New Jersey (**Group Two:** Existing Standardized Protocols)

- Child and Adolescent Needs and Strengths (CANS)

Overview

The New Jersey Division of Child Behavioral Health Services (DCBHS) is implementing a behavioral health carve out, formerly called the New Jersey Partnership, serving a statewide, total population of children and adolescents with emotional and behavioral disturbances and their families. The population includes both Medicaid and non-Medicaid eligible children and those with both acute and extended care needs. The DCBHS reform creates a single statewide integrated system of behavioral health care to replace the previously fragmented system in which multiple child-serving systems (e.g., child welfare, juvenile justice, child mental health, and Medicaid) provided their own behavioral health services. System components include: a statewide Contracted Systems Administrator (an Administrative Services Organization, in effect); at the county level, Care Management Organizations (CMOs) charged with managing care for children with the most intensive needs and their families, as well as Family Support Organizations (FSOs), which are family-run organizations that work in partnership with the CMOs to provide peer mentors, family education and support and advocacy. In addition, the reform includes Youth Case Management, which is a distinct level of case management services for youngsters with less intensive needs than those served by the CMOs. The New Jersey Department of Human Services, Office of Children's Services, is the state purchaser, and the Partnership is being rolled out by county over a five-year period, with all counties participating by January 2006. The goals of the Partnership are to: increase funding for children's behavioral health care; provide a broader array of services and supports; organize and manage services; and provide care that is based on core values of individualized service planning, family/professional partnership, culturally competent services, and a strengths-based approach to care.

A key feature of the NJ system of care is the use of the Child and Adolescent Needs and Strengths (CANS) tool by all system partners across child-serving systems. The CANS is a standardized assessment instrument that incorporates a quantitative rating system within an individualized assessment process. The State worked with Dr. John Lyons of Northwestern University, the developer of the CANS, to adapt the instrument, leading to development of three versions of the CANS—one for crisis assessment, one for initial screening and assessment, and one for use by care management organizations to guide service planning for youth with the most intensive service needs.[57] The State mandates that the Crisis Assessment tool be used by the State's Mobile Response and Stabilization Services providers. The Needs Assessment instrument is mandated for use by the Contracted Systems Administrator, system partners, such as child welfare workers, and providers, at entry to screen for eligibility and level of intensity of service need. The comprehensive Strengths and Needs Assessment tool is mandated for use by the Care Management Organizations, by Youth Case Management providers[58] and by residential treatment providers for individualized service planning. The three instruments, which encompass similar domains, are designed to build on and inform one another. The State mandates their use

57 New Jersey's name for the CANS is the Strengths and Needs Assessment.

58 Youth Case Management is a distinct type of service separate from intensive care management provided by the CMOs. Youth Case Management is designed for youth at very high risk for out of home placement but not yet involved with a CMO.

as Information Management and Decision Support tools to guide and inform the process of care. New Jersey reportedly is the only State using the CANS statewide and the only State using a web-based certification process to support its use.

Goals

The State was interested in utilizing a standardized clinical decision making tool statewide for several reasons, not the least of which was to convey the sense of meaningful change intended by the Partnership initiative. The State's goal is to ensure that the issues of most importance to each child/family are considered in the assessment process and are embedded in service planning and outcomes management. This integration helps to ensure that quality improvement efforts stay focused on child and family issues. State-level stakeholders believe that use of the CANS keeps providers focused on the individual needs and strengths of each child and family and gives them a tool and a process to monitor and manage outcomes. They also indicated that they were interested in a tool that could be readily modified and adapted to meet their system needs, and they reported that they have found the CANS easy to modify. State-level stakeholders also noted that they were interested in use of a set of tools that would support programmatic and system wide practice change and give providers, families and youth a sense of change over time. For example, the CANS clearly identifies youth and family strengths; in this respect, the CANS, according to State-level stakeholders, supports the concept of resiliency.

Background

The Comprehensive Needs and Strengths Assessment and Crisis Assessment tools were developed in 2002 and the Needs Assessment tool in 2003. During planning for the Partnership, State-level stakeholders reviewed what other states were using in connection with EPSDT screening processes. Reportedly, they found primarily "long checklists" that did not meet New Jersey's interest in tying assessments to outcomes. They were interested in assessment instruments that could be used as information management and decision support tools to support the process of care and that could be used throughout the system at all levels, following children and families as they moved throughout the system. As State-level stakeholders noted, they were interested in finding or developing a "family of tools" that were relatively simple to administer and understandable to both providers and families. Use of the tools is increasingly embedded within all of the child-serving systems and is mandated for use by the management entities and providers within the NJ system of care.

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Description

All three of the CANS instruments used by New Jersey track child behavioral and emotional needs, child risk behaviors, child strengths, life domain functioning, and caregiver needs and strengths.[59] All three lead to assessment data that translate into four pathways related to how intense the service response should be. These can be summarized as including: "0-no response;" "1-watchful monitoring;" "2-action;" "3-'red flag,' immediate response." Each of the three instruments is discussed more specifically below.

The State's information material describes the Crisis Assessment instrument as follows: "This (instrument) is a decision support and communication tool to allow for the rapid and consistent communication of the needs of children experiencing a crisis that threatens their safety or well-being or the safety of the community. It is intended to be completed by the individuals who are directly involved with the crisis assessment. The form serves as a template to consistently integrate information about the needs of the child and family to support decision making at the time of the crisis. This tool is designed from a communication theory perspective. As such, the indicators are selected to represent the key information needed in order to decide the best intervention strategy for a child during a time of crisis."[60]

The **Crisis Assessment tool** addresses the following areas:

- Risk Behaviors, including: suicide risk; self-mutilation; other self harm (e.g., risk-taking behavior); danger to others; sexual aggression; runaway; judgment (e.g., poor decision making); fire setting; social behavior.
- Behavioral/Emotional Symptoms, including: psychosis; impulse/hyperactivity; depression; anxiety; oppositional; conduct; adjustment to trauma; anger control; substance use.
- Functioning Problems, including: living situation; community; school; peer functioning; developmental.
- Juvenile Justice, including: juvenile justice status; community safety; delinquency.
- Child Protection, including: abuse or neglect; domestic violence.
- Caregiver Needs and Strengths, including: health; supervision; involvement; social resources; residential stability.

The **Needs Assessment tool** is described by the State's informational material as follows:

> "The (instrument) is a referral tool to support decision making about level of need… It supports the rapid and consistent communication of the needs of children…It is intended to be completed by the individuals who are directly involved with the referral. The assessment tool serves as a template to consistently integrate information about the needs of the child and family to support decision making in order to ensure the child

59 For complete versions of the CANS instruments used by the NJ Partnership, see the following websites: www.njkidsoc.org and www.njmhi.org.

60 Children's Initiative Crisis Assessment Manual, Version 2.0. 2003. Division of children's behavioral health services. New jersey department of human services

and family receive the appropriate services."[61] The tool recognizes that in some areas information may not be known about a child and his/her family; it allows for these areas to be marked as "Unknown," and these become priority areas for assessment by the entity receiving the referral (i.e., by the Contracted Systems Administrator and Care Management Organizations that receive referrals).

The **Needs Assessment tool** incorporates all of the areas in the Crisis Assessment tool and adds additional items, including:

- Under Life Domain Functioning, the following areas are added: family (which has to do with relationships with family members); social development; recreation; vocational; legal; medical; physical; sexuality; relationship permanence (e.g., stability of relationships).
- Caregiver Needs and Strengths are separated into two fuller categories, including, under Caregiver Needs: physical; mental health; substance use; developmental; safety. Under Caregiver Strengths: supervision; involvement; knowledge; organization; social resources; residential stability.

The comprehensive Strengths and Needs Assessment tool is defined by State materials as follows: "The (instrument) is a comprehensive service planning assessment for use with children and families receiving the most intensive services…Care Management Organizations, Youth Case Managers, and Children's Residential Providers will utilize (the instrument) as their primary service planning assessment at initiation of services and subsequently as a monitor for outcomes."[62]

The **Strengths and Needs Assessment tool** incorporates all of the areas within the Crisis and Needs Assessment tools and adds additional items, including:

- Under Life Domain Functioning, adds: school behavior; school achievement; school attendance.
- Adds a specific Child Strengths category that includes: family; interpersonal; optimism; educational; vocational; talents/interest; spiritual/religious; community life; relationship permanence.
- Adds a new category called Acculturation, which includes: language; identity; ritual.

In addition to the above, the comprehensive Strengths and Needs Assessment tool builds on the Needs Assessment tool by providing more in-depth information on key issues and also incorporates several new modules, including:

- **Developmental Disability Module**, including: cognitive; communication; developmental; self-care daily living skills

61 Division of child behavioral health services needs assessment manual, Version 2.0. 2003. Division of child behavioral health services. New jersey department of human services

62 Partnership for children strengths and needs assessment manual. 2003. Partnership for children. New jersey department of human services.

- **Sexuality Module**, including: Under Sex Related Problems: promiscuity; masturbation; reactive sexual behavior; knowledge of sex; choice of relationships; sexual identity; Under Sexual Deviance: voyeurism; frotteurism; exhibitionism; fetishism; pedophilia; sexual masochism; sexual sadism; transvestic fetishism.
- T**rauma Module**, including: Under "characteristics of the trauma experience": sexual abuse; physical abuse; emotional abuse; medical trauma; natural disaster; witness to family violence; witness to community violence; witness/victim to criminal activity; Under "if child has been sexually abused": emotional closeness to perpetrator; frequency of abuse; duration; force; reaction to disclosure; Under "adjustment": affect regulation; intrusions (e.g., intrusive thoughts of trauma); attachment; dissociation; time before treatment.
- **Substance Use Module**, including: severity of use; duration of use; stage of recovery; peer influences; parental influences; environmental influences.
- **Sexually Abusive Behavior Module**, including: relationship; physical force/threat; planning; age differential; type of sex act; response to accusation; temporal consistency; history of sexually abusive behavior; severity of sexual abuse; prior treatment.
- **Juvenile Justice Module**, including: seriousness; history; planning; community safety; peer influences; parental criminal behavior; environmental influences.
- **Fire Setting Module**, including: seriousness; history; planning; use of accelerants; intention to harm; community safety; response to accusation; remorse; likelihood of future fire setting.
- **Psychotropic Medication Module**, including long list of medications and opportunity to check current or past use and allergic/adverse reactions.

In all three assessment tools, the CANS incorporates the same rating system across all items covered in each. The scoring system includes:

- **0** indicates no evidence or no reason to believe that the rated item requires any action
- **1** indicates a need for watchful waiting, monitoring or possibly preventive action
- **2** indicates a need for action; some strategy is needed to address the problem/need
- **3** indicates a need for immediate or intensive action; this level indicates an immediate safety concern or a priority for intervention.

The CANS allows "some clinical judgment to determine the rating when no clear choice is obvious."[63] Also, State information materials make it clear that a "primary goal of the (tools) is to further communication with both the individual child and family and integrate information for the ..system of care."[64] As discussed more fully below, the State mandates formal training in the use of the tools and ongoing certification.

63 Ibid.
64 Ibid.

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Individualized, Culturally Competent Family Focus

As noted earlier, the CANS tools incorporate many items related to caregiver needs and strengths, and the comprehensive Strengths and Needs Assessment tool addresses issues related to culture, race and ethnicity. In addition, the values and organizational elements of the NJ system of care reflect a strong commitment to partnering with families and youth and to individualizing care, particularly for youth with serious disorders. State-level stakeholders feel that no other assessment tool they considered is as flexible as the CANS or as compatible with an individualized approach to care. Having said that, they also reported that they still get some criticism that the CANS is not sufficiently culturally competent or family-friendly, but the State's analysis of these concerns suggests that the problems lie not with the instruments themselves but with the users of the instrument. If a user is not sensitive to issues of partnering with families or is not culturally competent, his/her use of the CANS will reflect that.

State-level stakeholders also reported that they have modified certain aspects of the tools in response to concerns voiced by families. For example, the State pulled together a group of families and youth to review the language in the original comprehensive Strengths and Needs Assessment tool to make it more family and youth friendly.

Impact of Service Availability

State-level stakeholders noted that some of the resistance among practitioners to using the CANS initially was that it would lead to identification of problems for which no services were available. The State reportedly is trying to use the CANS to help identify service gaps when this occurs. State-level stakeholders also noted, however, that in most cases, the available array of services and supports can be individualized to match a level of need even if the plan is an interim one.

State-level stakeholders believe that use of the CANS is helping to support broadened access to services because the CANS promotes a common language and a shared vision. They pointed to, for example, youth involved in the juvenile justice system for whom the CANS is providing a "common language" between the behavioral health and juvenile corrections communities that is increasing access for this population.

Training, Fidelity and Oversight

As noted earlier, the State mandates formal training in use of the tools and ongoing certification. It has contracted with the University of Medicine and Dentistry of New Jersey to provide training and technical assistance to support system of care implementation, including training related to the CANS. The training is free and meets social work continuing education requirements. In addition, much of the training material is in a distance-learning format -- online, web-based and on compact disc. There is an active website with training schedules, with training offered frequently. The State and its technical assistance providers have built a web-based certification system for use of the CANS so that the State can maintain a database of everyone who is trained in the CANS. They also have in place an online "help desk" both for content and technical support related to the CANS certification process.

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State-level stakeholders noted that they did not take an "expert model" view of training but instead opted to "train everyone" in order to create shared values and consistency throughout the State. They pointed out that, to date, they have mandated training in the CANS for juvenile corrections staff, child welfare workers, staff in secure facilities, youth case managers, mental health providers, care management organizations, and mobile response and stabilization staff, and trainings are open to parents at any time. To date, there are over 1500 users of the CANS who have been trained by the State.

The State also developed a second level of training in the CANS to create a group of "super users" who are at a supervisory level within programs and agencies. These users receive two additional days of training on the science behind the instruments and to become more comfortable with the tools so that they can exercise a level of quality control over other users at their locales.

As noted earlier, the State is interested in utilizing the CANS outcomes management process for quality monitoring. Their goal is to have both care management staff and quality assurance staff in the Care Management Organizations, for example, thinking about how to use the CANS to monitor the quality of care plans and access to appropriate services and supports. They are hoping that the "super users" described earlier will be influential in this process; the goal is to have super users in the CMOs, in child welfare, juvenile corrections, and in Youth Case Management. The State is planning to set up quarterly "super user" meetings to foster peer-to-peer exchange and support for using the CANS with fidelity and to support quality monitoring. State-level stakeholders noted that they are trying to break down the attitude that use of the CANS is "the case manager's responsibility," and instead help supervisors and administrators to see the CANS as a vehicle for quality monitoring and systems management.

Experience To Date

State-level stakeholders believe that use of the CANS is helping to build a true system of care with a shared vision and a shared "language" for clinical and other service decision-making. However, they also reported that there has been and continues to be resistance to use of the tools in some quarters. For example, at first, juvenile justice staff expressed concern that use of the tools would require more work. State-level stakeholders reported that, over time, as these staff have used the tools, they find the CANS to be helpful because it keeps the focus on the child, and as noted earlier, creates a common language between behavioral health and juvenile justice that can support increased access to services for youth involved in juvenile justice. Mental health clinicians also expressed reservations and, according to State-level stakeholders, were among the most resistant. Some clinicians reportedly did not see how a quantitative tool with "little bubbles that had to be checked" could begin to capture all the nuances of their work with children and families. Also, clinicians tended to be skeptical that the reform effort would endure and were inclined to adopt the attitude of "this too shall pass." Other clinicians did respond to the idea that the CANS could help to ensure that their recommendations would be translated into action.

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State-level stakeholders noted that clinicians often have the most difficulty at first in completing the CANS because they reportedly tend to "over-think" responses when the tool is really asking for common sense responses. State-level stakeholders reported that even their Contracted Systems Administrator (a commercial behavioral health managed care company) was at first resistant to use of the CANS because they felt they had their own "level of care" criteria. However, the CSA now reportedly embraces the CANS as a tool to create a common language throughout the system, and the CSA is using the CANS to help identify populations of children who are in inappropriate levels of care, for example, "low needs" children in out-of-home treatment settings.

State-level stakeholders reported that as clinicians and others who are at first resistant to use of the CANS gain experience with it, they realize its utility as a decision support tool. Also, the fact that the DCBHS reform seems to be enduring along with its mandated use of the CANS is a factor in counteracting resistance. State-level stakeholders also reported that one of the errors they made initially was to roll out the CANS in a top-down manner that was resisted by practitioners at the local level. In response, the State's technical assistance providers and Dr. Lyons met with every CMO, which helped to break down the resistance and promote state-local partnership.

To provide an alternative to direct on-line entry for child welfare workers, the CSA has provided an auto-fax system that allows workers to fax the assessment forms to the CSA.

Major Benefits, Concerns, and Lessons Learned

State-level stakeholders described the major strengths of their use of the CANS as creating a common language across child-serving systems. Also, the tools support the values and goals of the system reform and the "action-oriented" intention of the reform's service planning processes. State-level stakeholders also noted as a strength the fact that the tools build off one another to support an integrated care planning and management process. They stressed as strengths the fact that the tools address both needs and strengths of children and caregivers and keep the focus foremost on the child. They view the CANS as very adaptable so that there can be ongoing quality improvement and adaptation as needed, and they pointed out that the tool is in the public domain so "it is free." They also noted that the CANS is adaptable to different child-serving systems; for example, they noted that New Jersey's child welfare system is being required to have in place an integrated assessment process for every child and that the CANS will enable them to do that from prevention to early intervention to treatment. State-level stakeholders also reported as a strength that use of the CANS helps to create a transparency and accountability in the system; the basis on which clinical and other service decisions are made is no longer a mystery to families and others. These stakeholders also indicated that use of the CANS lends itself to a team approach involving families, supporting the notion that everyone involved in a child's life has expertise to bring to the table and that expertise is not the sole domain of clinical experts. They feel that the strength of the CANS is that it is a communications theory-based tool that anyone can use.

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State-level stakeholders described the major challenge as one of "scaling up." They began with providers and systems serving the most intensive-needs children and families and are just now turning to the broader outpatient community. In addition, they noted as a challenge getting managers and clinical supervisors to take full advantage of the CANS for quality monitoring and system management purposes.