI stakeholders indicated that, occasionally, they get criticized for using only one tool, and they are aware that, in some other states, multiple tools are used. However, they feel that use of multiple tools has more to do with the system's needs than with what families want and need. Their basic attitude and practice is to use the CAFAS as a guide and not let it dominate practice; as one stakeholder said, "we do not let ourselves become prisoners of the CAFAS."

Major Benefits, Concerns, and Lessons Learned

CEI stakeholders offered a number of "lessons learned" from their use of the CAFAS, including the following:

- It is essential to integrate the CAFAS into everyday documentation and make it part of the "language" of the agency.
- Use of the CAFAS works best when it is embedded into a system that is strengths-based, solution-focused and committed to the principle of individualized care. CEI emphasized that its priority in hiring clinicians is to select those who understand and can practice this philosophy, rather than those wedded to an "expert mentality."
- While CEI stakeholders acknowledge that CAFAS scores could be used to "rate" clinicians, they strongly advise against it. They pointed out that in their system, they take a team approach to care and that every family is different, making comparisons about clinician competencies based on CAFAS scores problematic. They stressed instead using the CAFAS as an "accountability measure" for their program as a whole. Similarly, CEI stakeholders caution against tying rewards or penalties to reliability in use of the CAFAS.
- Based on their experience with the CAFAS, CEI stakeholders reported that they are heading increasingly toward an outcome-driven practice model rather than doing lots of assessments. They have found the CAFAS to be a tool that supports an outcome orientation, reduction in paperwork, and partnerships between families and clinicians in assessing strengths and needs and developing solution-focused treatment approaches. [56]

56 Hodges, K & Grunwald, H. (2005). The use of propensity scores to evaluate outcomes for community clinics: identification of an exceptional home-based program. The Journal of Behavioral Health Services & Research, 32(3), 294-305.