Maryland CANS-F

Implementation and Initial Findings: July-December 2015

This report was developed by the Institute for Innovation and Implementation at the University of Maryland School of Social Work in support of Maryland's IV-E Waiver Demonstration Project. The Institute provides training and technical assistance on the CANS-F and is also contracted as the independent evaluator for the IV-E Waiver Demonstration Project.

Maryland Child and Adolescent Needs and Strengths (CANS-F)

Overview

This report provides information about Maryland's initial training and implementation of the CANS-F from July 1- December 31, 2016. In addition to details about implementation, the report provides preliminary descriptive findings about the most prevalent needs and strengths among families, youth, and caregivers.

Introduction

The Child and Adolescent Needs and Strengths – Family Version for In-Home Services (CANS-F) assessment is intended to support caseworkers in a consensus based approach to assessment and planning with families and youth. The tool can assist with family and youth engagement, accurate identification of a family's needs and strengths and the measurement of change in functioning throughout the life of a case. The CANS-F assessment captures information about family functioning, individual caregiver's needs and strengths, trauma exposure and youth needs and strengths in the areas of mental health, risk and safety, and overall functioning[1].

Implementation of CANS-F in Maryland

Exploration Stage/Early Installation:

Prior to the Statewide Implementation of CANS-F by July 1, 2015, Maryland piloted CANS-F in 3 jurisdictions (Anne Arundel, Frederick and Talbot counties). For the pilot, Maryland used a Macro-enhanced Microsoft Word version of the assessment.

Between April 28, 2015 and November 20, 2015, Maryland provided 28 separate trainings in 17 different jurisdictions. The trainings were targeted to in-home service workers within Maryland's 24 local jurisdictions. The training sessions were scheduled for a day and a half. As of December 31, 2015, of the identified 654 in-service staff, 549 (84%) of staff across Maryland was trained on using CANS-F.

After training, staff have the option to be certified through a national program to demonstrate rater reliability as a CANS-F assessor. At this time, certification is not required by SSA. Of those trained, 226 have gone on to the complete the online test to earn their CANS-F certification. The table (Table 1.) below highlights the number of staff trained, and the number (percentage) of staff that have completed the CANS-F certification.

[1] More information about the CANS-F Assessment can be found on Institute website (https://theinstitute.umaryland.edu/topics/sat/cans.cfm) or by contacting Neil Mallon (nmallon@ssw.umaryland.edu) or David Chen (dchen@ssw.umaryland.edu).

Table 1. Staff Trained and Certified by Jurisdiction

County	# of Staff Trained	# (%) of Staff Certified	
Allegany County	12	10	83%
Anne Arundel County	49	26	53%
Baltimore City	106	9	8%
Baltimore County	37	2	5%
Calvert County	12	9	75%
Caroline County	15	8	53%
Carroll County	15	2	13%
Cecil County	23	10	43%
Charles County	21	2	10%
Dorchester County	9	0	0%
Frederick County	23	19	83%
Garrett County	6	3	50%
Harford County	12	8	67%
Howard County	9	4	44%
Kent County	2	0	0%
Montgomery County	41	8	20%
Prince George's County	26	21	81%
Queen Anne's County	6	3	50%
Somerset County	11	8	73%
St. Mary's County	20	3	15%
Talbot County	12	6	50%
Washington County	46	43	93%
Wicomico County	24	15	63%
Worcester County	12	7	58%
TOTAL	**549**	**226**	**41%**

Initial Implementation

To support implementation efforts, the CANS-F Implementation Team will provide ongoing technical assistance and training opportunities to local jurisdictions. The table below (Table 2.) highlights the technical assistance/trainings available to staff to support CANS-F implementation across Maryland:

Table 2. Technical Assistance/Training Activities Available to Support CANS-F Implementation

Technical Assistance/Training Activity	Description
CANS Re-Certification Support	Staff experiencing difficulty in passing the re-certification test, Test Support can schedule technical assistance via tele-conference with the staff person.

CANS Brown Bag Meetings	A one-hour, facilitated open discussion intended for staff at all levels (workers, supervisors, and administrators. Topics of discussion to include: • Identifying barriers to implementation • Exploring assessment strategies • Reviewing county level data with staff
CANS in Practice Training	A foundational skills training series focused on connecting the assessment to practice. The training series also helps participants learn skills to support a collaborative assessment process with youth and families, as well as show staff how to connect the CANS-F assessment with their service/treatment planning process. The training sessions are typically 1-3 hours.
CANS Supervisor Training	Training sessions designed to assist supervisors integrate the CANS into supervision, to improve the assessment and planning skills of staff and ensure CANS-F assessments accurately reflect/communicate the needs of the family. The training sessions are typically 1-3 hours.
Intro to CANS for Quality Service Review (QSR) Staff Training	An introduction to CANS Training will be available to QSR staff to provide an overview of the CANS-F instrument, assessment principles, scoring guidelines and item definitions. This training will support the integration of the CANS assessment as a part of the QSR case review process.

Full Implementation

On July 1, 2015, Maryland implemented CANS-F statewide with the completion of the build in MD CHESSIE, Maryland's SACWIS system. However, one jurisdiction, Baltimore City delayed their implementation until January 1, 2016, to align their revised Standard of Practice (SOP) for In-Home Services with the roll out of CANS. The revised SOP was finalized in December 2015. Four additional CANS-F trainings were scheduled between January and February 2016 for 94 additional Baltimore City In-Home Services staff who had not attended one of the previous trainings in 2015. The last CANS-F training is scheduled for Baltimore City on February 24, 2016.

With the full implementation of CANS-F, the CANS Implementation team will monitor the utilization of CANS-F using the same process developed for Maryland CANS tracking the following:

- Compliance with CANS-F Completion according to Policy
- Families in need of an assessment
- Summaries of identified strengths and needs
- Summaries of change in CANS-F Needs and Strengths
- Case intensity reports

Data Results

Data Included in this Report

This report is based on CANS-F assessments completed with families with an open in-home service case in the MD CHESSIE System between July 1, 2015 and December 31, 2015 (SFY16 Q1/2). This report is organized into the following sections:

I. CANS-F Completion and Compliance by County
II. Percentage of Actionable Needs and Strengths for:
    a. Families,
    b. Caregivers and
    c. Youth
III. Trauma Experiences

Completion

The total number of families, caregivers, and youth with a CANS-F assessment completed between July 1, 2015 through December 31, 2015 are provided in Table 3.

As outlined in policy #SSA-CW #16-01, the CANS-F Assessment is required for families receiving In Home Family Services (IHFS), Inter-agency Family Preservation Services (IFPS), Services to Families with Children – Intake (SFC-I) and Risk of Harm (ROH). Depending upon the program assignment, the timeframes for completion vary.

Between July 1st - December 31st, 2,152 families completed at least one CANS-F assessment. Given that multiple caregivers and children can be assessed, there were a total of 3,030 caregivers and 4,619 youth.

Table 3. Number of Families with a CANS-F Assessment (July 1 – December 31, 2015)

County	Number of Families with at least one CANS-F Assessment	Number of Caregivers with at least one CANS-F Assessment	Number of Youth with at least one CANS-F Assessment
Allegany	95	128	198
Anne Arundel	268	443	574
Baltimore City	15	18	24
Baltimore County	298	466	647
Calvert	41	60	86
Caroline	21	35	50
Carroll	107	171	214

Cecil	44	52	82
Charles	103	137	258
Dorchester	30	39	79
Frederick	170	240	369
Garrett	23	29	47
Harford	12	16	32
Howard	76	101	172
Kent	16	21	39
Montgomery	50	63	95
Prince George's	352	407	740
Queen Anne's	34	56	65
Somerset	3	4	6
St. Mary's	49	60	104
Talbot	31	42	71
Washington	149	215	301
Wicomico	66	79	146
Worcester	99	148	220
Grand Total	**2,152**	**3,030**	**4,619**

Compliance

Compliance measures how many in-home families served between July 1, 2015 and December 31, 2015 who were required to have at least one CANS-F assessment had been assessed with the CANS-F. The compliance data by county in Table 4 reflects different numbers than Table 3 because compliance is based on who was required to have a CANS-F, as opposed to who actually completed a CANS-F[2].

For example, families whose cases opened in December were not included in the compliance numbers

[2] Compliance = Number of Families Required to Complete a CANS-F (n= 1,461)/
Total Families who should have a CANS-F during Reporting Period (n= 2,270)

(whether or not a CANS-F had been completed) because the family was not yet served for a full month, the timeline for a required CANS-F. Other cases were excluded from compliance monitoring because they did not conform to similar timeframe requirements[3].

County compliance is provided in Table 4. This data represents the number of completed CANS-F as compared to the number of CANS-F that were required during the reporting period[4].

Table 4. Compliance (July 1 – December 31, 2015)

County	Number of Families that Completed a Required CANS-F	Total Families who should have a CANS-F during the Reporting Period	Compliance Percentage
Allegany	72	107	67%
Anne Arundel	198	240	83%
Baltimore County	231	351	66%
Calvert	28	42	67%
Caroline	19	36	53%
Carroll	68	98	69%
Cecil	13	55	24%
Charles	73	92	79%
Dorchester	22	57	39%
Frederick	118	145	81%
Garrett	14	25	56%
Harford	9	81	11%
Howard	59	72	82%
Kent	13	14	93%
Montgomery	33	129	26%

[3] CANS-F requirements differ according to family service types: Services to Families with Children – Intake (SFC-I), Inter-agency Family Preservation Services (IFPS), or Consolidated In-Home Family Services (IHFS). SFC-I cases are required to have an initial CANS-F within 30 days of acceptance. IFPS cases require an initial CANS-F within 30 days of acceptance and every 90 days thereafter. IHFS cases require an initial CANS-F within 45 days of acceptance and every 90 days thereafter.

[4] Baltimore City was not included for compliance, as implementation was delayed until January 1, 2016.

Prince Georges	239	287	83%
Queen Annes	23	27	85%
Somerset	5	34	15%
St. Marys	39	112	35%
Talbot	20	26	77%
Washington	58	80	73%
Wicomico	52	89	58%
Worcester	55	71	77%
Grand Total	**1461**	**2270**	64%

II. Prevalence of Needs

Descriptive findings are reported for the most recent CANS-F assessment completed (regardless of whether they were required to have a CANS-F) by the family (Figures 1-6), caregiver (Figures 7 & 8), and youth (Figures 9-13, figure 12 based on valid responses and 13 based on actionable responses). These figures reflect the prevalence of needs and strengths identified on CANS-F completed for families between July 1, 2015 and December 31, 2015.[5]

Figure 1 illustrates the percentage of "Actionable Needs" items (i.e. items rated as a 2 [ACT to address need] or 3 [ACT immediately, intensely]) across all CANS-F domains. As illustrated in Figure 1, 43.68% (n = 940) of CANS-F assessments did not identify any family, caregiver, or youth items as actionable. This suggests that some additional training and technical assistance may be helpful to ensure workers are recording the needs that brought a family to the attention of child welfare in the CANS-F assessment. Building rapport with families to fully assess their needs may be a challenge within the CANS-F completion timelines. Further exploration of the needs and/or reasons for involvement with the child welfare system is warranted for these cases.

[5] The frequencies reported are based upon the most recent assessment completed by the family, which could occur during any time frame (i.e., initial, 6 months, change in family circumstances, or end of service).

Figure 1. Percentage of Family, Caregiver and Youth Needs (n = 2,152)

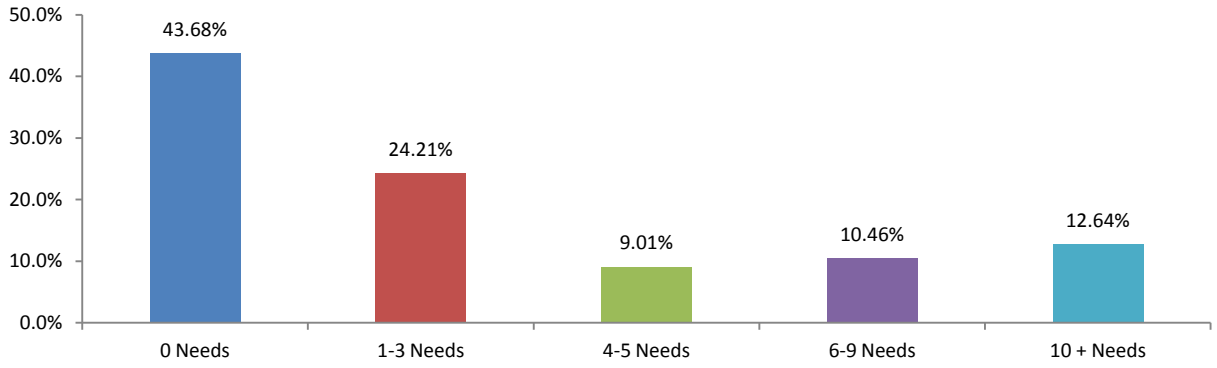
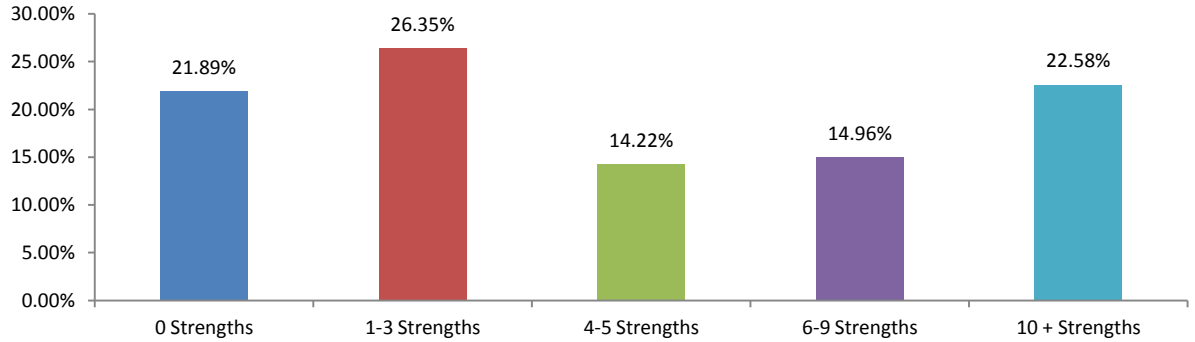


Figure 2 illustrates "Useful Strengths".[6] Approximately 79% of CANS-F assessments identified at least 1 family, caregiver, or youth strength, and 22.58% (n = 486) assessment identified ten or more strengths.

Figure 2. Percentage of Family, Caregiver and Youth Strengths (n = 2,152)



One way to utilize this data in practice could be to focus on the needs and strengths that are identified most frequently for families with an open service case. For more information on the definition of these needs and strengths please consult the CANS-F manual here: https://theinstitute.umaryland.edu/topics/sat/CANS-F_Scoring_Manual_Complete.pdf

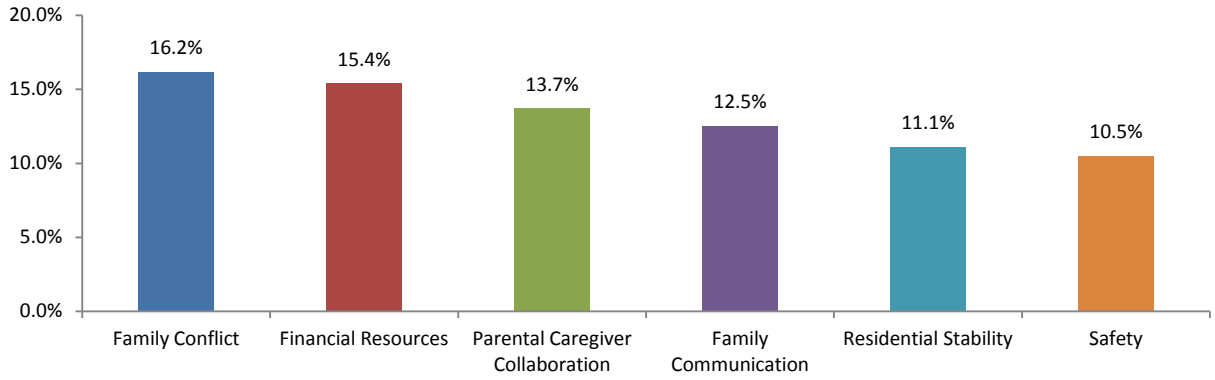
Family Needs and Strengths

Family functioning is assessed at the family system level, and includes ten family functioning indicators: 1) parental-caregiver collaboration; 2) relations among siblings; 3) extended family relations; 4) family conflict; 5) family communication; 6) family role appropriateness; 7) safety; 8) social resources; 9) financial resources; and, 10) residential stability. Across the 2,152 most recent CANS-F assessments completed, the most commonly identified family functioning need was family conflict (16.2%). This was following by financial resources and parental-caregiver collaboration, at 15.4% and 13.7%, respectively

[6] To identify a strength in the CANS-F, the assessor would select the strength box for the respective indicator.

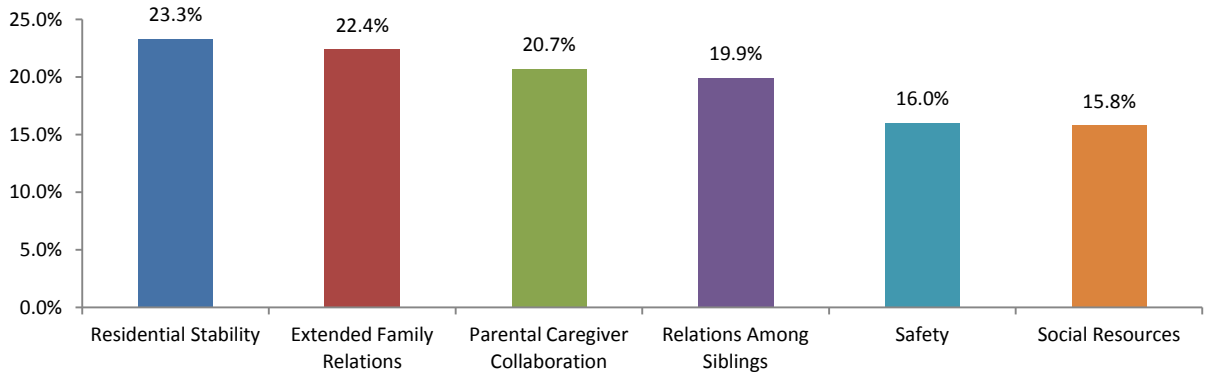
(see Figure 3). Any item assessed with a 2 (ACT to address need) or 3 (ACT immediately, intensely) were considered "actionable".

Figure 3. Percentage of Actionable Needs – Family Functioning (n = 2,152)



Numerous family functioning strengths were also identified (see Figure 4). Twenty-three percent of families had stable house, and 22.4% had extended family relations.

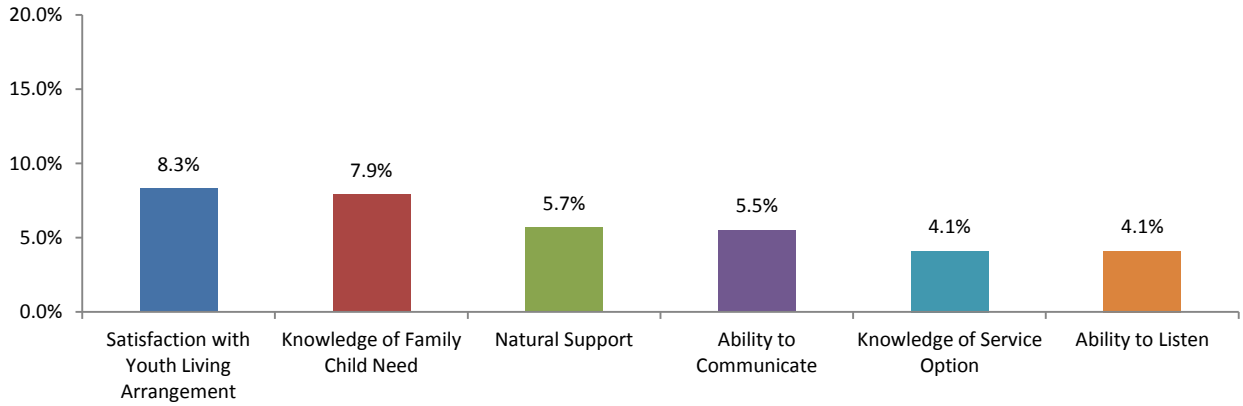
Figure 4. Percentage of Identified Strengths – Family Functioning (n = 2,152)



The Caregiver Advocacy domain is also assessed at the family system level, and explores the needs and strengths related to the caregiver(s)' role as advocates in their family system. This scale is comprised of nine indicators, including: 1) knowledge of family-child needs; 2) knowledge of service options; 3) knowledge of rights and responsibilities; 4) ability to listen; 5) ability to communicate; 6) natural supports; 7) satisfaction with youth living arrangements; 8) satisfaction with youth educational arrangement; and, 9) satisfaction with service arrangement.

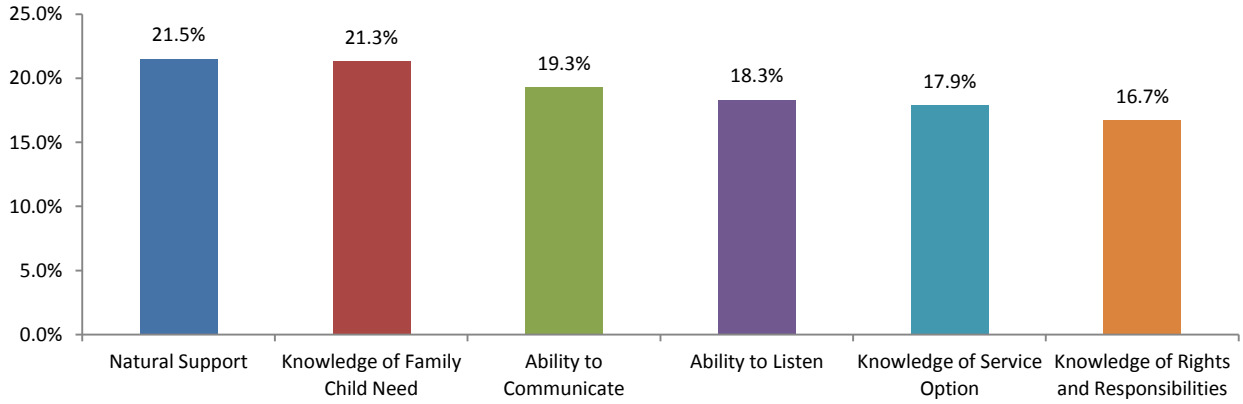
The proportion of CANS-F assessments that identified needs for common caregiver advocacy indicators is illustrated in Figure 5. Overall, few families required action on these items.

Figure 5. Percentage of Actionable Needs – Caregiver Advocacy (n = 2,152)



Caregiver advocacy strengths are illustrated in Figure 6. Twenty-one percent of families had access to natural support and/or knowledge of family-child needs. Approximately 1 in 5 families also had the ability to communicate (19.3%), listen (18.3%), or possessed knowledge of service options (17.9%).

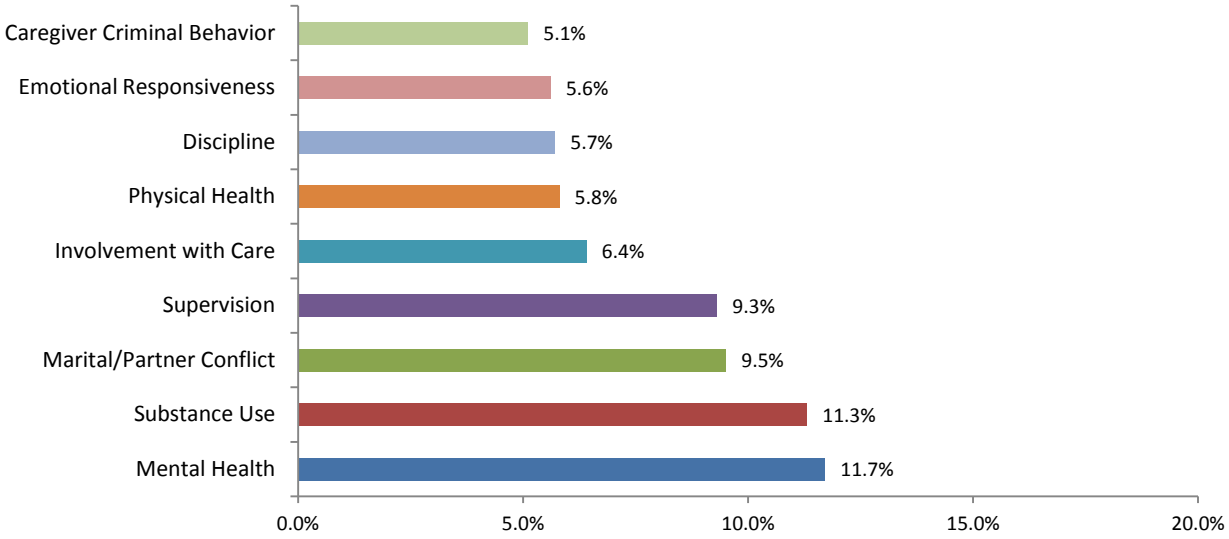
Figure 6. Percentage of Identified Strengths – Caregiver Advocacy (n = 2,152)



Caregiver Needs

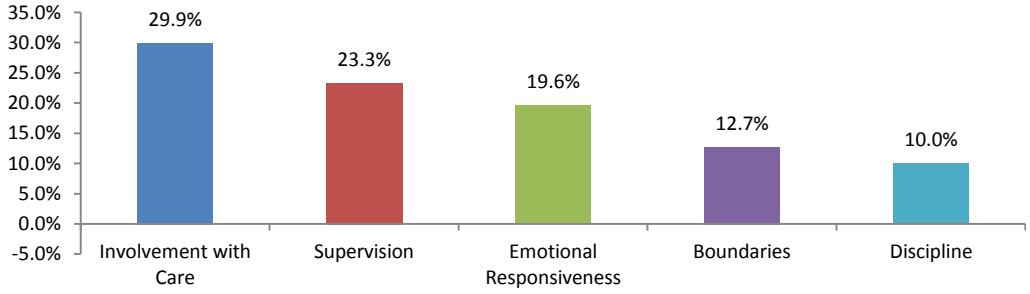
A total of 3,030 caregivers completed the Caregiver Needs and Strengths domain in the CANS-F assessment between July 1, 2015 and December 31, 2015 (M = 1.4 caregivers). The CANS-F Caregiver Needs and Strengths domain includes the following twelve indicators: 1) supervision; 2) involvement with care; 3) emotional responsiveness; 4) boundaries; 5) discipline; 6) post-traumatic reactions; 7) marital/partner conflict; 8) physical health; 9) mental health; 10) developmental; 11) substance use; and, 12) caregiver criminal behavior. The figures below illustrate the proportion of caregivers with actionable needs (Figure 7) and identified strengths (Figure 8) for the most prevalent indicators within this domain. The most common actionable Caregiver Needs included mental health (11.7%), substance use (11.3%), marital/partner conflict (9.5%), and supervision (9.3%).

Figure 7. Percentage of Actionable Caregiver Needs (n = 3,030)



The most commonly identified Caregiver Strengths are provided in Figure 8. The three most commonly identified strengths included involvement with care (29.9%), supervision (23.3%), and emotional responsiveness (19.6%).

Figure 8. Percentage of Caregiver Strengths (n = 3,030)

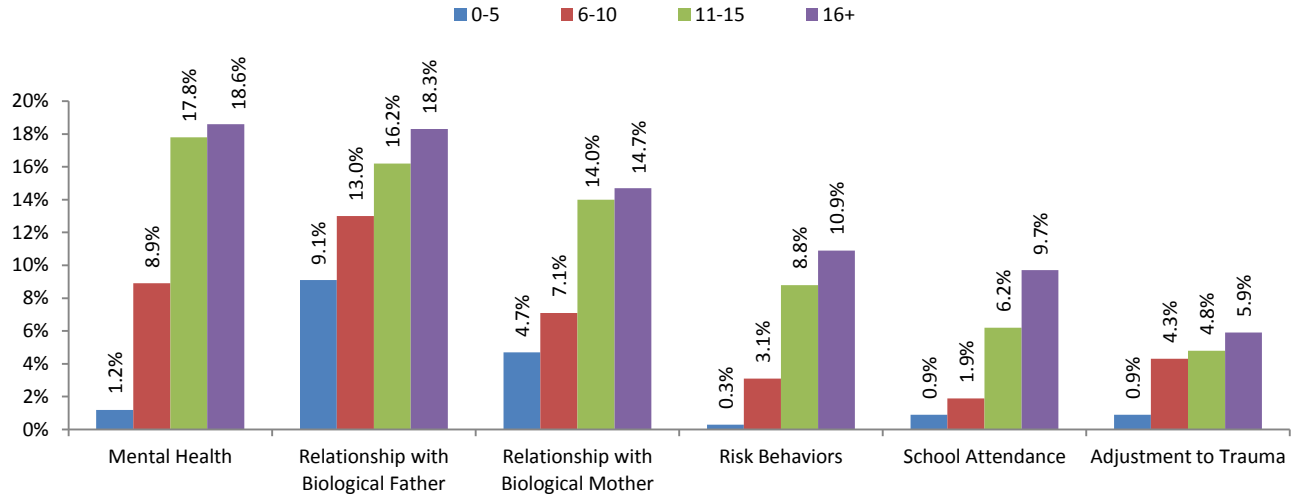


Child Functioning

The Child Functioning domain is used to describe the strengths and needs of all children and youth under the age of 18 living in the family. The Child Functioning domain included an assessment of a total of 4,619 youth. On average, 2.15 youth were assessed per CANS-F assessment, and the average age of the youth was 7 years. Sixteen child functioning indicators are included in this domain. These indicators include: 1) relationship with biological mother; 2) relationship with biological father; 3) relationship with primary caregiver; 4) relationship with other family adults; 5) relationship with siblings; 6) medical/physical; 7) intellectual (IQ only); 8) speech language delay; 9) autism spectrum/PDD; 10) social functioning; 11) school attendance; 12) school achievement; 13) school behavior; 14) mental health

needs; 15) risk behaviors; and, 16) adjustment to trauma. The most commonly reported child functioning needs per age group are illustrated in Figure 9.

Figure 9A. Percentage of Actionable Needs - Child Functioning by Age Group



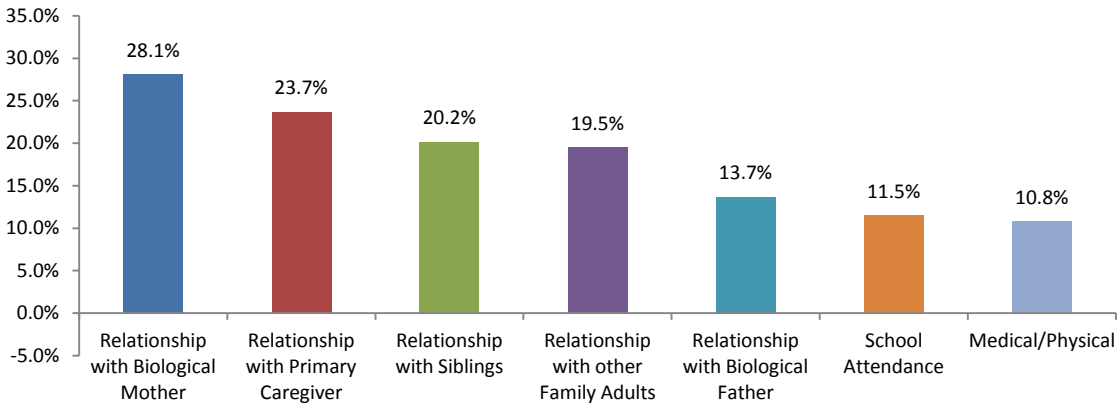
Child Functioning Strengths

Each Child Functioning indictor could also be endorsed as a strength for each youth. Caseworkers identified whether or not each indicator embodied a potential strength that could be drawn upon in treatment.

Child Strengths

Figure 10 illustrates the prevalence of all frequently endorsed Child Strengths. The most commonly identified Child Strengths pertained to relationships with family members.

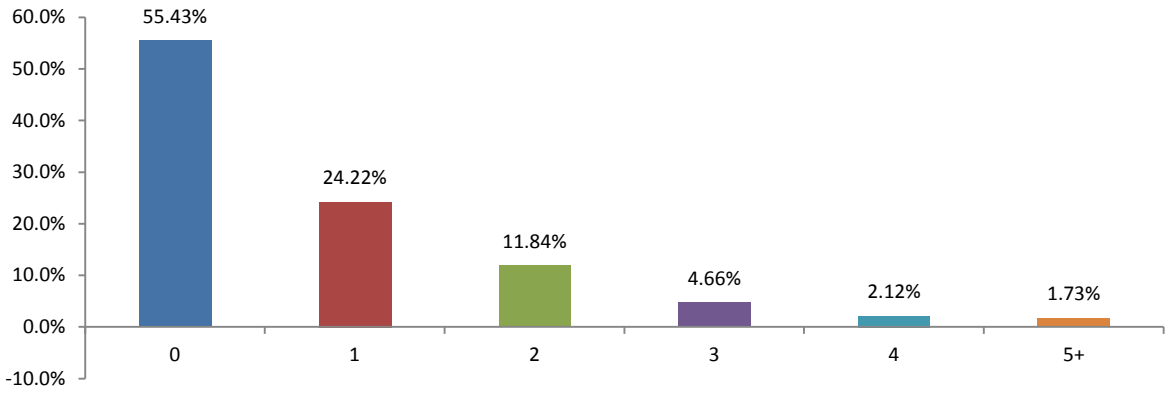
Figure 10. Percentage of Child Strengths (n = 4,619)



Prevalence of Child Trauma

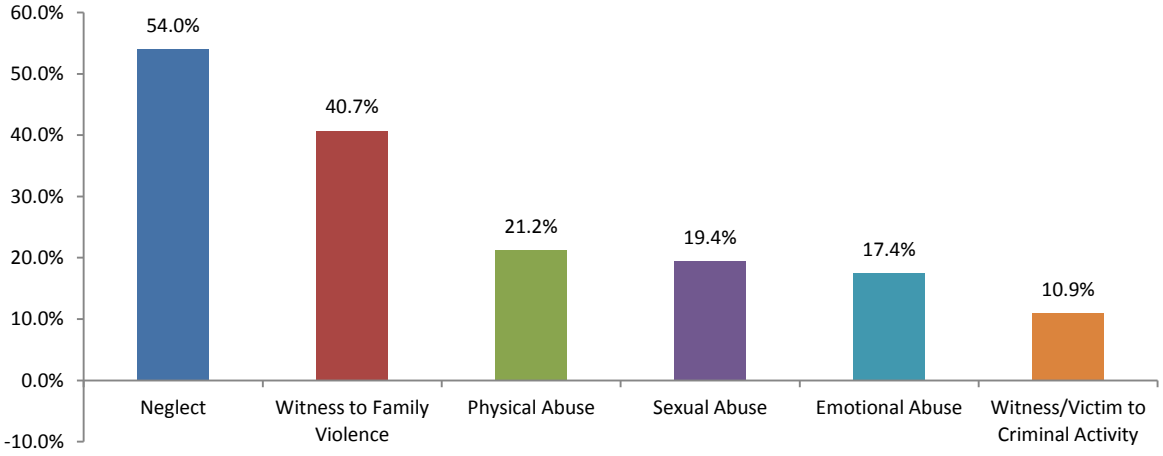
A total of 3,819 youth had a completed Traumatic Experiences domain. Trauma experiences were included if they obtained a score of 1, 2, or 3 (indicating any lifetime exposure to trauma) on the Adjustment to Trauma item in the Child Functioning domain[7]. On average, the number of lifetime trauma experiences was .86, with 55.43% of youth reported no exposure to traumatic experiences.

Figure 11. Prevalence of Exposure to Traumatic Experiences (n = 3,819)



Trauma experiences including the following items: 1) sexual abuse; 2) physical abuse; 3) emotional abuse; 4) neglect; 5) medical trauma; 6) witness to family violence; 7) community violence; 8) school violence; 9) natural/man-made disasters; 10) war-affected; 11) terrorism-affected; and, 12) witness/victim to criminal activity. After removing the youth with no identified traumatic experience (n = 2,117), the prevalence of traumatic experiences is provided in Figure 12.

Figure 12. Percentage of Trauma Experiences Among Youth with at Least One Trauma (n = 1,702)



[7] 1 = exposure to this trauma is suspected or considered mild; 2 = moderate exposure to this trauma type; 3 = severe exposure to this trauma type (often with medical and physical consequences)

Summary

Implementation

Findings from this report suggest that Maryland is progressing in the initial implementation of CANS-F in all 24 jurisdictions in the state. A large number of in-home workers have been trained in completion of the CANS-F, although certification rates in each county vary widely, from 0 to 93%. By providing technical assistance and support to individual jurisdictions, the rates of certification and compliance are anticipated to increase.

During the first six months of implementation, more than 2,000 Maryland families were assessed with the CANS-F. These families were receiving various in-home services from their local Department of Social Services. A single CANS-F assessment can reflect multiple caregivers in the home as well as multiple youth. As a result, the sample population assessed includes over 3,000 caregivers and more than 4,600 youth.

Prevalence of Strengths and Needs

In exploring the descriptive findings from the CANS-F assessments, more than 40% of families were assessed to have no actionable needs. This finding likely underscores a training issue in which workers are failing to identify the needs that brought these families to the attention of child welfare services. However, about one-fourth of families assessed were noted to have six or more actionable needs, suggesting that a significant minority of families may have complex needs. Among the actionable needs identified, the most common included family conflict and financial resources. Family strengths were also identified and were most commonly residential stability and supportive extended family relationships. For caregivers, the most common needs identified included mental health and substance use. For youth, challenges in functioning varied by the youth's age. Older youth had higher levels of actionable needs related to their mental health as well as relationships with their biological parents. Youth were also assessed for their exposure to trauma. The most common traumas reported were exposure to neglect or being a witness to family violence.

Overall, findings from the CANS-F assessments suggest that needs may be under-reported by workers in this early implementation stage. However, some families are clearly experiencing a large number of needs. Notably, mental health issues are prominent for both caregivers and youth (especially among older youth).

Next Steps

During the next review period, the evaluation team will continue the evaluation of the CANS-F implementation. The report at the end of the first year of CANS-F implementation will include updated compliance/implementation information and descriptive information about the families who have been assessed. Annual statewide rates of maltreatment investigations and removals will also be reported to assess any changes over time during the course of the Waiver. Also, the evaluation will begin to build knowledge about how CANS-F assessment scores change from intake to a later timepoint. In addition, a substudy will explore whether the needs the worker assessed at CANS-F intake are addressed in subsequent service delivery.