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Development of the Clinician Assessment of Financial Incapability (CAFI)

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Abstract

The Social Security Administration (SSA) provides financial support to adults disabled by psychiatric conditions to provide for their basic needs. For beneficiaries identified as incapable of managing their funds, representative payee assignment is mandated. However, studies indicate that the current SSA method of determining capability leads to idiosyncratic payee assignment, with a tendency to under-identify beneficiaries needing payees. Over two phases with data from 78 mental health clinicians treating 134 patient-beneficiaries, we describe the development of a new assessment, the Clinician Assessment of Financial Incapability (CAFI). Item generation, subscale construction, and preliminary assessments of validity are described. We also describe the simultaneous development of a criterion measure of capability, a comprehensive review of all data. Experts identified four subscales mapping to four criteria of incapability; factor analysis provided support for this item structure. Close to one-half of patients were determined to be incapable by review of all data. CAFI and SSA methods correctly classified 73% of cases, but errors with CAFI were more evenly distributed between false negatives and false positives. The implications of classification error are considered, and advantages of CAFI over the SSA method are enumerated. Plans for future instrument revision are briefly described.

Keywords

assessment; financial capability; representative payee; Social Security; psychiatric; income

1. Introduction

1.1. Social Security Disability Income and assignment of representative payees

Adults disabled by psychiatric disorders are eligible to receive Social Security Disability Insurance (SSDI) or Supplemental Security Income (SSI) to provide for their basic needs. In

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2011, 2.7 million Americans with mental impairments (excluding developmental, childhood, and intellectual disorders) received these federal financial supports (SSA, 2012a). To protect funds from being misused, the Social Security Administration (SSA) mandates that any beneficiary who is incapable of managing his or her own money be assigned a representative payee - a person or institution who receives and manages Social Security funds on the beneficiary's behalf - to ensure that person's needs are met. By SSA policy, legally competent beneficiaries are presumed capable of managing their money independently unless evidence is available to the contrary (SSA, 2013). SSA relies heavily on mental health professionals to judge their patients' capability (SSA, 2012b), and requests notification when a beneficiary is or becomes incapable (SSA, 2013).

Although assignment of payees is mandated by statute for people who are incapable of managing their funds, determinations of who needs the support appear to be made inconsistently. Broad SSA guidelines for determining capability status are subject to idiosyncratic interpretation, and clinicians have reported considering a range of factors, some of which were unrelated to the beneficiary's financial functioning (Luchins et al., 1998; Luchins et al., 2004; Marson et al., 2006; Rosen et al., 2002). For example, clinicians indicate more willingness to assign representative payees when beneficiaries are inclined to accept them (Rosen et al., 2002). Other studies have highlighted a tendency to under-identify beneficiaries who needed payee assignment. In several studies of adults with mental illness, as many as a quarter of beneficiaries were not assigned a representative payee despite their apparent need for one (Black et al., 2008; Rosen et al., 2002). An audit conducted by the Office of the Inspector General of SSA benefits paid to adults with mental impairments concluded that 23% of the beneficiaries reviewed were likely incapable of managing their income, but had not been assigned a payee (SSA, 2012c). The auditors estimated that up to \$200 million in monthly benefits had been directed to individuals who could not manage the money as intended.

A more accurate, validated method is needed to standardize the identification of beneficiaries who are incapable of managing their funds. Although no gold-standard operationalization of the construct has been developed, literature suggests there is consensus about the construct's functional definition.

1.2. Consensus definition of financial capability

There is general consensus among mental health experts that Social Security disability beneficiaries who are not financially capable and need payee assistance are those who, in their day-to-day lives, cannot manage their funds, even if they are *cognitively* capable of making a budget and counting change. The construct was operationalized more formally by Conrad and colleagues' (1998) Determination of Need for a Representative Payee (DONREP) questionnaire. The DONREP's questions, developed from focus groups with case managers and input from an expert panel define financial capability in terms of ability to meet basic needs, vulnerability to victimization, addiction, and psychiatric impairment. Although the DONREP items have not been tested more formally, their scope is consistent with other working definitions of financial capability, including reasons identified by case managers for recommending a payee (Dixon et al., 1999; Luchins, et al., 1998; Luchins, et al., 2004), target outcomes of money management educational interventions (Elbogen et al., 2011, 2013; Rosen et al., 2003, 2010), statistical models differentiating beneficiaries with and without payees (Conrad, et al., 1998), legislative history of assigning representative payees to individuals because of disabling substance use (Swartz et al., 2000) and expert recommendations for defining capability that emphasized substance use, impairment, and the ability to meet basic needs (Rosen & Rosenheck, 1999).

To address the need for more valid determinations, we developed the Clinician Assessment of Financial Incapability (CAFI), a structured questionnaire informed by the consensus definition and expert consultation. Because no validating criterion exists for comparison, we also developed a comprehensive assessment of financial capability to derive *fully-informed* determinations of capability to serve as the gold-standard. This paper describes the CAFI development and preliminary assessments of validity. Capability determinations concluded by the CAFI are compared to those derived by comprehensive assessment, and by the current SSA method.

2. Methods

The study was conducted in two phases involving independent samples. In Phase 1 we conducted a preliminary review of candidate items, and in Phase 2 we pilot tested the complete instrument.

2.1. Participants

For both phases, study participants were clinicians identified by study-enrolled patients as the people who could best answer questions about them for the past six months. Patients enrolled in the study were adults receiving inpatient or intensive outpatient psychiatric services at study sites, who received and managed their own SSI/SSDI benefits, and had diagnoses of substance abuse or dependence. Patients signed informed consent forms for participation and clinicians assented after receiving study information sheets.

2.1.1. Phase 1

Patients: Fifteen patients ranging in age from 30–62 years (Mean=45) were enrolled. Nine (60%) were female; 9 (60%) were Caucasian, 4 (27%) were African-American, and 2 (13%) were Hispanic. Patients had diagnoses of Bipolar Disorder (n=7; 47%), Schizophrenia-spectrum Disorder (n=2; 13%), Borderline Personality Disorder (n=1; 7%), and Anxiety Disorder (n=1; 7%). Two participants (13%) had more than one psychiatric diagnoses, and three (20%) had no documented diagnosis.

Clinicians: Thirteen clinicians were identified by the 15 enrolled patients. Ten (77%) were female; 10 (77%) were social workers and the remaining three were doctoral-level practitioners. Seven clinicians worked in intensive outpatient programs and six worked in outpatient settings. At the time of enrollment, the majority (87%) had worked with their patients 20 months or less (*Med*=6 months, Range = 1–71). Most (85%) had seen their patients at least 4 times in the last 60 days (*Med*=7 times, Range=1–18).

2.1.2. Phase 2

Patients: In this phase, 119 patients were enrolled, ranging in age from 20–65 years (Mean=46). The majority (n=70; 59%) were Caucasian, 34 (29%) were African-American, and 15 (13%) were Hispanic. Participants had diagnoses of Depressive Disorder (n=48; 40%), Schizophrenia-spectrum Disorders (n=32; 27%), Bipolar Disorder (n=21; 18%), Anxiety Disorder (n=7; 6%), Borderline Personality Disorder (n=3; 3%), and other disorders (n=3; 3%). Forty-nine participants (41%) had more than one diagnosis and five participants (4%) had no documented diagnosis.

Clinicians: A total of 65 mental health professionals were identified by the 119 enrolled patients. The majority (n=34; 52%) were Social Workers, 5 (8%) were psychologists, 5 (8%) were mental health workers, 2 (3%) were psychiatrists, and 19 (29%) comprised case managers, nurses, psychotherapists, counselors, interns, and one physician. At the time of enrollment, clinicians had worked with patients 1 – 160 months (*Median* =2 months), and

the majority (n=80; 67%) had seen patients at least 4 times in the last 60 days (*Median*=7 times).

2.2. Assessments of capability

2.2.1. Comprehensive (criterion) assessment—A comprehensive review of data served as the criterion assessment of financial capability. Informed by methods proposed by Spitzer (1983), we designed the semi-structured instrument to guide the collection and integration of all available, relevant, current and historical patient data to derive independent assessments of capability (instrument available at www.behaviorchange.yale.edu). Sources of data included patient interview, medical chart review, patient self-report assessments completed for this study (including psychosocial history, recent residential history, recent substance use, Money Management Measure (Conrad et al., 2006), and Beck Depression Inventory (Beck et al., 1996), and the CAFI completed by a study-enrolled clinician.

Experts in mental health, representative payeeship (Rosen, Rosenheck, Ries, and Ames), scale development (Rounsaville, McMahon and Ball), and competency assessment (Ames) evaluated the scope of the comprehensive assessment to ensure congruency with the consensus definition of financial capability.

The instrument guided assessors to summarize patient capability on four primary criteria; three of the criteria summarized behavioral indicators of incapability and the fourth addressed the likelihood that incapability would continue in the future:

1. money needed for basic needs was spent on other things (in the last 6 months)
2. basic needs have not been met (in the last 6 months)
3. substantial funds were spent that risked personal harm (in the last 6 months)
4. misspending (a: not meeting basic needs) and/or (b: spending to cause harm) is likely to be corrected.

Study-affiliated assessors with Master's or doctoral degrees in Social Work and Psychology completed the comprehensive assessments, and made final capability determinations by following an algorithm that integrated the four criteria above into a single, dichotomous determination of capability. An individual was determined *not* capable if either:

- A. criteria 1 and 2 were met, and 4 was not met (1 AND 2, NOT 4)

OR

- B. criterion 3 was met, and 4 was not met (3 NOT 4)

To determine whether the four criteria sufficiently summarized capability for all patients, and to permit consideration of additional factors, assessors had the option to "override" the algorithm and conclude different capability determinations. Additional factors suggested on the assessment included impaired judgment or disorganized behavior, another person's recommendation to assign or oppose assignment of a payee, a physical condition effecting inability to manage funds, and the availability of an intervention likely to improve management of funds (manuscript in preparation).

2.2.2. Social Security Administration (SSA) method—SSA asks treating clinicians to determine their patients' capability by completing questions on the "Physician's/Medical Officer's Statement of Patient's Capability to Manage Benefits" form (SSA Form 787; SSA, 2010). Instructions advise that form completion should take about 5 minutes, including time to read instructions and gather necessary facts. Instructions include a brief summary of who may need a payee, followed by two questions about the patient in question:

Some individuals age 18 and older who have mental or physical impairments are not capable of handling their funds or directing others how to handle them to meet their basic needs, so we select a representative payee to receive their payments. Examples of impairments which may cause incapability are senility, severe brain damage or chronic schizophrenia. However, even though a person may need some assistance with such things as bill paying, etc., does not necessarily mean he/she cannot make decisions concerning basic needs and is incapable of managing his/her own money.

1. Do you believe the patient is capable of managing or directing the management of benefits in his or her own best interest?
2. Do you expect the patient to be able to manage funds in the future (for example, the patient is temporarily unconscious)?

2.2.3. Clinician Assessment of Financial Incapability (CAFI)—Figure 1 illustrates the steps of instrument development.

Generation and scaling of candidate items: Forty-six unique items were generated to sample the four criteria of incapability identified by content experts in the comprehensive assessment. Items inquired about spending on substance use and gambling, impulsive spending, failure to pay bills, over-spending on nonessential items, poor management of funds, debt, worsened psychiatric symptoms, financial victimization, conflict, and putting oneself at risk of, or having sustained, harm. To determine which of two alternate measurement scales would better differentiate rates of behavior, items were measured on both a scale measuring the number of *days* of occurrence in the last six months, and one measuring number of *times* of occurrence in the last 6 months, with a “don’t know” option available for both scales. The “days” response option was scaled 0–4, where 0=Never, 1=1–7 days, 2=8–30 days, 3=31–90 days and 4= > 90 days. “Times” responses also were scaled 0–4 where 0=Never, 1=1–2 times, 2=3–4 times, 3=5–10 times and 4= >10 times.

To assess the likelihood of continued mismanagement of funds into the future, we included nine items that asked the clinician to broadly rate the beneficiaries’ financial decision-making in the *past* six months, and repeated the same nine items to inquire about expected decision-making in the *next* six months. Items probed issues of judgment to manage funds, specific impairments of judgment, misuse of funds, and risk of harm. Items were rated on a 9- point Likert scale anchored by 0: completely disagree and 8: completely agree.

Preliminary review of candidate items (Phase I): Clinicians completed the candidate items of the CAFI questionnaire and then provided feedback about the instrument in semi-structured interviews with research staff.

Pilot testing (Phase II): The pilot version of the CAFI included instructions for completion, with directions to use all available sources of information to answer questions. Instructions directed clinicians to answer the SSA Form 787 questions (embedded, with SSA directions, in the pilot instrument immediately before CAFI items) before proceeding to answer the CAFI items. Clinicians were paid \$25 for participating (except when employer restrictions limited payment to \$10).

2.3. Data analysis

2.3.1. Descriptive analyses—CAFI item response distributions were analyzed and compared across response scales to determine (1) which items to eliminate from further analysis due to limited response variability or high rates of missing data, and (2) which item

scaling produced more optimal distributions (e.g., resulted in lower rates of missing data, greater variability and normality in distributions).

2.3.2. Item dimensionality—Items retained after initial trimming were mapped to the four incapability criteria by content experts, specifying an a priori structure to the items. Items that did not correspond closely to any criteria were eliminated. To test the proposed structure empirically, we conducted exploratory factor analyses (EFA) for ordinal/categorical variables in MPlus (version 6; Muthén & Muthén, 1998–2010) and for the Likert-scaled variables in SPSS (version 19; IBM Corporation, 2010). Because sample size did not permit EFA of all items simultaneously, items conceptually associated with each criterion were tested in sequential EFAs. Items were trimmed from factors based on factor loadings $\leq .40$ and model fit indices. Then, to test the robustness of the factor solutions to violation of the assumption of independence (we modeled observations as independent because we could not conduct multilevel EFA with the small sample), we aggregated observations within raters by calculating the median score for each item within clinician, and re-estimated the models. Finally, subscale scores were calculated by summing the item scores within each subscale.

2.3.3. ROC analysis and accuracy of capability conclusions—CAFI subscales were entered individually into ROC analysis to determine cut scores that optimized sensitivity and specificity for each of the four incapability criteria. Participants' subscale scores were then submitted to the same algorithm applied in the comprehensive assessment, using cut scores to determine decisions for each criterion. For example, if a participant's subscale scores corresponding to criteria 1 and 2 exceeded the ROC-determined cut scores for those two subscales, respectively, and his subscale score corresponding to criterion 4 did *not* exceed the cut score for that subscale, that participant was determined to be incapable.

To compare classification accuracy across assessment methods, capability determinations derived by CAFI, SSA, and CAFI plus SSA methods were compared to determinations derived by the comprehensive assessment.

3. Results

3.1. Phase I

Six of the 46 candidate items were eliminated from the CAFI due to redundancy in wording.

Clinicians indicated in interviews that some of the terms used within items were unclear, and requested definitions. Hence, when the term “non-essentials” was used in an item, it was defined as any purchase that interfered with the ability to meet basic needs for food, shelter, clothing, and medical care. The terms “alcohol problems” and “drug problems” were subsequently defined as experiencing intoxication, withdrawal, or problems from use. Additionally, various formatting changes were made based on recommendations.

Additional clinician feedback provided insight into clinicians' challenges in determining capability. Two clinicians indicated they had not known patients for long enough to describe their behaviors over the previous six months as called for in the CAFI. Two reported difficulty estimating the frequency of behavior because of seeing patients infrequently. One clinician reported only moderate confidence with his answers because of doubt about the accuracy of his patient's self-report. Several clinicians reported they were not aware of specifics about bill paying, victimization, gambling, and other financial behavior because the information had never been discussed with the patient. A common theme was that clinicians knew what patients spontaneously offered about their financial situations, but few

other specifics. One clinician was unsure whether to rate items “never” or “don’t know” if the patient had never brought up the subject.

3.2. Phase II

3.2.1. Item response distributions and re-scaling—Although clinicians generally did not skip items, rates of “don’t know” responses were high, ranging from 3% – 57% across items (Table 1). Clinicians had difficulty answering questions about specific financial behaviors, especially those that did not have immediate serious consequences. These included questions about failure to pay bills, borrowing from others to meet expenses, and lending to others. Clinicians were more likely to know answers for items relating to lacking basic needs, losing housing, and using substances. For all items, a zero was imputed in place of “don’t know” responses to represent that “don’t know” indicated the respondent did not know of, and had no data to suggest, any event occurrence. This approach was consistent with SSA’s policy of presuming capability in the absence of information to the contrary.

Two items measuring loss and harm from gambling were removed because of restricted response variability. For those items, more than 90% of responses were zero.

Histograms revealed that most items had similar score distributions for both measurement scales (number of days and number of times of occurrence), and only a small number of items were better measured by one scale or the other. For many items there were low rates of responses at the highest level of both scales (indicating events happened 5–10 or more times, or on 31–90 or more days). To improve response distributions, we created a 3-point ordinal scale by combining the original scales as follows: 0=0: no or no known occurrence, 1=1: low rate/infrequent occurrence on at least one scale, 2–4=2: more than infrequent occurrence on at least one scale. Subsequent analyses were conducted using the re-scaled items.

3.2.2. CAFI item mapping and factor analysis—Thirty-five items were mapped to the four incapability criteria by content experts (Table 1). EFA results for ordinally-scaled variables largely supported the conceptual grouping of items (i.e., non-significant χ^2 test, factor loadings > .40; CFI > .90, RMSEA < .05) for criteria 1 and 2, but not for criterion 3, “substantial funds were spent that risked personal harm” (RMSEA = .234; CFI=.937). For that criterion, removing two items measuring problems with alcohol use ((1) “Had alcohol-related problems (*intoxication, withdrawal, problems from use*)” and (2) “Drank alcohol to intoxication (*enough to get a buzz*)”) would improve model fit, but experts agreed these items were consistent with the theoretical scope of the criterion and should be retained. In the fourth EFA, two factors were identified that differentiated the items mapped to the two dimensions of criterion 4 ((a) not meeting basic needs and (b) spending to cause harm). In total, two items (one each from criteria 1 and 3) were removed for weak factor loadings, and one item (from criterion 4a) was removed for statistical redundancy with another item. Ultimately, 32 of the 35 items were retained.

Repeating the EFA with aggregated data did not result in substantially different factor loadings, except for one item in criterion 1. The “gambling” item had a factor loading of .217, suggesting it should be dropped from the model. As expected with the smaller sample size (reduced due to aggregation), model fit indices indicated poorer fit to the data.

3.2.3. Capability determinations and classification accuracy—Using the comprehensive assessment as the gold standard for financial capability determinations, assessors concluded that 62 individuals (52%) were financially capable, and 57 were not capable (manuscript in preparation).

Applying the comprehensive assessment algorithm to the CAFI subscales, using subscale cut scores determined by ROC analysis (Table 2), 68 individuals (57%) were classified as capable and 51 were not capable. Of these, 87 (73%) capability determinations matched those from the comprehensive assessment method (Table 3). Of the errors in determination, 19/32 (59%) were false positive determinations of capability.

SSA criteria determined that 80 participants (67%) were financially capable and 39 were not capable. Whereas classification accuracy matched that for CAFI (87/119 cases were accurately classified), 25/32 (78%) errors were false positives. Combining CAFI and SSA criteria¹ increased classification accuracy only slightly, to 89/119 (75%) of cases with 13/30 (43%) false positive classifications.

4. Discussion

4.1. Comprehensive assessment

In this sample of beneficiaries with severe psychiatric impairments, all of whom were receiving intensive inpatient or day program treatment for mental illness and/or substance use at the time of enrollment *and were managing their own money*, a comprehensive review of data determined that 48% were financially incapable. This percentage substantially exceeds estimates reported in other studies, and likely reflects the severity of impairments among the study's target population. Review of the comprehensive assessments revealed self-reports of substantial funds spent on alcohol and drugs or lost to victimization, paralyzing debt, homelessness, foregone medication doses that exacerbated illnesses, and prolonged periods of hunger.

The comprehensive assessments used to establish true capability determinations involved lengthy reviews of records that are not practical or feasible for acute care settings.

4.2. Alternate methods

CAFI and SSA methods performed similarly as alternatives to the comprehensive assessment, correctly identifying approximately three-quarters of participants. However classification errors by the SSA method were disproportionately false positives. This result is consistent with previous studies showing a tendency to under-identify beneficiaries needing a representative payee. Errors in classification by the CAFI method were more balanced, with false positives accounting for slightly more than half of errors.

Whereas no measurement of psychological constructs can be expected to occur without error, test designers can often influence the direction of errors (i.e., the sensitivity vs. specificity of the test) by their selection of cut scores. In the measure of financial capability, the relative harm of misclassifying individuals in either direction is an important consideration. Mandated payee assignment has far-reaching consequences. Beneficiaries assigned a payee lose an important part of their autonomy, and may feel coerced by their payees (Appelbaum & Redlich, 2006; Elbogen et al., 2007; Rosen et al., 2005), leading to conflicts that may threaten clinical or personal relationships (Angell, 2007; Elbogen et al., 2007, 2008). On the other hand, misuse of funds can interfere with beneficiaries' ability to maintain housing and other basic needs (e.g., Claycomb et al., 2013; Rosen et al., 2002), and in extreme cases has resulted in malnutrition, homelessness, and premature death (Frank & Degan, 1997).

¹Assessments were combined as follows: Incapable IF (SSA determination=Not Capable OR (SSA determination=Capable AND CAFI Spending to Cause Harm>=threshold AND CAFI Future Misspending>=threshold)).

We propose that greater harm is likely to occur when an individual is incorrectly identified as capable by an instrument, and a representative payee is not recommended when one is needed. There are other protections in the system against over-zealous assignment of payees, permitting a client to appeal the decision to a clinician, SSA, or to the payee, if one is assigned. While our position favors using the CAFI over the SSA method, neither instrument's validity was fully supported, and further development is necessary.

In this study, high rates of “don’t know” responses to many of the CAFI items indicated that specifics about money management may not be routinely assessed or discussed between clinicians and patients, and highlighted the need to target information about patients that clinicians are more likely to know. Items scaled to assess the impact, rather than the frequency, of money mismanagement events may be more plausible for clinicians to answer. Additionally, more strongly emphasizing the option to use available sources of data (e.g., the patient himself and/or a medical chart) and removing the “don't know” option might ensure better response rates in future iterations.

4.3. Other potential uses for CAFI

The CAFI offers other advantages over the current SSA method. Operationalizing financial incapability as a collection of measurable events creates the opportunity to target specific aspects of money mismanagement in treatment planning, and to measure progress toward goals over time. The instrument also may be incorporated into routine psychosocial assessment batteries, and can serve as a prompt to initiate discussion about money management that patients might otherwise avoid.

4.4. Limitations and future research

The study's small sample size necessitated imposing un-tested assumptions about the data (i.e., the accuracy of clinicians' a priori sorting of items) and adapting large-sample analytical techniques in order to make analyses feasible. Thus, results of this study are preliminary, and tentative. Nevertheless, the results and potential utility of the CAFI suggest a promising alternative to current SSA methods of capability assessment. Plans are underway to test a revised version of the CAFI, informed by results of this study.

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Figure 1.
Flowchart illustrating development of the Clinician Assessment of Financial Incapability

CAFI item statistics.

Table 1

LEAD Criterion	Original Item	% DK	Resp dist (%)/ Mean (SD)			Factor Loading
			0	1	2	
Basic Needs Have Not Been Met	No money for rent, not enough money to make the full rent payment	25	64	12	25	.982
	Rent overdue because rent money spent on something else, stayed somewhere other than his/her own place because he had no money for rent, evicted	23	66	12	22	.968
	Failed to pay a bill resulting in conflict with significant others, legal problems, risk of eviction	53	73	8	19	.850
	Food problems – got free food from a soup kitchen, church or other place because could not afford to buy food	27	66	6	28	.781
	Had no utilities – lacked heat, water, or electricity	24	82	7	12	.757
	Had no stable address	8	74	5	21	.709
	Begged for money, or stole money	42	85	5	10	.603
	Borrowed money from other people to meet living expenses	47	55	3	42	.571
	Spent money for alcohol or drugs that was needed for other purposes	21	41	12	48	.570
	Clothing problems – disheveled, unclean clothes, wrong clothes for weather	16	60	17	23	.553
Funds Needed for Basic Needs Spent on Something Else	Funds needed by the client were given to someone else, loaned to someone else, or stolen by someone else	38	70	8	22	.402
	Spent money he/she could not afford to spend	27	35	19	46	.976
	Bought things he/she could not afford	39	54	13	33	.833
	Spent too much on non-essentials (any purchases that interfered with ability to meet basic needs of food, shelter, clothing, medical care)	27	45	15	40	.799
	Impulsively spent money/ check as soon as client got it	43	56	17	27	.722
	Lost more than a small amount gambling (betting, lottery tickets, on-line gambling, playing numbers)	36	95	2	3	.603
	Used an illicit drug	12	43	8	49	.930
	Used illicit drugs he/she bought	24	55	3	42	.918
	Had alcohol-related problems (intoxication, withdrawal, problems from use)	21	50	15	35	.903
	Drank alcohol to intoxication (enough to get a buzz)	27	46	12	42	.884
Substantial Funds Were Spent to Cause Harm	Had drug problems (intoxication, withdrawal, problems from use)	12	38	14	48	.848

LEAD Criterion	Original Item	% DK	Resp dist (%) / Mean (SD)			Factor Loading
			0	1	2	
Misspending (Not Meeting Basic Needs) Will Continue	Spent enough money on drugs or alcohol to impair functioning. (Examples of impairment caused by substance use include worsened psychiatric symptoms, medical worsening or risk, conflict with someone else, or putting someone else at risk of harm)	17	37	12	51	.842
	Substance use issues prevented rational financial decision-making	N/A	39	17	44	.824
	Client was worse when he/she got money or checks – examples of being worse are substance use, missed appointments, lost housing, being hospitalized	34	56	9	31	.794
	In a substance abuse treatment program or detoxification program	8	38	19	43	.583
	Substantial debt put the client at risk of harm (legal action, eviction, loss of utilities, physical harm)	N/A	56	20	24	.370
	The client will lack the judgment to manage his/her funds	N/A	3.1 (2.1)			.905
	The client will not understand the consequences of his/her spending decisions	N/A	2.5 (2.0)			.883
	The client will be unable to make financial decisions in his/her best interest	N/A	3.1 (2.1)			.882
	Mental impairment (intellectual ability, memory impairment, disorganized thinking) will preclude making necessary expenditures	N/A	2.6 (2.1)			.870
	Psychiatric issues will prevent rational financial decision-making	N/A	3.3 (2.0)			.867
Misspending (on Harmful Things) Will Continue	The client will be unable to rationally weigh pros and cons of spending decisions	N/A	3.1 (2.1)			.836
	Substantial debt will put the client at risk of harm (legal action, eviction, loss of utilities, physical harm)	N/A	2.9 (2.3)			.657
	The client will spend much of his/her income to fund a compulsion, habit, or addiction	N/A	3.2 (2.4)			.955
	Substance use issues will prevent rational financial decision-making	N/A	3.4 (2.4)			.883

Table 2

CAFI subscales.

Subscale	# Items	Mean (SD)	Cut Score	Sensitivity	Specificity
Basic Needs Not Met	10	5.5 (5.4)	4.5	.65	.80
Funds needed for Basic Needs spent on something else	5	3.5 (3.0)	3.5	.60	.70
Substantial Funds Spent to Cause Harm	9	8.6 (6.0)	11.5	.52	.82
Misspending (Not Meeting Basic Needs) Will Continue	6	3.1 (1.8)	3.0	.73	.68
Misspending (on Harmful Things) Will Continue	2	3.3 (2.3)	3.3	.67	.74

Table 3

Classification by assessment method (n=119).

Assessment Method	Capable	Not Capable	# Correctly Classified*	# Incorrect-Capable	# Incorrect-Not Capable
Comprehensive Assessment	62	57	N/A	N/A	N/A
SSA Criteria	80	39	87	25	7
CAFI	68	51	87	19	13
CAFI plus SSA	61	58	89	13	17

* Using comprehensive assessment determinations as the validating criterion