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ABSTRACT

These four symposium papers provide examples of different states that have experimented with various criteria and approaches in developing youth mental health services. The four states profiled, North Carolina, Arizona, Louisiana, and Massachusetts, are using the Child and Adolescent Functional Assessment Scale (CAFAS) to assess impairment in youth functioning. The CAFAS provides a score that reflects youth functioning in eight areas: school/work, home, community, behavior towards others, mood, self-harmful behavior, abnormal thinking, and substance abuse. The four papers highlight the factors that are being considered for inclusion as eligibility criteria other than impairment. The papers include: (1) "Criteria for Assessing Child Mental Health and Substance Abuse Services in North Carolina" (Lenore Behar and Lynn Stelle); (2) "Proposed Eligibility Criteria and Procedures for Enrollment in Department of Mental Health Continuing Care" (Elizabeth Irvin and Phyllis Hersch); (3) "Using the Child and Adolescent Functional Assessment Scale (CAFAS) To Establish Level-of-Need for Medicaid Manage Care Services" (Randall Lemoine and others); and (4) "Criteria Used in Determining Appropriateness of Service Utilization in Arizona" (Aimee Schwartz and Stephen Perkins). (Three of the papers include references.) (CR)

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Symposium

Shaping State Public Policies: Determining Access to Care and Level of Care Provided to Youth in Need of Mental Health Services

Introduction

Public managed care practices are in some stage of development in each state. The implications of these policies are far-reaching, yet there is little empirical data on which to base these decisions. Criteria are being developed for determining eligibility for receiving public mental health care and for determining the levels of care that will be made available to consumers. These summaries are intended to provide examples of how state administrators have struggled with, and to some extent already experimented with, various criteria and approaches.

The systems that are taking shape in the following states will be described in detail: North Carolina, Arizona, Louisiana, and Massachusetts. Each State is using the Child and Adolescent Functional Assessment Scale (CAFAS) developed by Hodges to assess impairment in the youth's functioning. The CAFAS provides a score reflecting on the youth's functioning in eight areas: school/work, home, community, behavior toward others, mood, self-harmful behavior, abnormal thinking, and substance use. The

caregivers can also be rated on two scales that reflect on the caregiver's ability to provide for the youth's material needs and for the youth's emotional and social needs. These summaries highlight the factors that are being considered for inclusion as eligibility criteria, other than impairment. The process by which these guidelines are being developed will also be discussed.

Criteria for Accessing Child Mental Health and Substance Abuse Services in North Carolina

Lenore Behar, Ph.D. & Lynn Stelle

In January 1994, the North Carolina state office of Mental Health, Developmental Disabilities, and Substance Abuse Services (NIHIDDISAS) and the local MH/DD/SA programs began a Medicaid capitated, managed care waiver program for children, under age 18, with mental health or substance abuse diagnoses. Developed jointly by the state and local entities, the waiver program, called Carolina Alternatives, has been piloted in 32 of the state's 100 counties with a plan to be statewide by 1997. All children eligible for Medicaid and in need of treatment are to be served. As a part of the changes required to operate the waiver, there have been numerous revisions in policies and procedures over the past two years. During the past six months, a committee has drafted criteria for levels of care to be authorized through the managed care program.

As a second part of the waiver program, in addition to being a statewide program for children, the capitated managed care program will be expanded during 1996-98 to include adults with mental health and substance abuse problems who are eligible for Medicaid funded services. Thus, the criteria were developed to apply to current children and to adults when that population is included in the waiver program. The following discussion will cover issues related only to the development and application of the criteria for levels of care for children. The process by which these criteria are being developed involves the following:

- First, it was important to begin operation of the program to enable service providers to gain an experiential understanding of the changes required in a managed care approach to service delivery. Staff in the local MH/DD/SA programs gained familiarity with the process of managing care, that is determining if services were needed and what services were needed and then estimating the amount of service needed to address the child/adolescent's mental health or substance abuse problems. In addition to gaining specificity in treatment planning, the staff also gained experience in learning to authorize, coordinate, and manage care with networks of other public and private providers, including inpatient settings. These new experiences provided a foundation on which to build a set of criteria that could be used to authorize

build a set of criteria that could be used to authorize levels of care that were related to levels of intensity of services.

- A committee of clinical services providers, administrators, and members of consumer/parent advocacy groups was formed to develop the criteria. Starting with the levels of care criteria developed in the Fort Bragg Project, the committee made revisions they thought would clarify or improve the Fort Bragg product. They added the North Carolina Functional Assessment Scale (NCFAS) for adults and the Child and Adolescent Functional Assessment Scale (CAFAS) for children to divide clients into six categories of severity that were to be related to six levels of care. The product of the committee was reviewed by a senior level group composed of directors of local MH/DD/SA programs.
- Following approval by this senior group, the draft criteria were circulated to a wide range of stakeholders, including consumer groups, advocacy groups, professional organizations, public and private provider groups and all local MH/DD/SA programs. After receiving comments from this wide group of stakeholders, due by the end of February, a final draft will be forwarded to the Director of MH/DD/SAS as the recommended criteria for determining levels of care. It is planned that following approval from the Director and his staff, these criteria will be used for six months for a period of pilot testing. After six months of use, revisions will be made, if needed, and the decision will be made whether or not to codify the criteria into rules.

A set of six principles has been developed to apply to all levels of care. A summary of the principles follows.

- Treatment must be medically necessary.
- A deficiency in adaptive functioning must be evident and based on clinical symptoms related to DSM-IV diagnoses approved for Carolina Alternatives.
- Treatment is to alleviate problems associated with DSM-IV, Axis I diagnoses and/or to lessen manifestations of Axis II diagnoses.
- Treatment is to be provided in the most clinically appropriate level of care in the least restrictive, least intensive manner. Treatment is to be time sensitive and strength oriented and should focus on solutions, building on family strengths and resources.
- Outcomes of treatment should be improved adaptive ability, prevention of relapse, or for emergency situations, stabilization.
- The needs of the client are the primary focus of treatment. The convenience of the community, family or judiciary are not grounds for medical necessity.

Draft criteria have been developed to address six levels of care ranging from preventive services to inpatient services. Each level of care, except prevention, is accompanied by a recommended review period. For each level of care, criteria

recommended review period. For each level of care, criteria are provided both for admission to the service and for continuation of the service. The levels of care including types of services and recommended review periods follows.

Prevention: respite services, after-school services, drop-in services, screening or evaluation; no recommended review period.

Level A: group therapy, high risk intervention-periodic (group), community-based intervention (group); the recommended review period is six months. The latter two categories are essentially wraparound services provided by professional staff and by nonprofessional staff.

Level B: individual therapy, high risk intervention (individual), community-based intervention (individual); the recommended review period is three months.

Level C: partial hospitalization, day treatment, case management; the recommended review period is two months.

Level D: moderate or intensive treatment in a residential setting, facility-based crisis intervention; the recommended review period is one month.

Level E: inpatient; the recommended review period is daily.

The criteria for admission to services at each of the six levels are based on severity of the child's problems. Continuation criteria are based on documentation of continued need for treatment at that level of care. Severity is determined by a CAFAS score for all levels except: (a) the minimal level which provides for the delivery of prevention services and (b) the maximum level which provides for the use of inpatient services.

1. To qualify for prevention services, the child or family must demonstrate a need for such services to prevent or delay onset of psychiatric problems in the child or to decrease the likelihood of onset.

2. To qualify for services at the inpatient level, in addition to a CAFAS score greater than 100, the child must: (1) have a DSM-IV diagnosis; **and** (2) must be considered dangerous to him/herself, dangerous to others, have a psychosis or other severely disorganizing condition, or have a life threatening medical condition (e.g., toxic drug level), or need complex diagnostic procedures or supervision of medication; and (3) constant and skilled monitoring/treatment must be provided by a physician; and (4) other less intensive services will not suffice.

As noted above, these criteria are currently under review and most likely will be modified before pilot testing. Pilot testing is scheduled to last for six months, or possibly more if needed, so that there is confidence in and comfort with the

if needed, so that there is confidence in and comfort with the application of these criteria to clinical services.

Proposed Eligibility Criteria and Procedures for Enrollment in Department of Mental Health Continuing Care

Elizabeth Irvin, Ph.D. & Phyllis Hersch, Ph.D.

Legislation referred to as Chapter 599 established the primary mission for the Massachusetts Department of Mental Health (DMH): "to provide services to citizens with long-term or serious mental illness." This requires the Department to target programs and services to persons with long-term or serious mental illness. Therefore, the primary mission of DMH is to direct its services to adults with serious or long-term mental illness and children and adolescents with serious emotional disturbances. These priority clients may access continuing care services funded by or provided by the DMH.

The purpose of this summary is to describe the clinical assessment criteria and procedures being proposed by the Department of Mental Health to assess the eligibility of children and adolescents for enrollment as priority clients in DMH continuing care services. Inclusion in the target population defined by these criteria is based on the presence of a serious emotional disorder that has resulted in functional impairment that substantially interferes with or limits the performance of one or more major life activities. These criteria integrate federal definitions for serious emotional disorder with the Department's current eligibility guidelines for children and adolescents.

Youth applying for any DMH-funded service will be assessed for their level of need for mental health services using the criteria described in this document. Based on the findings from the assessment, children and adolescents who meet eligibility criteria will be enrolled as a DMH continuing care client and assigned to a Care Management site for treatment planning and service authorization. Care management sites are located in communities across the state and are part of the Comprehensive Community Support System of Services. Care Management personnel provide clinical oversight, care planning, service authorization, service coordination, referral, and advocacy for eligible, enrolled members. All DMH services are authorized through Care Management and are targeted to level of need and provided within available resources.

Although all youth whose continuing care services are funded through DMH must fall within the eligibility criteria described in this summary, there is no intention to restrict the flexibility or responsibility of the Department of Mental Health or the Division of Medical Assistance to tailor publicly funded service systems to meet local mental health needs and priorities.

Proposed Definition of Children and Adolescents with a Serious Emotional Disorder

To be determined eligible for DMH services, children and adolescents must have a diagnosable mental, behavioral, or emotional disorder that has resulted in significant functional impairment. Specifically, to qualify for continuing care services through the Department of Mental Health, the youth must be 18 years of age or younger at the time of application and have a qualifying mental, behavioral, or emotional disorder of sufficient duration to meet criteria specified within the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (DSM-IV; APA, 1994). The qualifying disorder must have existed for at least six months prior to application and be expected to last for at least one year, and the disorder must have resulted in functional impairment which substantially interferes with or limits the youth's role or functioning in family, school, or community activities. The service history of youth meeting these eligibility criteria will be reviewed prior to final approval for enrollment.

For purposes of determining eligibility for DMH services, a child or adolescent with a serious emotional disturbance is one whose progressive personality development is interfered with or arrested by a variety of factors so that there is impairment in the capacity expected, given the child or adolescent's age and endowment. All of these disorders have episodic, recurrent, or persistent features; however, they vary in terms of severity and disabling effects. Thus, children and adolescents with serious emotional disturbances will have a diminished capacity to reasonably and accurately perceive the world around them, control their impulses, maintain satisfying or satisfactory relations with others, and/or to learn. Serious or long-term emotional disturbances include schizophrenia and disorders of affect and personality, as well as other qualifying disorders depending on the severity and duration of the illness. Children and adolescents with serious emotional disturbances may have disorders of impulse control or attention deficit. However, all youth meeting the general eligibility criteria must also meet the functional impairment criteria. The five eligibility criteria contained in this definition are further defined below:

Criterion A: Qualifying Mental Disorder. Qualifying mental disorders are all disorders listed in the DSM-IV with the exception of those specifically excluded. Excluded disorders are usually first diagnosed in infancy, childhood, or adolescence, and include, but are not limited to mental retardation, pervasive developmental disorders, and autism. Also excluded are (a) conditions categorized under Delirium, Dementia, Amnestic, and Other Cognitive Disorders; (b) mental disorders due to a general medical condition; and (c) conditions listed under Substance-Related Disorders. While mental health practitioners are frequently involved in treatment planning and service delivery for

involved in treatment planning and service delivery for these children and adolescents, separate Federal block grant funds and processes for needs assessments address these population groups.

Criterion B: Duration of Qualifying Disorder. The qualifying mental, behavioral, or emotional disorder shall have existed for six months prior to application and be expected to last for at least one year.

Criterion C: Functional Impairment. Functional impairment is defined as difficulties that substantially interfere with or limit a child or adolescent from achieving or maintaining one or more developmentally appropriate social, behavioral, cognitive, communicative, or adaptive skills. Functional impairment of episodic, recurrent, and continuous duration are included unless they are temporary and expected responses to stressful events in the child or adolescent's environment.

Operationally, functional impairment related to a qualifying behavioral, emotional, or mental disorder will be evaluated using standards outlined in the Child Adolescent Functional Assessment Scale (CAFAS: Hodges, 1994). The results of an evaluation using these standards will determine if the applicant meets functional impairment criteria for enrollment in DMH continuing care; specific impairment thresholds for eligibility are under study and will be described once the Youth Eligibility Pilot is completed (April 15,1996).

Criterion D: Duration of Severe Functional Impairment. This is an indication of how long the youth has been functioning in the severely impaired range. Severely impaired functioning may be a relatively constant feature of the youth's disorder, or may come and go. The period of impairment need not be consecutive. To determine the duration of severe functional impairment, the cumulative number of months during the past year that the youth was dysfunctional, as identified by the CAFAS, is utilized.

Criterion E: Service Utilization. Applications will be reviewed for the adequacy of services the youth received in the six months prior to referral. Insured youth who meet eligibility criteria for Groups 2 or 3, who have not been offered services matched to their level of need and ability to utilize such services during the six months prior to referral, may at the discretion of the Department, not be enrolled in DMH-funded services until appropriate interventions have been tried in the community.

Procedures

Standardized criteria are used to evaluate eligibility for DMH services and to classify eligible applicants into one of four clinically related groups. The criteria are: (a) diagnosis, (b) duration of illness, (c) severity of functional impairment, and (d) duration of severe functional impairment.

The general approach is to establish that the youth meets clinical criteria for a qualifying DSM-IV psychiatric diagnosis and that the youth is functionally impaired as a result of the qualifying disorder. Using duration of functional impairment criteria, eligible youth are then classified into one of three clinically related groups: *Severe and Persistent Mental or Behavioral Disorder* (Group 1), *Severe Mental or Behavioral Disorder* (Group 2), and *Moderately Severe Mental or Behavioral Disorder* (Group 3). Youth who meet eligibility criteria for Groups 1, 2, or 3 are also evaluated with regard to their prior services. Youth who have not had services matched to their level of need during the six months prior to referral, may at the discretion of the Department, not be enrolled until appropriate interventions have been tried in the community. The Department reserves the right to enroll persons who require advocacy to access the full benefit of their insurance.

Eligible service recipients will be enrolled regardless of their ability to pay. Third party reimbursement or client funds will be accessed when service recipients have this alternative available prior to use of DMH funds. Enrollment in DMH continuing care does not constitute an entitlement for, or a guarantee of services. Youth enrolled in DMH will be served based upon available resources, and services will be available to priority clients most in need of those services. DMH services may be terminated once the youth no longer requires continuing care services using standard criteria.

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Using the Child and Adolescent Functional Assessment Scale (CAFAS) to Establish Level-of-Need for Medicaid Managed Care Services

Randall Lemoine, Ph.D., Tony Speier, Ph.D., Sally Ellzey, BCSW, & Jo Pine, MSW

Over the past two years, the Louisiana Office of Mental Health (OMH) has initiated public managed care practices in an effort to better manage costs and to promote quality of services for Medicaid-funded programs. These practices have included prior-authorization for services based on target population eligibility and level-of-need criteria; allocation of a fixed amount of services based on assessed

allocation of a fixed amount of services based on assessed level-of-need; and ongoing monitoring of service utilization and outcomes. OMH initiated these practices statewide for case management services in 1994 and recently designed a significantly enhanced program for mental health rehabilitation services, enabling a very flexible but managed wraparound package of services. The CAFAS was selected as the instrument to establish the initial level-of-need and to monitor changes in child/family need and outcomes over the course of service. Wraparound service packages were designed for child/families with high, medium, and low levels of need as assessed by the CAFAS. This summary paper will discuss the selection and use of the CAFAS for this program which was implemented in December, 1995.

Method

The Medicaid Mental Health Rehabilitation (MHR) program was implemented statewide in Fiscal Year (FY) 1992 as a fee-for-service program serving both adults with serious mental illness and children/youth with severe emotional/behavior disorders. It was designed to supplement the existing array of OMH clinical and case management services and to offer a broad range of treatments and supports in natural community settings (e.g., home, school, etc.) outside the clinic environment. These services included both traditional clinical and more contemporary psycho- social rehabilitation services. For example, individual, group, or family psychotherapy could be offered as well as psycho-social skills training and a range of support services (i.e., professional and paraprofessional), as long as these did not duplicate clinic based services. OMH viewed this program as providing the basis for future development of a comprehensive, community-based service array. The program was initially administered and monitored completely through the state Medicaid agency.

The MHR program showed tremendous growth over the three year period of FY 92-95, increasing from an initial $6M program to a $35M program. By July, 1995, there were about 335 providers and nearly 8,000 children/youth served statewide. Whereas this growth could have been considered positive in terms of increasing the amount of mental health services available to children/youth in the state program, reviews indicated that there were actually widespread program abuses. There was increasing concern that this program was on a "runaway course." The growing provider network was largely inexperienced with delivery of individualized, wraparound services in natural settings, and many agencies appeared driven more by the "business opportunity" of the program than by an interest in delivering quality care. Program reviews indicated that the service population included large numbers of children/youth who did not meet target population eligibility criteria of serious emotional/behavioral disorder, and services were fragmented.

During this time, the state also experienced a severe budget crisis which affected all Medicaid programs. With regard to the MHR program, the legislature slashed the program budget for the coming FY 96 from $35M to $12.9M, a 63% reduction, and required that it be capped at that level funding. The legislature further required that the program expenditures be audited monthly and gave the state Medicaid agency 180 days to "fix" the program or eliminate it. The fiscal crisis and the program abuses that preceded provided OMH and the Medicaid agency with an opportunity and incentive to redesign the program utilizing public-based managed care practices to contain costs, promote quality, and to protect the scarce dollars remaining for the children/youth most-in-need of this service.

The redesign took place very quickly in two phases, the first being the "quick fix" to gain immediate program control, and the second, and the subject of this summary, initiating a more sound and permanent program design that included several enhancements to promote quality and outcome of care. The entire redesign process was done in a close partnership with the Medicaid agency, based on the foundation of the prior positive experience observed in the successful case management program. During Phase I of the redesign, OMH became an administrative agent of Medicaid, as had been done previously with case management, and utilized its experienced regional prior-authorization (PA) staff (most of whom were seasoned OMH clinicians) to pre-certify cases based on explicit target population eligibility criteria (i.e., diagnosis, disability, and duration). This step alone was quite effective in assuring children/families most-in-need were receiving services.

Under Phase II, each agency was to offer a comprehensive, wraparound plan of professional and paraprofessional services through pre-established service packages based on the child/family's assessed levels of need for the service. Three tiers of service packages were designed: High, Medium, and Low (i.e., High being intensive and Low being the maintenance level). In order to assure a uniform and complete data base for target population and level-of-need eligibility determination by PA staff, OMH required provider agencies to submit a standardized clinical evaluation completed by both a psychiatrist/psychologist and social worker. Finally, a case-rate payment methodology was developed to pay provider agencies for the menu of services delivered.

A key component of the redesigned program was the assessment of level of need (LON). This required an instrument that would enable OMH regional PA staff to reliably assess the child/family current service need levels based on data submitted by the provider. OMH needed an instrument that was relatively brief, but comprehensive and sound. The instrument also needed to have adjustable leveling criteria and be utilized relatively objectively, yet still be rated from clinical records. The development team reviewed other states' experience in use of LON technology.

reviewed other states' experience in use of LON technology. Only a few states had begun to employ LON technology, but those that did were utilizing multidimensional level-of-functioning instruments to assess need in addition to target population eligibility criteria. The OMH development team was impressed with North Carolina's Level-of-Eligibility (LOE) approach, using the Child and Adolescent Functional Assessment Scale (CAFAS). This approach had an established track record for identifying eligibility and service levels along with other pertinent factors, and the CAFAS had undergone impressive recent developments (Hodges, 1994). In addition, the CAFAS included both child and caregiver scales, so that family issues could be incorporated into the LON ratings. After some initial piloting, the CAFAS (1994 version) was selected for use. In order that the selection of cases to be served would be sensitive to both child and family needs, OMH decided to utilize the combined total of the five youth clinical and two caregiver scores as defining the overall LON.

Because the program budget was so limited, a difficult administrative decision had to be made to first serve only those child/youth that rated at a high LON. It was understood that if more money was made available and added to the program later, OMH would have the ability to serve persons at the moderate and low levels of need at program entry.

All remaining MHR cases (N = 551) were rated by PAs using the CAFAS. The distribution of scores was reviewed to determine the cut-off points that would be used for high, medium, and low levels. In setting the levels of need based on the CAFAS total ratings, OMH was guided by what had been previously used by North Carolina for level of eligibility criteria and by the established CAFAS guidelines for total of the youth scales.

Results

The distribution of total CAFAS scores (combined total youth and caregiver scores) was normally distributed and showed a mean, median, and modal rating of 90, with a standard deviation of 30. A total score of 90 on the youth scales alone has been utilized in North Carolina for Level I, the highest of the four levels of eligibility. Since 90 was the mean and modal level for the select group of child/youth known to meet target population eligibility by prior-authorization, OMH determined that the high level score cutoff would have to be above this level. A total CAFAS score of 120 would be about one standard deviation above the mean. A score of 60 would be one standard deviation below the mean. So OMH decided on levels at 120 or above for High, 60 to 110 for Medium, and 50 or below for Low. This resulted in 23% (or a total of 120) of then active cases being classified as High and eligible for the program at the time of re-implementation. These score

cutoffs were considered meaningful by the PAs based on their personal experience with the assessment data for cases they were rating. The redesigned program was implemented in December, 1995, using these cutoff scores.

Conclusions

Program reviews over the early stages of this program have indicated that the combination of target population eligibility criteria and level-of-need, as measured by the CAFAS, has been working well in identifying those most-in-need for the service. In addition, much is being learned about applying level-of-need technology. There have been ongoing discussions regarding the concept of LON and how it may be further developed. One important consideration is that LON is based solely on current level of functioning or impairment, which is subject to a variety of influences, especially the existing level of services/supports received. Several provider agencies argued that children/families with high-needs did not score at the High level because they were receiving a level of services at the time of the rating which lowered their CAFAS score; that is, maintained them at the moderate or low levels. How to adjust the LON to accommodate for existing services/supports at the time of program registration has been an issue under study. OMH has also been studying the use of the Caregiver Scales in the LON determination and how ratings on these scales interact with the youth scales.

Some agencies have argued that youth with serious disturbances and fairly functional families do not meet the high level-of-need criteria. Some PAs have suggested weighting scales separately. Similarly, some PAs have recommended scoring each of the Role Performance sub-domains (i.e., home, school, and community) areas separately.

A child with a severe rating on two or more of these subscales is much more in need than one with severe rating in only one. Finally, it has been noted that the CAFAS does not appear to be as sensitive to high needs at preadolescent age levels as it is for adolescents. This may be attributed to scores reflecting impairment appropriate for these age groups. In other words, there is more opportunity to score higher or be rated as more impaired on the CAFAS as the child grows older.

OMH will be continuously refining and improving this program and the level-of-need methodology over the coming year. The authors are hopeful that our experience will not only put this program on a sound foundation but also is paving the way to quality, managed, community-based mental health services for children/youth and families in need in Louisiana.

Criteria Used in Determining Appropriateness

of Service Utilization in Arizona

Aimee Schwartz, M.D. & Stephen Perkins, M.A.

For the past several years, the Division of Behavioral Health Services of the Arizona Department of Health Services (ADHS/BHS) has mandated the use of the Child and Adolescent Functional Assessment Scale (CAFAS; Hodges, 1994) to determine the need for case management for children and adolescents. A score of 90 or higher, not including the caregiver scales, has been used to qualify children and adolescents for Intensive Case Management services. An override is also in place, in the event the child did not qualify by a 90 CAFAS score, but requires case management services. The Division of Behavioral Health Services also uses the Arizona Level of Functioning Assessment (ALFA), which is based on the Colorado Client Assessment Report (CCAR; Ellis, Wilson, & Foster, 1984) to capture functional levels for both adults and children.

The Arizona behavioral health service system plans to enhance the case management process by establishing three phases of case management. The first phase is provided for children and adolescents in multiple child-serving agencies who have a history of repeated use of restrictive services and treatment non-compliance. The second phase is for those children and adolescents requiring ongoing support to access treatment services. The third phase, case coordination, is for those children who are able to improve with brief intervention, or who will improve with minimal intervention.

Methods/Procedures

To better discriminate the child's level of need, BHS is considering enhancing use of CAFAS or ALFA scales with the addition of a diagnostic classification system to suggest level of functioning, service level, and treatment intervention for children and adolescents.

This usage would replicate the Adult Mental Services Level Checklist, which is an instrument that was originally designed in 1992 for determination of Adult Seriously Mentally Ill (SMI) and service level need for the adult population. As mentioned above, the Arizona Level of Functional Assessment (ALFA) for adults provides function measures based on the Colorado Client Assessment Report (CCAR).

The first step would be determination of the diagnostic classification. The DSM IV Axis I and II principal diagnoses have been separated into four categories: major biological disorders, disorders requiring specialized reviews, other diagnoses not requiring specialized reviews, and those diagnoses typically associated with children being served through other non-mental health related services.

Category I includes diagnoses occurring with major biological disorders, including Bipolar Disorders, Major Depression, Schizophrenia, and other diagnoses of a biological nature.

Category II includes those diagnoses which may require specialized reviews. Disorders such as conduct, depressive, identity, and borderline personality may require further review for secondary diagnostic codings. Disorders falling into this group often coincide with other diagnoses and many times require different service interventions than the Category I group.

Category III includes other diagnoses that have initial onset in childhood, and do not require specialized reviews for secondary diagnoses or other symptomatic reviews.

The final Category, IV, includes those diagnoses that are typically found in children involved in other child-serving agencies. Conduct Disorder, although typically found in children served by multiple agencies, is classified only in Category II due to its requirement for specialized review.

The second step of the service level determination process would utilize either the ALFA or CAFAS scores. The CAFAS consists of eight scales describing the youth's functioning and two that rate the youth's family/caregiver. Six of the CAFAS scale (or five of the ALFA scores) would be summed to yield a total that is used to help determine the appropriate level of case management services. When the CAFAS is used, School/Work, Home, Community, Behavior Toward Others, Substance Use, and Family/Social Support scales would be conceptualized as functional indicators. Since each scale is rated on a four point scale (i.e., 30, 20, 10, 0), the range of scores for these six CAFAS scales is 0 to 180, with higher scores reflecting greater impairment.

The two remaining CAFAS scales used to rate the youth (i.e., Mood/Self-Harm and Thinking), would not be considered in determining service level. Rather, they could be used in conjunction with the diagnostic classification to predict and aid in determining the type of service intervention rather than the service level.

The three service levels correspond to the three phases of case management. First level services, including phase one case management, are for those children and adolescents scoring over 120. Service level number two, including phase two case management, are for those children and adolescents scoring between 70 and 120. Those children receiving under a 70 functional score are able to receive level three services.

Assigned service levels are also an option when service providers do not agree on the predicted service level. This allows for the child to receive a different level of case

management. This overrule will be in effect until such time that State officials determine the appropriate cutoff scores for the service levels.

Conclusion

This service level determination process will be developed and piloted statewide for a six-month period. At the time a review of the service utilization and grouping of children based on diagnoses and functioning levels will be conducted. A review of the "assigned service levels" will be compared to the "predicted service levels" to determine appropriate cut-off scores for the three service levels. Six month data will be used to determine appropriateness of CAFAS scales versus ALFA scales used to determine the three service levels. Cluster analysis of these scores will be conducted based on the "assigned service levels." These "assigned service levels" will then be compared to the "predicted service levels" to determine appropriateness of established cutoff scores for service levels.

Determination of service level is anticipated to provide state reviewers an opportunity to conduct desk audits of services being provided to groups of children and adolescents. In addition, the process should help case managers better define the array of treatment interventions that may be required for children and adolescents.

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