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**Use of the Child and Adolescent Needs and Strengths (CANS)
in Child Welfare in the United States**

Report prepared for the



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Background

Over the past several decades there has been growing interest in the use of common assessment strategies to inform decision-making in the child serving system. The reasons for the development and implementation of these strategies include support of case planning, decision support for placement and level of care, and monitoring the impact of interventions. As such, all of these strategies are generally understood within the broader framework of monitoring and managing outcomes. Child welfare organizations have been among the leaders in efforts to develop and implement these strategies. In child welfare the three primary outcome targets have been identified as safety, permanency and well-being. Safety has been managed using information about risk. Permanency has been managed using information regarding foster care stability and re-unification/adoption. The measurement and management of well-being has lagged behind these two constructs. However, in the past decade, an increasing number of child welfare jurisdictions have worked to measure wellbeing. The present report details the uses of the one of these strategies—the Child and Adolescent Needs and Strengths (CANS).

About the CANS

At the present time, the CANS is the most widely used common assessment strategy for monitoring wellbeing in the child serving system in North America. The CANS is a multi-purpose tool developed for children's services to support decision making, including level of care and service planning, to facilitate quality improvement initiatives, and to allow for the monitoring of outcomes of services. Versions of the CANS are currently used in 37 states in child welfare, mental health, juvenile justice, autism and other developmental challenges, and early intervention applications. A comprehensive, multi-system version exists as well.

The CANS was developed from a communication perspective so as to facilitate the linkage between the assessment process and the design of individualized service plans including the application of evidence-based practices. The CANS is easy to learn and is well liked by parents, providers and other partners in the services system because it is easy to understand and does not necessarily require scoring in order to be meaningful to an individual child and family. Coming from communication theory, the CANS is a communimetric measure. There are six key principles of this theory of measurement which functions more like a practice model than a traditional measure:

SIX KEY COMPONENTS OF A COMMUNIMETRIC TOOL

1. Items are selected based on relevance to planning.
2. Action levels for all items
3. Consider culture and development before establishing the action level
4. Agnostic as to etiology—descriptive, no cause and effect

5. About the child, not about the service. Rate needs when masked by interventions.
6. Specific ratings window (e.g. 30 days) can be over-ridden based on action levels

The way the CANS works is that each item suggests different pathways for service planning. There are four levels of each item with anchored definitions; however, these definitions are designed to translate into the following action levels (separate for needs and strengths):

For needs:

- | | |
|---|-----------------------------|
| 0 | No evidence |
| 1 | Watchful waiting/prevention |
| 2 | Action |
| 3 | Immediate/Intensive Action |

For strengths:

- | | |
|---|--|
| 0 | Centerpiece strength |
| 1 | Strength that you can use in planning |
| 2 | Strength has been identified-must be built |
| 3 | No strength identified |

Decision support applications include the development of specific algorithms for levels of care including treatment foster care, residential treatment, intensive community services, and traditional outpatient care. Algorithms can be localized for sensitivity to varying service delivery systems and cultures. The applications of CANS-based decision algorithms have documented dramatic impacts on service system. In Illinois, use of a simple decision model for residential treatment resulted in savings of approximately \$80 million per year in residential treatment in the late 1990's. In Philadelphia, their use of a decision model for Treatment Foster Care reduced lengths of stay dramatically and saved the city \$11 million in the first year of use.

In terms of quality improvement activities, a number of settings have utilized a fidelity model approach to look at service/treatment/action planning based on the CANS assessment. A rating of '2' or '3' on a CANS needs suggests that this area must be addressed in the plan. A rating of a '0' or '1' identifies a strength that can be used for strength-based planning and a '2' or '3' a strength that should be the focus on strength-building activities.

Finally, the CANS can be used to monitor outcomes. This can be accomplished in two ways. First, items that are initially rated a '2' or '3' are monitored over time to determine the percent of youth who move to a rating of '0' or '1' (resolved need, built strength). Or, dimension scores can be

generated by summing items within each of the dimensions (Problems, Risk Behaviors, Functioning, etc.). These scores can be compared over the course of treatment. CANS dimension scores have been shown to be valid outcome measures in residential treatment, intensive community treatment, foster care and treatment foster care, community mental health, and juvenile justice programs.

The CANS has demonstrated reliability and validity. With training, anyone with a bachelor's degree can learn to complete the tool reliably, although some applications require a higher degree. The average reliability of the CANS is 0.75 with vignettes, 0.84 with case records, and can be above 0.90 with live cases. The CANS is auditable and audit reliabilities demonstrate that the CANS is reliable at the item level. Validity is demonstrated with the CANS relationship to level of care decisions and other similar measures of symptoms, risk behaviors, and functioning.

The CANS is an open domain tool that is free for anyone to use. However, certification is required for ethical use and two years ago, the Praed Foundation decided to centralize all certification to help guarantee the integrity of the approach. With the growing use, problems had begun to be identified about inconsistent criteria for certification or even failure to require certification prior to use.

About Total Clinical Outcomes Management

The CANS is the only theoretically-driven approach to outcomes management currently in existence. The over-arching conceptual model is called Total Clinical Outcomes Management (TCOM). TCOM is built on the following three concepts:

- managing transformational offerings is fundamentally different than managing services
- while there is expertise in the system, it is not always in the room with the people we serve; therefore, you need to engineer collective wisdom into the work
- the work is complicated by the multiple perspectives that operate simultaneously with often competing agendas

Services involve managing how much time professionals spend with people. Transformational management is the process of managing the business of personal change. Many aspects of child welfare are intended to be transformations not services. Second, since services simply involve payment for time and space, then finding the least expensive people to actually spend time with our children and families is a logical extension of this business. As such, often the people who spend the most time and space with our children and families are actually the least paid, least experienced people in the workforce. So, although we have expertise, it is not always in the room with our children and families. Finally, human serving enterprises, including health care, are often complex because of the number of different people involved in the process of care. In complex systems participants always have different perspectives and often have competing responsibilities and objectives. Total Clinical Outcomes Management is a conceptual framework for managing complex system. Within this framework there is a philosophy, a strategy, and a set of tactics all designed to facilitate an effective and integrated approach to addressing the needs of people. So, the goal of TCOM is to engineer the management of the business of personal change in complex environment through the use of shared visioning approaches.

Philosophy: The TCOM approach is grounded in the concept that the various perspectives in a complex service system create conflicts. The tensions that results from these conflicts are best managed by keeping a focus on common objectives—a shared vision. In human service enterprises, the shared vision is the person (or people served). In health care, the shared vision is the patient; in the child serving system, it is the child and family, and so forth. By creating systems that all return to this shared vision, it is easier to create and manage effective and equitable systems.

Strategy: In order to accurately represent the shared vision, a structured assessment is created that directly informs service/intervention planning. This assessment tool is used to communicate the shared vision throughout the system. Since the individuals working directly with people are in the best position to already make their decisions based on the shared vision (the people they are serving), it is critical that the structured assessment is useful to them so that it is completed with reliability and validity.

Tactics: Figure 1 displays example TCOM tactics. This grid is organized by types of applications of information from the structured assessment in the rows to levels of the system in the columns. The idea is that one strategy can be used to perform a variety of activities at different levels of the system, from service planning at the individual level to resource management at the system level.

TCOM Grid of Tactics

	Family & Youth	Program	System
Decision Support	Care Planning Effective practices EBP's	Eligibility Step-down	Resource Management Right-sizing
Outcome Monitoring	Service Transitions & Celebrations	Evaluation	Provider Profiles/ Performance Contracting
Quality Improvement	Case Management Integrated Care Supervision	CQI/QA Accreditation Program Redesign	Transformation Business Model Design

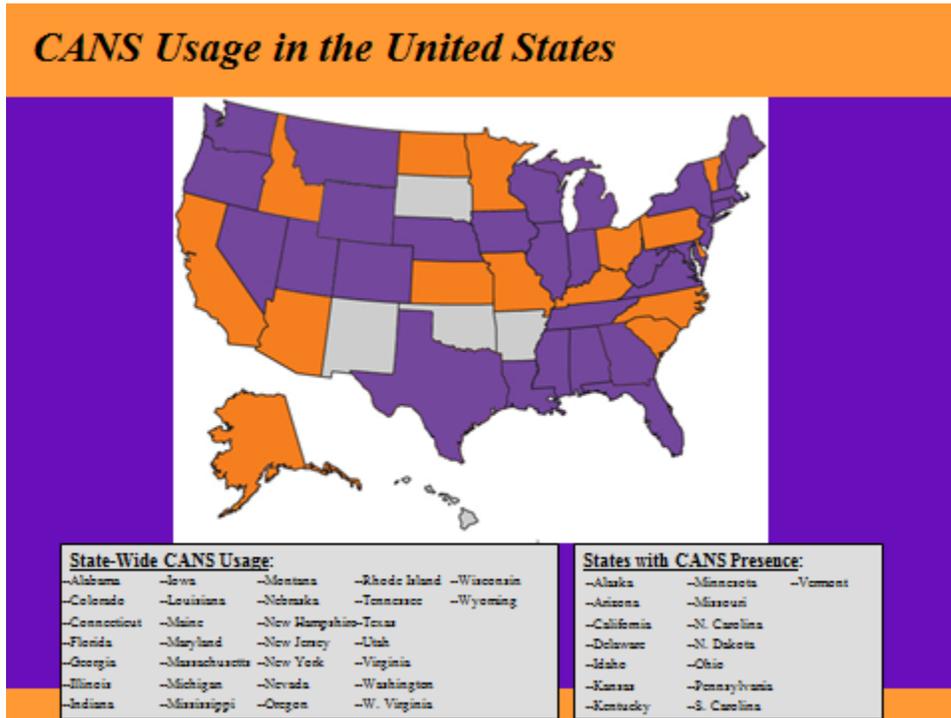
There are applications in all cells of the TCOM grid of activities across the US in child welfare implementations. Perhaps the most interesting, however, are the program level decision support strategies. These are efforts to use the CANS to guide decisions regarding placement, intensity of care, program and treatment referrals. In addition, several states use these strategies to set case rates for the management of resources within the child welfare system.

Traditional measures create decision support applications by generating scores and then creating cut-offs for those scores. For example, the CAFAS makes different recommendations for scores above 80 and the again above 120. From a communimetrics, perspective cut-offs are problematic. For example, if you had nine behavioral health items on a version, you could get a score of 9 based on nine '1' ratings or based on three ratings of '3'. A child with nine needs to keep an eye on (i.e. watchful waiting/prevention) is substantially different than a child with three dangerous or disabling needs. As such, the CANS uses algorithms to guide decision support. Several examples are provided in the Appendix. These algorithms are complexity indicators with high levels of care or intensity of service tied to greater levels of complexity (i.e., more needs to address across multiple dimensions). Given the action level structure of the CANS, it is possible to then put these mathematical models into common language promoting a clear understanding of the factors that result in escalating levels of care. Wisconsin's algorithm is included in the Appendix as it is particularly interesting because in their model the sought to separate placement from intensity of care so that a child would not necessarily have to move because of escalating needs/complexity.

There is a growing body of published research that has demonstrated that use of these decision models result in improved outcomes by better matching children to placements and level of intensity of care (e.g. Brian Chor at Northwestern University, Richard Epstein at Vanderbilt University). However, it is important to note that to dates these models have not integrated strengths into the algorithms. That integration is an area for future enhancement because it does appear that the presence of strengths (e.g. family, community, educational) moderate the level of needs in terms of moderating the impact of needs. In other words it is possible to serve higher need children in community in the presence of these strengths. The modeling is complicated by the common funding mechanisms that use a health insurance model that has historically focused on the presence or absence of needs for funding eligibility.

REVIEW OF IMPLEMENTATIONS IN THE UNITED STATES

The use of the CANS is rapidly growing across the United States. The following is a map of CANS usage across the US that was presented at the 9th annual CANS conference in San Francisco last November. While additional states have begun to sign on since this conference, this map gives a fairly clear sense of where the statewide implementations exist.



Not all states use the CANS in child welfare, however. Some use it in mental health, some use it in juvenile justice and a rapidly growing number use it cross systems. The following is a review of child welfare applications by state.

Alabama

Alabama has used the CANS (although they call it the MAT since there is acronym overlaps in the state) for a number of years. The primary purpose of this application has been to serve as a decision support for placement in and step down from Treatment Foster Care . Thus the CANS is used as both an eligibility and step down tool to support decisions around the best use of Treatment Foster care resources. An interesting innovation in this state has been to say that step down is indicated after two consecutive assessments where the child is below the original eligibility level of their algorithm. Trained and certified case workers complete the MAT to guide these decisions.

The mental health system in Alabama also uses a somewhat different version of the CANS which creates opportunities for cross systems communication and recognizing and addressing sectoral differences in perspectives in identifying needs and strengths.

Arkansas

Arkansas is in the very early days of their planned implementation. They have gone through a process of designing their version of the CANS to be used in child welfare. Initially the plan is to use the CANS as a part of their Title IV-E waiver project in six counties and then expand the use to state wide over the next year. They will have their implementation plan and design of the Arkansas version of the CANS completed by the end of this fiscal year.

The current plan calls for case workers to be trained and certified in the use of the Arkansas version of the CANS. The state will utilize the supervisor and trainer approach developed in Indiana and Wisconsin. All children in custody will be assessed initially and on an ongoing basis using the CANS. Decision models will be developed to support level of care and placement decisions.

California

There is no state-wide implementation of the CANS in California although there are discussions of a possible implementation as a part of the settlement of the Katie A lawsuit. Los Angeles County uses the CANS as a part of their Katie A settlement process. LA County has two basic CANS applications. In the Resources Utilization teams they use the CANS to support level of care/placement decision-making. These CANS are completed in a team-decision making model and the county has developed an algorithm for level of care/placement. This algorithm can be found in the Appendix of this report.

A number of other counties have implementations of the CANS either in child welfare specifically or more commonly in mental health as it interfaces with child welfare. Most counties use the Comprehensive version from Virginia. The following is a list of counties in California that have CANS implementations that exist in child welfare or overlap with children in care:

Contra Costa	Sacramento
Fresno	San Diego
Humboldt	San Francisco
Kings	Santa Clara
Madera	Santa Cruz
Marin	Shasta
Medocino	Siskiyou
Monterey	Sonoma
Placer	Stanislaus
San Bernadino	Yolo

The CANS is also widely used in school in California since the state paced regulations for their SELPA's to provide mental health treatment in schools. Once schools were funded to provide in school

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treatment, the interest in using tools to support identification of children with needs increased dramatically.

Three large statewide providers for child welfare using the CANS across their agencies. Apiranet, EMQ Family First, and Victor all have adopted the CANS and TCOM as management strategies within their agencies. Most use it as a treatment planning, supervision and outcome monitoring tool with some program evaluation uses.

Florida

Florida was the second state-wide implementation in child welfare following Illinois. All children who becomes wards of the state have a CANS completed by an independent assessor as a part of their initial assessment process. Unfortunately this implementation is not well supported by the state so it is very hard to know whether the CANS are done by actively certified individuals and whether they are used for any purpose relative to the child's care. There is substantial reason to believe that while the CANS is generally completed on every child in state custody, the use of the information is variable in its impact on case planning and decision making. Several geographically-based lead agencies support more effective uses of the CANS (e.g. Seminole and Orange Counties). In these counties, the CANS approaches a more appropriate use.

Illinois

Illinois had the original implementation of the CANS, although at the time it was called the Childhood Severity of Psychiatric Illness (CSPI). The CSPI was originally used for a community re-investment project in which youth were moved from residential treatment to living in the community freeing up dollars to re-invest in intensive community services. The approach worked quite well and resulted in facilitating a one-third reduction in the number of youth placed in residential treatment. The millions of dollars saved were successfully re-invested creating significant new capacity to more effectively serve wards of the state in their communities (Lyons, et al, 1998).

The CANS was then used within these intensive community programs as a treatment planning, quality improvement, and outcome monitoring tool. In this context it has been used for a number of specific projects. For example, the standard use of the CANS across the system allow it to be used to facilitate the referral to and testing of three trauma informed evidence-based practices (Weiner, et al 2008).

Currently the CANS is used as the output of the Integrated Assessment process which occurs in the first 30 days of custody. A Master's prepared psychologist (or higher degreed) completed the IA by initiating an individualized assessment process depending on the presenting needs of the child. At the end of this process a CANS is generated that is passed to the child welfare worker as a planning and monitoring tool. In addition, the CANS is used as a decision support tool when a placement disruption occurs. Using a child family team format, the CANS is a component of the decision process about placements. A decision model has been developed to support placement decision making. This model

has been validated a recommending placements that result in better child level outcomes (Chor, et al, 2012).

The Illinois version of the CANS was the first trauma-informed version of this approach. Cassandra Kisiel, Ph.D. and a team of traumatologists associated with the National Child Traumatic Stress Network (NCTSN) had created a trauma-informed version of the CANS. After a study revealed that the Adjustment to Trauma item was one of the best predictors of placement disruption for children in state custody, Illinois DCFS launched a trauma initiative under then director, Bryan Samuels. The first statewide implementation of a trauma-informed version of the CANS was then accomplished in Illinois. Northwestern University has a NCTSN funded site for further development of this approach along with supports for training and implementation of trauma-informed care guided by the CANS. Evidence-based practices for the treatment of traumatic stress have been implemented guided through micro-algorithms using the CANS.

Currently, the Mental Health Services and Policy Program at Northwestern University manages the substantial CANS database and generates both ongoing and ad hoc reports to support policy and planning activities for the state. Copies of these example reports are available upon request.

Indiana

Indiana has a cross systems application of the CANS in both child welfare and mental health, with some use in Juvenile Justice. All sectors use the same version. The child welfare system in Indiana uses the CANS for all children in custody of the state. They use the CANS in concert with their child-family teaming process at the beginning of care and throughout the duration of the child's time in care. They have developed and implemented a decision support model for placement and intensity of care and use that to support these decisions at the case work level. All case workers are trained and certified on the CANS using a graded recertification process--- 0.70 to 0.75 results in a six month certification, 0.76 to 0.80 one year and certification reliabilities of 0.80 or higher result in a two year certification period. Indiana was the first state to implement this type of recertification process to incentivize the highest levels of reliability on the approach.

The child welfare implementation in Indiana was the first one that started with the training of all supervisors as trainers. Supervisors then trained their direct report caseworker staff in the approach. This process worked quite well to encourage effective learning of the approach and full use in the implementation. Ensuring that the supervisor level is trained, certified, and skilled in the approach is now recognized as a fundamental for effective implementation. Currently, Indiana University supports the state's use of the CANS. Ad hoc reports are generated both internally and externally to support policy and planning.

Maryland

Maryland is one of the states in which the CANS is completed by case workers for all children in the custody of the state. All case workers are trained and certified in the CANS and the CANS is

administered to all children in state custody at the beginning and updated throughout the course of the child's time in state custody. The CANS is used for individual case planning and supports placement decisions. The University of Maryland supports the state's use of the CANS from both a training and analytic perspective. The university partners analyze and report CANS data back to the state on both a routine and ad hoc basis to support planning and policy.

Massachusetts

In Massachusetts the mental health system uses the CANS as a component of its intensive community interventions. In child welfare, they have used the CANS to manage decisions about placement in residential treatment. Because of union issues, supervisors complete the CANS after speaking with case workers.

New Jersey

New Jersey was the third state to implement the CANS in a statewide system when they began using the Comprehensive version (called the Strengths and Needs Assessment among their various versions) within their intensive community intervention initiative originally called the Partnership for Children about 13 years ago. This initiative which is now in the Division of Children's Behavioral Health was a cross-systems initiative to integrated intensive interventions of children and families with child welfare, juvenile justice and/or mental health needs. Using a wraparound philosophy the state funded geographically organized Care Management Organizations (CMOs) that provided assessment (using the CANS) and service brokerage to optimally meet the needs of children and families in the community. The CMOs also will follow a youth during a residential placement to ensure continuity of care and facilitate more rapid return to the community. The CANS is used as a case planning tool, a decision support tool and, to a lesser extent, as an outcome monitoring tool. New Jersey hires a Administrative Services Only (ASO) to collect CANS information. They generate reports on a regular and ad hoc basis to support planning and policy. Recently, New Jersey completed a planned revision of their initial CANS and will be rolling out this second version within the next year.

New York

New York has developed a special version of the CANS that is a blended version for both mental health and child welfare. The child welfare uses the CANS it is Bridges to Health (B2H) program that has a wraparound philosophy for intensive in-home care. The CANS is also used for residential treatment placements throughout the state. New York City's Administration for Children's Services (ACS) is planning to roll out the full use of the CANS for all case workers starting next fiscal year. The intention is to follow this implementation with a statewide implementation of the CANS for all children in custody of the state within the next several years.

Many county-based Single Points of Access (SPOA) use the CANS as their decision support tool. Some counties have integrated their SPOAs with the child welfare system while others have not. Most

of the counties in which child welfare has a very active role in the SPOAs are in the western part of the state.

Oregon

Oregon currently uses a short version of the CANS to manage decision making about eligibility into Treatment Foster Care. They have separate versions for pre-school (0 to 5 years) and school age (5 and older). There is a plan to expand the use of the approach and use the FAST with 'prevention/differential response' programs.

Pennsylvania

Pennsylvania is in the midst of a five county implementation of both the FAST and the CANS as a part of their IV-E Waiver implementation. They use the FAST for prevention cases and then the CANS if either a child is taken into state care or the child is rated with an actionable need on mental health, substance use, or cognitive/developmental indicator items on the FAST. The five counties in the demonstration are Allegheny, Dauphin, Lakawana, Philadelphia and Vernango. This implementation is less than one year old but more than 1200 child welfare professional in the state have been trained and certified.

Several other counties have CANS implementations including Chester, Crawford, Franklin, and Westmoreland. In these implementations the CANS is used primarily as a case planning and outcome monitoring tool.

Rhode Island

The Rhode Island implementation is in the system of care sites. As such, the only overlap with the child welfare system is for any children served in the system of care who are also child welfare involved.

Tennessee

Tennessee was the first state to have case workers complete the CANS entirely themselves. This approach was controversial at the time because some people argued that case workers did not have the clinical or educational background that would allow them to do so reliably. This implementation is really the first one that began to realize that simply the process of training on and completing the CANS during ones regular work was both an educational and an engineering activity. Case workers actually would supported in learning out to do their jobs more effectively by learning and doing the approach. In Tennessee was is called learning how to 'work smarter, rather than harder'. Some very early successes were well advertised facilitating one of the more efficient implementations of the approach.

The model used in Tennessee required the Child Protective Services Worker to start the CANS during the investigation phase and turn over whatever had been completed at the time of a decision to take custody of the child. The child welfare worker would then complete the CANS in time to inform

each child-family team meeting during the first week or two of custody. This goal is accomplished about 85% of the time. The CANS is monitored and updated over time during the course of the child's involvement with the state. A level of care decision model is used that has four levels.

Another novel aspect of the approach is that the state funded Vanderbilt University to form a team of CANS consultants to be seconded to child welfare offices around the state to coach case workers in the completion of the CANS. This model worked quite well as little coaching is needed by very skilled case workers but others took some time to learn the approach. Having a highly trained coach was a key strategy for the skilled building/engineering approach as it was conceptualized in this implementation.

Recently, as a part of their Title IV-E Waiver project, Tennessee decided to fully implement the family version of this approach—the FAST—for family in which no child has been taken into custody. These prevention cases are family based and thus using a family-based version of the approach makes the most sense for these types of interventions.

Vanderbilt University housing a Center of Excellence that supports training, certification in the CANS (and FAST) and provides both routine and ad hoc reporting to the state using CANS data. The CANS roll out in Tennessee was novel in that Vanderbilt developed CANS Coaches that were essentially seconded to child welfare offices to help case workers learn and complete their CANS. Initially these coaches support the training and certification but they would then work individually with case workers, particularly those who needed more assistance to master the approach. In some early cases, the coach would complete the CANS for the worker while the worker shadowed them.

Texas

Texas does not have a statewide implementation of the CANS in the child welfare system, although the mental health system implemented this approach across the state in 2013. Several counties, however, have begun to use the CANS (e.g. Harris County) and there have been discussions of a state-wide approach in child welfare. Given the use of the CANS (and the ANSA) in the public mental health system, many children (and parents) with child welfare involvement are already being assessed with this approach so there have been efforts to begin to realize the potential of optimizing communication and collaboration between the child welfare system and the mental health system.

Utah

Utah has been using the CANS in its child welfare system for several years but because of the culture of the state, it often finds itself responsible for very large family cohorts of children. Individual CANS on all of these children did not always make sense as they moved to more of a 'family welfare' model away from a traditional 'child welfare' approach. Given this circumstance, Utah is the first state to have integrated the FAST and the CANS into a single approach which they call the UFACET (see appendix). They have been working with this approach for the past year and use it for case planning and intensity of care decisions.

Virginia

Virginia currently uses the CANS in a cross-system program called the Community Services Arrangement (CSA), although there are discussions regarding expanded use in both child welfare and mental health. Currently, the CANS is used as a referral, treatment planning, and outcome monitoring tool within the CSA which is an intensive community program with a wraparound philosophy. Cross systems teams use the CANS to create a shared vision and common language regarding working with a specific youth. The state has begun to use the CANS data to guide planning and policy.

Washington

Washington State's child welfare implementation is just rolling out starting in March, 2014. They are using a brief screen version and then a version called the CANS-F which is the Family version of the approach (their name for their version of the FAST). They have 58 certified trainers in the state and plan to have relevant providers trained by the start of next fiscal year. They are using the CANS-F to replace the NCFAS which is currently used in their system without success. Their prevention program (FAR) will be using a screening version of the CANS-F and providers across most of their evidence-based programs (Triple-P, etc.) will be using a longer version of the tool to communicate with social workers (case workers for the state) and monitor outcomes.

Simultaneously, the mental health system in Washington is moving to the CANS and a statewide approach to TCOM. They are using a version similar to the Comprehensive version but also have a shorter screen version for eligibility decisions into wraparound care.

West Virginia

West Virginia has been using the CANS in a limited fashion in child welfare for a number of years but it about to expand its use throughout the system. Currently, the CANS is used with high need cases. The plan is for all children in the custody of the state to have a CANS completed to support case planning and effective decision making.

Wisconsin

Wisconsin is among the national leaders in their CANS implementation. The CANS is currently completed on all children in custody beginning in the first 30 days of custody and routinely monitored over the course of their involvement as a ward of the state. They have applications in all of the grids of the TCOM grid as described above. Wisconsin's child welfare system is the first to establish a formal rate setting structure based on the CANS.

All case workers are trained and certified in the use of the CANS. The version selected is based on the trauma-informed version developed in Illinois; however, the Wisconsin version has an enhanced section on culture that allows for a more in-depth identification and understanding of cultural needs as they might influence good case work.

Multi-State/National Agencies

In addition to the statewide implementations in child welfare described above, there are a number of agencies that work across states that use the CANS in their work. Casey Family Programs has developed a version of the CANS for each of their offices. Mentor uses the CANS-Comprehensive Trauma version nationally. Both the Bair Foundation and the National Youth Advocate Program use the CANS-Comprehensive across its sites. Choices, Inc. uses the CANS in its care management activities in each of its implementations.

Reported Challenges

The most commonly reported problem with the use of the CANS across all implementations is the challenge of getting professionals to view their documentation as part of their work rather than as a reporting out paperwork activity. The implementations that have successfully helped individuals completing the CANS understand its value in the performance of their work have much more successful implementations than those for which it is paperwork. The key component to this success appears to be ongoing support and attention to its full use. Key to creating that support is the use in supervision. So states like Indiana and Wisconsin which trained their supervisors to be trainers have superior implementations compared to states that provide less support (e.g. Illinois' initial implementation with case workers).

When CANS scores are used to make decisions that involve the allocation of resources, there is always concern expressed by parties at risk. In other words, if people get paid differently based on CANS scores, then those CANS scores matter in a different way to involved parties than when scores have no financial implications. It appears that the best strategy for balancing this issue involved two simultaneous activities:

1. Consensus. Making sure the CANS is completed as a shared visioning activity rather than the opinion of one person.
2. Transparency. Ensuring that in circumstances when the CANS is used to support placement, level of care, or intensity of intervention decisions that it is also used for other work as well (i.e. creating the permanency plan).

In applications where the CANS is completed by both mental health and child welfare professionals without attention to shared visioning, it is the consistent finding that mental health professionals describe children as higher need than child welfare professionals. The CANS doesn't cause that phenomenon—it merely explicates it. There are several reasons for this difference to occur. First, mental health professionals are trained to detect needs. That is their business. In fact, they are only paid if they successfully do detect needs. Therefore, clear professional and financial incentives encourage the detection of things requiring intervention. Second, in child welfare, the detection of a need almost invariably requires more work by the professional. So the short term incentive in child welfare is not to detect needs because otherwise something else will have to be done. Of course, what

many child welfare professionals recognize over time is failure to detect needs actually results in more work later (e.g. failed placements) but that's not an obvious recognition in the middle of a busy day.

Similar to the above challenge, the second major challenge is when the CANS is seen as 'just one more thing' that is piled onto the work of the caseworker and/or supervisor. This dynamic can set up a number of problems including case workers trying to 'out wait' the implementation (i.e. it will go away if we ignore it) or supervisors defending their workers by sabotaging the intervention, among other problems. The best implementations make it clear that the CANS is replacing other documentation not simply adding documentation burden.

Reported Advantages

Many advantages have been reported to the use of the CANS at the child, program and system levels consistent with the vision of TCOM. Among these, the primary advantages reported at the individual level have been

1. Shared vision approach helps shift from the investigative aspects of Protective Services to the Transformational focus of child welfare. Engaging youth and families in actively collaborating on the assessment process is helpful to starting personal change. The appropriate use of the CANS is an engagement strategy.
2. Having an organized way of communication about children and families facilitates (professionalizes) case worker communications with other partners, in particular, the courts and mental health professionals.
3. Creates a model that informs effective case planning and linking children and family needs to specific strategies and placements.

At the program level, among the advantages reported, the following are primary

1. Provides supervisors with a way for their case workers to organize themselves so that supervision is more targeted and efficient.
2. Reveals training needs and opportunities for practice development
3. Allows the monitoring of effectiveness of interventions
4. Improves cross communication both simultaneous and consecutive (i.e. at the same time for teaming and overtime to support transitions)

At the system level, the following advantages have been reported among others

1. Significant savings for re-investment from better management of expensive interventions
2. Improved resource mapping for system right-sizing.
3. Re-structuring payment and rate setting systems to better match children and families and encourage improvement.