FAS Functional Assessment Systems
CAFAS | PECFAS | JIFF | CWL

www.fasoutcomes.com
FAS@FASOUTCOMES.COM
P: 734-769-9725

The Child And Adolescent Functional Assessment Scale (CAFAS®) –A Quick Overview
By Kay Hodges, Ph.D.

Psychometric data

The CAFAS has far more psychometric data than any other measure designed to assess youth with problems. There are over 80 articles published in peer-reviewed journals, with the vast majority of them authored by others than the developer (see the document CAFAS® Reliability and Validity in "Downloads" → "Reference Materials" at www.FASoutcomes.com, which lists over 60 key articles).

- **Outcomes:** The CAFAS is sensitive to assessing the degree and rate of change over time. It has been used as an outcomes measure in numerous studies, including evaluating outcomes in three large studies and assessing effectiveness of a variety of evidence-based treatments. From 1993 – 2000, SAMHSA required the use of the CAFAS as the evaluation measure by all of the demonstration service grants for developing Systems of Care (Holden, Friedman, & Santiago, 2001; Manteuffel, Stephens, & Santiago, 2002). In the SAMHSA funded evaluation, the youth had been diagnosed as having a serious emotional disturbance (SED), were for the most part from impoverished families, were a diverse group in terms of socio-demographic characteristics and involvement with multiple agencies serving children and families, and received mental health services within developing systems of care which were sponsored with the grant awards (Hodges, Doucette-Gates, & Liao, 1999; Hodges, Doucette-Gates, & Kim, 2000). Each grantee was required to contribute data to a national sample, which was managed by Macro International Inc., in collaboration with partners at the University of South Florida and staff assistance from the Federation of Families for Children's Mental Health.

- **Predictive Validity:** CAFAS scores at intake/entry predicted over the subsequent 6 months to 2 years later, (depending on the study): level of care (restrictiveness of setting), service utilization (number of days of treatment, bed days), service cost, contact with the law, attendance at school, and recidivism for youth discharged from residential juvenile justice facility . (This means that the CAFAS Total score and subscale scores at intake are a good gauge as to which cases likely need higher levels of care or intensity and type of services.)

- **Concurrent Validity:** There are many studies (over 20) showing concurrent validity (i.e., CAFAS scores are consistent with scores for similar measures or indicators of problems).

- **Reliability:** The CAFAS is reliable, with studies evaluating its inter-rater reliability, internal consistency, and test-retest reliability.

Background:

- The CAFAS was developed in 1989 and has had little modification because the original validity studies showed that it was the best predictor of outcome. It is a standardized; the CAFAS items and instructions for scoring have remained stable over the years, regardless of the setting in which it is used.

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- CAFAS has been successfully used to assess functional impairment in a wide array of service settings (mental health, juvenile justice, schools, and child welfare) and with youth from diverse backgrounds (as demonstrated via over 75 systems of care grants throughout the US). Traditionally, it has been the gold standard measure for children with mental health problems, including children with Severe Emotional Disturbance (SED). In addition, there are over 10 articles in which the CAFAS has been used Juvenile Justice.

How the CAFAS works:

- Assesses day-to-day functioning in 8 youth domains (School, Home, Community [delinquency], Behavior Toward Others, Moods [trauma, depression, anxiety], Self-Harm Potential, Substance Use, And Thinking) and in 2 caregiver domains (Material Support; Parental Support of Youth's Developmental Needs). For each domain, target behaviors [problems interfering with functioning], strengths, and goals are identified.

- Staff choose specific behavioral items that describe the youth. It typically takes no more than 10 minutes to complete the CAFAS. The scores for each CAFAS subscale (domain) are determined by the behavioral item selected. In other words, staff do not give generic ratings, such as 0 to 3. Selection of items is based on information collected by routine interview, etc. The items chosen provide a description of the youth's problematic behaviors/reported symptoms— individualized for each youth. Custom items are added to any subscale, if needed to describe a child.

Results are generated by the CAFAS for each youth (can also be aggregated across youth- see below).

- Total score, Subscale scores (8 for youth, 2 for caregiver).

- Presence/absence of specific risk behaviors.

- Presence/absence of clinical markers (at intake) that predict likelihood of poor progress with treatment-as-usual. Based on empirical studies in peer-reviewed journals.

- CAFAS client types or classification (referred to as CAFAS Tiers®) (e.g., thinking problems, substance use, self-harmful, delinquency, behavior problems, etc.) which can be matched to effective treatments. (Information on matching to treatments is available).

- Improvement (or lack thereof) on research-based outcome indicators (Meaningful and reliable improvement achieved; absence of severe impairments at exit; and absence of pervasive behavioral impairment [across settings, including School, Home, and General behavior toward others] at exit).

- Whether Parent Management Training is recommended for the family (based on profile across CAFAS subscale scores).

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Online, web-based software solution provides for:

- Guiding service/treatment selection that is individualized for each youth. Provides practitioner and family with:
    - Meaningful interpretive results that guide service/treatment selection, based on the youth's specific needs. Automatically generates a *Client Assessment Report* for each assessment with results (along the lines described below) and a *Family Report* (to share with the family) that shows gains over time and focuses on strengths and goals. Sets up an optional *Treatment Plan*, in which the target behaviors, strengths and goals are pre-populated, and the practitioner and family specify the plan for each CAFAS subscale. Treatment plan fields are customizable.
    - At each re-assessment, shows a chart tracking change in CAFAS scores and research-based outcome indicators. Since results are immediately available, ineffective treatment can be changed mid-course, to prevent poor outcomes.
- Managing cases and outcomes by supervisors (using Supervisor Dashboard). Data are aggregated for selected programs and time period, and includes risk behaviors, clinical markers (at intake), and outcome results (for cases with more than 1 assessment). For example, gives a list of cases that are not improving, and from that list, the supervisor can "drill down" to the youth's specific clinical data to help determine how the youth's plan may be changed.
- Informing directors and administrators of the needs of youth entering services (with *Aggregate Intake Report*) and outcomes for youth existing services (with *Aggregate Outcome Report*). In addition, all data are available at all times, to the organization.

Online Software Application is designed for partners across the system of care.

The web-hosted application can meet the needs of different partners across the system of care, whose resources differ. It includes three other evidence-based assessment measures: PECFAS, which is a version of the CAFAS for preschoolers; JIFF (a self-administered, computerized interview derived from the CAFAS and used by agencies which do not have the resources to do clinical interviews), and the Caregiver Wish List (self-assessment of parenting skills). Several Systems of Care use this suite of measures. English & Spanish versions available.