



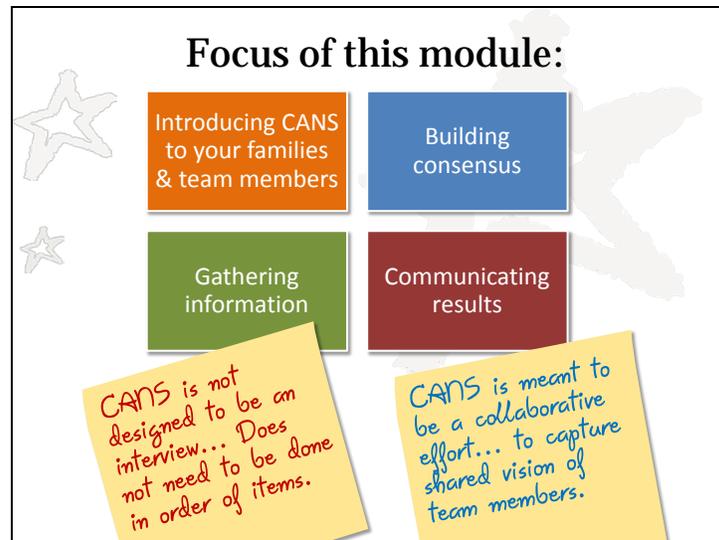
# Wisconsin CANS Online Training

## Child and Adolescent Needs and Strengths

### Module 2: Integrating CANS Into Your Practice

Slide 1

A promotional banner for CANS Online Training. It features a central orange-to-white gradient banner with the text "CANS Online Training", "Child and Adolescent Needs and Strengths", and "Module 2: Integrating CANS Into Your Practice". Below the banner is a group of diverse children smiling. In the top right corner, there is a small icon of a person with the text "Is your sound on?". In the bottom right corner, there is a blue button with the text "Get Started" and a right-pointing arrow.

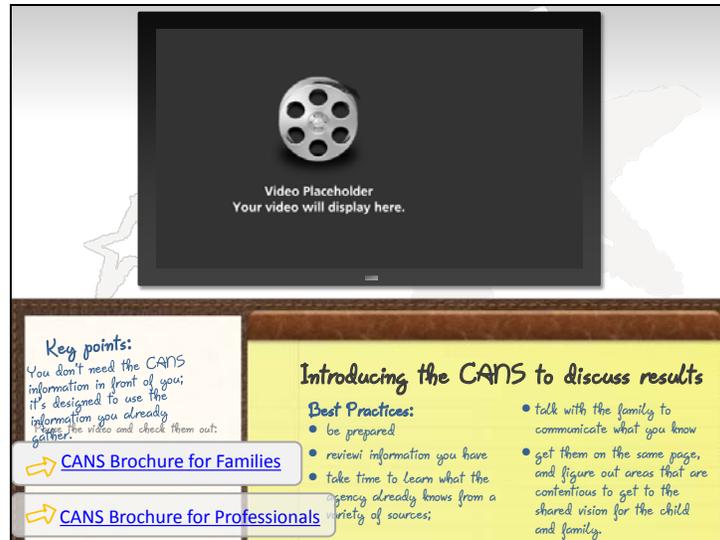


Now that you've learned about what the CANS is and what it is designed to do, let's talk about how you will integrate this into your daily practice with children and families. You will hear from Dr. Lyons about how to introduce the CANS to your families and other team members, how to build consensus on the team, how to gather the information to complete the CANS (and how it's not very different from the information that you already gather), and how to communicate the results of the CANS.

You will hear that the CANS is not designed to be an interview and does not need to be done in the order that the items are listed on the results sheet. The CANS is meant to be a collaborative effort of the child's team and is meant to capture the shared vision of the team members.

Slide 3

How do you introduce CANS to  
families and providers?



**Dr. John Lyons:**

“You really have a number of different choices in terms of how you introduce the CANS. Around the country people use different strategies, and in Wisconsin we've developed brochures that you can give family members and you can give providers. They're somewhat different, they're written at different levels. And so, that's one way so they have some information. Now, of course, some people will read those and some people don't right. That's not a universal strategy. But, it's one strategy that you can use to introduce it.

What some folks do is they'll do a brief overview, of this is what it is, this is what it's about as you work to get it. That's if you're going to do the CANS interactively. It kind of depends on how you choose to embed the CANS in your work. Some folks do their normal assessment process and they really introduce the CANS when they're talking about the results, right. They get the output report that list the actionable needs and so forth and they take that opportunity to explain what that is to families and youth. So, you can introduce it that way because you can do the CANS without looking like you're doing the CANS. You're helping people tell their story and you're checking in on actionable needs and so forth. So, you don't necessarily have to have the paper in front of you in order to get the information you need because, remember, it's designed to be the information you need regardless. And, this is just one way of reminding you what you need. So, some people do it transparently with families that this is now we're going to do the CANS. And some people do it on the back end but then communicate back. Okay, based on all our conversations, based on all this input this is how we're

understanding things. And do you agree, you know, this is how you're seeing things and so forth? So, those are a couple of your choices. What a lot of folks do, and I think it's probably the best practice, because, I don't know, I mean the way I think about it is, have you ever been to the doctor where the doctor has no idea who you are? They come into the exam room holding your chart and they're flipping through it and trying to talk to you. And you kind of probably experience it as pretty disrespectful and not particularly helpful. Have you also had the experience where you had a doctor who actually prepared and knew who you were and that reviewed your chart before he or she came into the exam room? And you say this is nice they actually are, you know, taking the time to learn about me before they are working with me. That's the best way to use the CANS is you're going to have quite a bit of information from a variety of sources before you meet families. And so, it's not a bad idea to try and complete the CANS as much as you can. And then, use the family interaction to both communicate, this is what you already know but also kind of check in and make sure you can get them on the same page. And that gives you a chance to identify issues that may be contentious where they're not so sure they agree with the perspective of other partners in the, in this shared vision. So, those are your basic strategies of how you engage family members. Most places, if you do it well, most places, the biggest advocates for CANS are family members because they really do feel like they get a voice and they really do feel like the system becomes more focused on what they need, what's going to be helpful to them.

One issue that's come up sometimes as a barrier to initial use is that there are some folks who feel a little shy about bringing up issues of caregiver needs in discussion with caregivers. And there's a whole variety of reasons for that. But, the overwhelming experience has been that if you do it from a caring perspective, families actually appreciate the opportunity to talk about their needs and to talk through what steps need to be taken to help them be able to meet the needs of their children. So, it's really all about how you approach it in terms of, and that's why it's designed as needs not problems, is, you know, the supervision need. You absolutely need the supervision sometimes because if you have a really, really challenging child, everybody's got those needs, right with that kind of child. So that's not a judgment; it's a statement of need. And so, again, it's about the what not about the why helps you with that regard as well but the framing them as needs and the fact that a zero for some of them are strengths is really helpful in that regard. So, although a lot of places have reported some initial hesitancy by a number of folks to actually begin that conversation directly with parents, the overwhelming experience is once that conversation's begun, it was a really good idea to have it. So, it's easy for me to say, it's harder, you know, to live the experience. But, if you do approach it from a caring perspective, you can anticipate that families, for the very large majority, will be quite interested and fully participate in that kind of process.”

Slide 5

*How do you build consensus?*



**Dr. John Lyons:**

“Yeah, the concept of this approach is you're really creating a shared vision about that child and family. And so, that's not any one person's opinion. This is, it's a shared vision. So, the shared vision is a consensus. And so the design of this approach, it's designed to be used with teams. And how do you build a consensus so that, because, what happens with the children and families is, you have a whole bunch of different perspectives. Sometimes you have different kinds of expertise that you need to bring to bear like you might need a developmental specialist, you might need a pediatrician, you might need a psychiatrist, you might need a special education expert, right. But, you also need to incorporate the perspective of the family and the perspective of the youth and some older children. And so, how do you do that? The core concept here is you're using the CANS as a way of building that shared vision. So, the purpose of it is to work to reach a consensus. Now, it's been our experience that there is a learning curve in terms of learning how to build a consensus because it's not always been how we have functioned. And sometimes, we're uncomfortable, for instance, talking about what we think is going on in front of parents and youth. But, know they're the folks that we want to help change. And so, you really shouldn't be having a lot of conversations behind people's backs. You should incorporate discussion with them, right. And our experience has been when you do that it becomes more powerful. And, you can talk about almost anything if you talk about it from a caring perspective. Now, the CANS is actually designed to support reaching a shared vision more easily. And, the key characteristic of that is it's about the what not about the why because that really helps you reach a consensus more readily. So, if you really cannot agree, you can always choose the one

option on the needs because that means you're not sure, that you're going to figure it out. And so, for instance, we had a situation in New Jersey where a mom was sleeping at all the meetings. And she said she was taking too much allergy medications, but her other members of the team thought she had a substance use problem. So, that's a contention right. That's a difference of opinion. Some people thought she was a two on substance use. She said no. So, what do you do about it? Well you mark it. You describe it. You say, you know, the way they did it is they said, "mom the problem is, you can't sleep at the meetings. You know, you can't really advocate for your children if you're asleep. So, we need to do something about this. Now, we're here to help you. We can help you no matter what. But, we've got to figure this out. You're saying you're taking too much allergy medication. What you should know is that people on the team think you might be using drugs. And so, we're here to help you we can help you either way. But, we've got to figure it out. So, we're going to mark this as a one on substance use because there's some disagreement here. And so, what has to happen is you need to go and talk to your physician and try to get your allergy medication right so that you're not sleeping at the meetings. And, if that turns out to be not the only issue then, you know, we're here to help you. So, let, we'll, let's figure it out." So, by setting the stage that way, then, when mom came back, she was able to own the fact that she did have a substance use problem. So, you're using the process, that's one of the ways this is a tool, using the process to resolve that. So, our experience is you can reach a consensus in about 98% of cases. So, it's not really the case that you're going to have a lot of contention. Every now and then you will at least on some items. Often times those are emotionally or financially motivated items. It's when those multiple competing agendas. I'll give you another example with the autism version was using at Ottawa. And they had a contention between the school and the family the family saying one thing the school saying a different thing. So, the school support person had each of the family and the school, each separately do the CANS and come together and figure it out. And what they discovered is they talked to the difference in perspective is the school recognized to their, to their credit that they had filled out the CANS based on what they could do rather than what that child needed. The parent was filling out based on what they, the child needed. And so, as soon as that reveals, you're revealing that hidden agenda basically and allows you to then resolve that particular difference in perspective. But that's how this is designed to be used."

How do I explain the results that  
I get to a child's team?

**Completing the CANS with the Team**

*Strategies*

**Option 1:** complete CANS prior to meeting with the team, then vet with the team.  
*Generally the most ideal option.*

**Option 2:** Do the CANS in the team; takes longer, useful when team is not functioning well and competing agendas, but can be worth the time.

- “Is this causing problems for someone? If so, then it is an actionable need.”
- Worker has ultimate authority as the rater.

*Number of times you would do it this way would be limited.*

**Option 3:** Do the CANS as a reporting out, use the team meeting to reach consensus, unless it is shared back with the team as an output of the team.

*Prepare it and make sure everyone is on the same page.*

**Dr. John Lyons:**

“Yeah there’s a variety of strategies that people use, I think it's useful to contextualize this into three different opportunities of how you might use this relative to a team. So, the three basic strategies people use is sometimes people complete the CANS prior to the team and they use the team to vet the CANS so that reduces the amount of time spent arguing about small differences and it starts, creates a foundation on which people react. So, that's one way, it helps put a little bit of consensus.

The second way is to do the CANS in the team. That takes longer. But, our experience has been that's quite a useful team building activity if you have a team that isn't functioning well because the reason teams don't necessarily work well is because there's other competing agendas. Either there's somebody who really need to be right, the smartest person in the room or there's money involved or there's some risk of embarrassment, or there's, you know, you're a mandate reporter and the parents don't want to own something. You know, there's a number of different competing agendas that get in the way of consensus. And, it's usually those competing agendas that make teams dysfunctional. So, it's a team building activity to do the CANS in the team. But, it does take longer. But, sometimes it's worth the time because you're really using it as an opportunity to build that shared vision. You're working through those disagreements. And, when you're stuck on things where people disagree, you ask them a little bit about why, you know, the why behind their disagreement because that begins to reveal the perspective issues. And so, that becomes quite important. So, some people underrate, some people overrate. You know, if you grew up in a rough and tumble area, you know,

you might say you know I went through that myself, I don't see it's a very big deal. If you grew up in a protective area, you might be overwhelmed with some of the things that our kids are involved in, right. So, there's those kinds of perspectives too that work against consensus. I mean, in general, what we find is that people in the mental health sector and people in the child welfare sector, there's a difference and there's a common stance. And people in child welfare tend to rate at a lower level than people in mental health. And so, probably the truth is somewhat in the middle. And so, you're looking for those opportunities to have that kind of discussion. The thing that really, really helps the consensus is the fact that you go back to the action levels. And, it's about the what not about the why. Do we need to do something because is this causing problems for anybody at all? Is this causing problems for anybody? If it is, then that's an actionable need. If it's dangerous or disabling for anybody, then that's an actionable need. And so, that makes it relatively simple because it's way easier to reach a consensus about that, then it is about some theory or behavior and other kinds of things that are much more complicated and potentially controversial. So, again, our experience has been that it's possible to reach that consensus about 98% of the time. So like, 2% of the time you're going to have issues where there's strong vested interest. And there you really might have to agree to disagree. And there, of course, since the worker is the certified CANS rater, they have the ultimate authority to complete the CANS. But, I would work towards consensus first before you resort to that because our experience has been vast, vast, vast majority of the time that's achievable. And, when you achieve the consensus early you end up working smarter not harder because you're able to do things that you couldn't do - less work in the long run.

And the third way to do it is to, as a reporting out. And, **I'm not real keen** about that as a best strategy where you have the team meeting, you reach a consensus, and then you use the CANS to report out because it runs a risk of it becoming just a form and reporting that kind of thing. So, unless that gets shared back to the team like minutes of a meeting then I'm a little bit uncomfortable because you want to make sure everybody's on the same page and actually is endorsing things on the actionable levels because that's how you reach that consensus and that's how you build the spirit that we're all working together in the best interest of this child and family. But, you can do it that way. So, you can do it before vetting with the team or you can do it in the team. And, when you do it in the team you don't necessarily have to do it item by item by item. You can focus on the things that are, have come up as issues and you're going to make sure everybody's on the same page. Or, you can do it after as a result, as an output of a team process of what did we describe as the actionable needs and so forth. And those are your three basic choices.

A number of times you'd actually just do it in the team is going to be pretty limited because you really are only going to do that in situations where we have some serious contention across team members. You might have a situation where you've got a particular agency that always wants a higher level than what you're giving them because they're really it's about getting the proper investment to support their efforts, right. So, if you've got that kind of circumstance then it can be quite useful to do the CANS in the team because that thing begins to expose that reality because, but you don't want to do that routinely because it just takes too much time. The most efficient

way, prepare the CANS, make sure the team's on the same page. And you wouldn't necessarily even do the whole rollout sheet in team. You might just present them with the actionable needs and make sure everybody's on the same page with that and the useful strengths, so."

What are some tips you can offer about  
completing a CANS?



The slide contains a video placeholder at the top center, a white sticky note on the bottom left, and a yellow sticky note on the bottom right.

**Video Placeholder**  
Your video will display here.

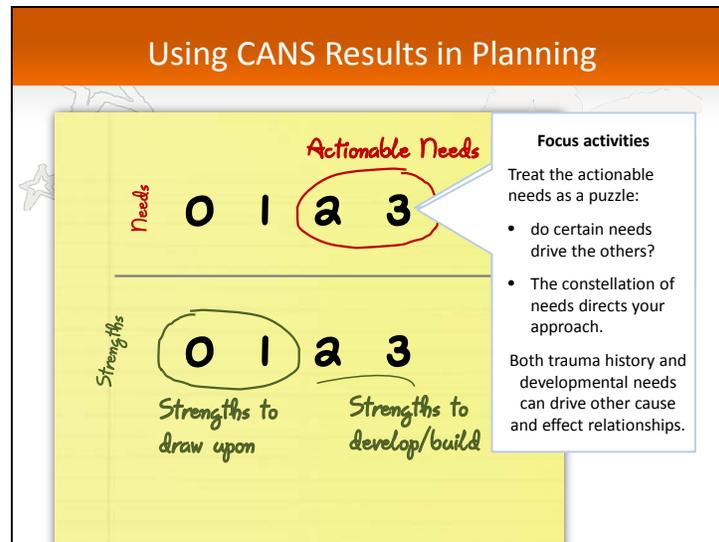
**Key point:**  
You do not have to do the items in the order they are presented

**Completion of the GANS**  
Establish the relationship of trust and caring  
Understanding of trauma influences how you understand the needs  
Start with functioning, end with strengths or vice versa

**Dr. John Lyons:**

“You may have taken a class in graduate school where you learned that if you change the order of items, you change the reliability and validity of the measure. If you add and subtract items you change the reliability and validity of the measure. And so, if you were trained in that particular way, you may see a measure and think you have to start at the beginning and go through to the end. That's not how this works. And what you should know is all the research that suggests that's true is based on research with college freshmen, so, where they're doing studies in which they don't care about it. And so, they're doing it and they're hypothesis-guessing. And so, the reason why you see that basic phenomenon is that they don't care about the content. And so, the order in what you ask the question, they're generating their hypothesis of why they're participating in an experiment that they don't care about. So, would you believe that in order to get accurate information, and all we're talking about reliable and validity are fancy words for accurate information. But is the best way to get accurate information is to force people to answer questions in an order you predetermine? No, I mean, the nature of our work is relational. So, you need to \*\*\* establish a relationship built on trust and caring in order to have optimal communication. My experience is that's not accomplished by cramming your agenda down somebody else's throat. It's listening to their story, right. So, you can do this in any order you want. The form itself is in a particular order. It starts with a trauma section but almost nobody would actually start an interview with trauma. It starts with the trauma section because it's really the organization of the care plan, it's at the output of the assessment process. And since Wisconsin's child welfare system is committed to becoming an increasingly trauma-informed system, \*\*\* you always want to

understand how that person's, how that youth, is that young person's needs are reflecting within the context of understanding their trauma history. So, the trauma items are static indicators not really CANS items, they're just indicators of trauma experiences because you really need to approach people differently based on that understanding. So, if you have complex trauma and you are not responsive, you know, you might be disassociating or you might be passive aggressive. It's hard to tell the difference between if somebody's passive aggressive and if somebody who's dissociating, right. So, but, you approach it completely different. If you've got a passive aggressive youth, you call them out. But, if they're disassociating because they're under stress and they're shutting down, you don't call them out. That'd actually re-traumatize them. You've got to let them come back to you in their own time, right. So, understanding a trauma background influences is how you understand the rest of the needs. And so, that's why it's first. But you don't start there, all right. You start wherever it makes sense. Personally I like to start \*\*\* with functioning and end with strengths personally. But, a lot of people like to start with strengths or start with needs whatever. So, I like to start with functioning because it's the 'how you doing' question, right, so. Now, the best way to do this is to prepare it beforehand, you know, and you got it as you're interacting with families."



**Dr. John Lyons:**

“Yeah, it's usually pretty straightforward because you really going to focus on, once you pull together all the information about a child and family, you're going to focus then on the twos and threes on the needs and you may be using the zeros and the ones on the strengths or you may be thinking about strength building for the twos and threes. So, it becomes, you have a greater focus at that point. And so, you're really, when you're talking to the team, you're really talking about the actionable needs. Now, where it can become a little bit challenging is for very, very complicated situations, you might have a lot of actionable needs. And so, it may still be overwhelming even when you, just focusing on what's actionable, you still might have a situation where you have 20 or 30 twos and threes among the different items on the CANS. So, you have to have a second level there. And there's what you really are looking for. There's two different ways to help continue to focus your activities. One would be the most traditional way is of those actionable needs, what do you think are the priorities? Generally speaking, that's going to be among the threes. But, even among the threes, you might not choose to intervene all at once on everything. You might choose to prioritize some things before you'd go otherwise. Usually it's about safety first, you know, it's kind of a reverse mass of hierarchy but, and then you're moving to other kinds of things. Maybe it's about getting them to go to school first and then you're going to deal with school behavior and so forth. But, you want to prioritize that. That's a first way to do it. A second way to do it is to treat the actionable needs as pieces of a puzzle and ask the question how do these things fit together? Do they fit together in a pattern that might suggest that certain needs drive the others? For instance, if you see a young person and their actionable needs,

their twos and threes include suicide, self-injuring behavior, other self-harm, anxiety, adjustment to trauma, intrusions, dissociation, well there you say, okay, well that's, what was that, about eight different actionable needs. But, when you look at that you say, okay, there's one of those needs that really is driving all of those needs and that's the adjustment to trauma. So, if I see that constellation of needs, I'm going to be thinking about trauma informed care. I need to get this young person with somebody who is sophisticated in how to address trauma because that's going to be the foundation of the approach. So, if you have, you know, trauma's a big one in terms of driving things.

The other item that's a big one in terms of creating a branch in logic is developmental needs because that's going to change how you do it. So, you look at the actionable needs and you say, okay, do these fit together in a pattern that suggests cause-and-effect kind of relationships. And that's a nice way, and you can use the team to kind of problem-solve that sometimes as well. And so, that would be the ways that you could use that information. But, it's relatively straightforward because you're really going to focus on the team should be addressing the needs that are actionable and that may be using strengths. And, I think, also, the opportunities for strength building shouldn't be forgotten. But, a big part of good child welfare work is looking for opportunities to build strengths. That appears to be particularly important for transition age young adults that, the opportunity there is to build strengths. And if you can, you'll have more sustainable positive outcomes.”

**Challenges of the CANS:**  
Averaging: Don't Do It

*Needs are bad things  
Strengths are good things*

Need	Strength
<p>0 Child is doing well in relationships with nuclear family members.</p> <p>1 Child is doing well in relationships with nuclear family members. Problems may exist but members may have relationships with each other.</p> <p>2 Child is having some problems with parents and/or siblings. Relationships are difficult.</p> <p>3 Child is having severe problems with parents and/or siblings. This would include problems of domestic violence, constant arguing, etc.</p>	<p>0 Significant family strengths. This level indicates a family with much love and respect for one another. Family members are central in each other's lives. Child is fully included in family activities.</p> <p>1 Family members are central in each other's lives. Child is included in family activities.</p> <p>2 Family members are central in each other's lives. Child is included in family activities.</p> <p>3 Family members are central in each other's lives. Child is included in family activities.</p>

**Dr. John Lyons:**

“One of the challenges that comes up with the CANS is that sometimes people want to average, you know, if you've got a child whose got needs and strengths and you want to average. And so, don't do that because the needs are the problems and the strengths are the assets and you don't want to average. So, for instance, you have family nuclear, family needs - functioning and then you have nuclear family strengths. And, you could have a three on one and a zero on the other or you could have a three on both. You can have a zero on one and a three on the other. So, a zero on nuclear family functioning and three on nuclear family strengths would be the child who has no nuclear family, right. The only advantage of having no family is you don't have to go to family therapy. That's a zero on function. There's no functioning issues because there's nobody to function with, right. So, you're not going to do a family systems intervention based on that. But there are no strengths, right. So that's a zero on functioning but a three on strengths. And the task is then adoption or if they're at a transition age, you know, they have the opportunity to hit the reset button on family and create their own brand new nuclear family. That's one of the great opportunities of young adults. So, good planning helps them with that. So, that's more strength based. You can also have a three on family function and a zero on family strength. Kinship care, right, so if you have an adult sibling who can raise you, even if you've been abused or neglected by your parents, that's a three on family function. You've got abuse or neglect in the family, nuclear family system. But, you have an adult sibling who can step up and raise you and that's a centerpiece family strength, right. So you have them both at the same time. So, don't average the needs are the bad things and the strengths are the good things.”

The slide features a central video placeholder with a film reel icon and the text "Video Placeholder Your video will display here." Below the placeholder are two sticky notes. The left note is white with blue handwriting, and the right note is yellow with black handwriting.

**Notes:**  
common risk behavior,  
this has a bit of a  
"why" in it  
"ruckus"... John is  
from Indiana

**Challenges of the CANS:**  
**Intentional Misbehavior**

- Misbehaving to mask a need
- Purposefully getting in trouble - evidence they wanted to get caught

**Dr. John Lyons:**

“Intentional misbehavior is frequently an item that gets confused. It's the most common risk behavior in North America. If we'd be frank we'd actually call it obnoxious things kids do to piss off adults; it's number one, number one in risk behavior. And, it's one of the three items that has a little bit of why in it because it's not just being obnoxious, it's being obnoxious with an agenda. So, let me tell you this story, of the origins of this item. This item actually came from a young man in Far Rockaway, New York, which is a neighborhood in Queens. And, he'd go to school each but each day he'd cause a ruckus. I'm from Indiana so I say a ruckus, a disturbance, a diversion. He'd, and if you don't want to be in school, give your teacher the finger, it works quite well, out you go. He'd push his desk, he'd start an argument with his peers. He'd go to school every day but every day he found a way to get himself kicked out. So, the folks who served him are brilliant, one of the best places I've ever visited, but they're particularly good with this guy. They do the assessment, what they discover is this guy would rather be a jerk than stupid. He wasn't tracking what was going on in school. He didn't want to ride the special bus. He didn't want to go to the special classroom. He didn't want his friends to think he was a dummy. It was way better for him to be a bad guy than risk being identified as a dumb guy. So, he was bound and determined to do that. So, he'd go to school every day. But every day he found a way to get himself kicked out because he was fearful that if he stayed in school people would catch on that he wasn't catching on. So, they went to his home and discovered he had no place to study. So, the intervention was actually to buy him a desk and work with his mom to enforce a study table. When he started to get on track academically he no longer needed to act up because he was no longer concerned about being dumb. He now understood that he did understand and he could succeed in school. And so he didn't have to act badly in order to get himself sanctioned. So, this particular item captures sanction seeking. It's kids who are purposely getting themselves in trouble. You know, it's, you've got young people who are about ready to be discharged from residential treatment and they act up to prevent it from happening. That's intentional misbehavior. You've got young people who get arrested and detained and become suicidal because they'd rather be in a hospital than a detention center. That's intentional misbehavior. I had a good friend, her daughter didn't want to go to preschool. So, like a good mom, she kept her in the backseat car seat. Clever young lady, she took off all her clothes, because what mom is going to take her naked baby into preschool? That's not a sexual disorder. It's got nothing to do with sex. It's a power struggle between mom and her daughter about going to preschool. I did a training with child welfare workers in New Jersey, and I told them that story, and one of them said to me, "John the same thing happened to me. I took my naked baby into preschool, it never happened again." I believe that's evidence-based practices. I do think you want to be a child welfare worker before you try it because otherwise somebody's making a hotline call, right. So, that's what this behavior is. It's

purposefully getting yourself into trouble. It's not just being obnoxious. It's purposefully getting yourself in trouble. So, when you're identifying it, you're really looking for evidence that the young person wanted to get caught.”

**Description of the LON**

**Re: Level of Need (LON) and Placement**

Child can be served at a level lower than assessed LON **IF** an exception has been granted

j

Agency must show that services and supports address assessed needs.

Exception is documented in the CANS

Child can be placed at a level higher than assessed LON without an exception.

A child's Level of Need (LON) does not require placement with a specific provider or Level of Care. In general a child should be served by a provider who is certified or has a Level of Care that is at or below the child's Level of Need. A child may be served at a Level of Care that is lower than his or her identified Level of Need **if** an exception has been granted by the placing agency, and the agency can show that services and supports are provided to address the identified needs of the child and provider. In these cases, this exception is documented on the child's CANS results page, and an email notification will be sent to the foster care licensor who is assigned for to the provider. This is to inform the foster care licensor that the provider may need additional supports and services in order to continue to care for the child.

A child can be placed at a Level of Care that is higher than his or her assessed Level of Need without the requirement to provide additional documentation, as providers with a higher Level of Care certification can be presumed to have the knowledge, skills, and abilities to appropriately care for those children.

How does TCOM relate to the completion of the  
CANS and how I work with the tool?

Video Placeholder  
Your video will display here.

Key point: items  
Do not rate the items  
based on what you can do;  
rate them on what the  
child's needs or strengths  
actually are

Determining LON and  
using LON in Planning  
LON:  
✓ patterns of actionable needs across different  
dimensions  
✓ a complexity indicator  
✓ compelling evidence that if you match what you do  
to what the child needs you get better outcomes

**Dr. John Lyons:**

“Well one of the applications of the CANS and TCOM is decision support of the program level that's eligibility. And that's really what the rate setting is, the identified level of need comes from that way of working. And, the concept behind that is that you want to base what you do for kids on their needs not on what's available or what you want to do or what you historically have done but what do our children need. And so, the way the level of need determination works for the CANS is it's patterns of actionable needs. There are a bunch of other measures where you get a score and you have cutoffs. But, there's problem with a cutoff methodology because it doesn't really represent people. So, you know, you could get a nine on the behavioral emotional needs from the CANS because you have nine ones or if you get a nine based on three three's. Those are two different kinds of kids. So, the way the level of need determination works in the CANS, it's patterns of actual needs across different dimensions, twos and threes across different dimensions. It's a complexity indicator. And, we've developed that over time in a lot of different jurisdictions and there's compelling evidence that demonstrates that if you match what you do to what the child needs you get more success. You have better outcomes matching what we do because what we do actually works quite well. But, it only really works for people who need it. It doesn't work for some people who don't need it and it's actually harmful to over or underserved kids who either need or don't need. So, it's designed in that way. So, what's the pattern of actionable needs that would lead you to different kinds of intensity of intervention - those are the levels of need. And, if you're able to match the level of intervention to the level of need, then that's ideal. Now, the reality of the circumstance is that's not always possible, right. Sometimes it's in the

best child's interest, it's in the best interest of the child to stay with a family who's not really licensed to provide consistent with the level of need. But then, you can do other things. So, the way the system in Wisconsin is designed is you can do what you think is right. The CANS is not an expert system. It's a decision support. It's information to help you think about how to best serve kids. But, if you can't necessarily match what you do to what the CANS suggest, then you just need to be able to justify that difference. You know, what are you doing to be able to serve a level three child in a level one home? That's certainly possible. But, you need to think through what are the things you're going to do in addition to what's the standard part of that level one home to make that work? Or, if you have a young person who's level two and they're in a level three setting, what's that? Why is that? What are you doing to address the specific needs of that child in that circumstance? So, it's designed to be a decision support strategy. It gives you a sense of where, if you're going to want to be as successful as you can be, you ideally match what you do to what a child needs not what you can do.

Historically we've had significant problems in this regard. I was trained, for instance, to pick the diagnosis that was least stigmatizing and most likely to result in reimbursement. One of the things that's happened is we've gotten backwards. If you only have a square hole you try and say, "okay how do I describe this child as a square peg so I can put it together?" Don't do this, this way. Do not do the CANS based on how you're going to justify what you're going to do. That's not the right way to do it. You want to describe as accurately as possible the child's needs, look at where that suggests, but then, recognize that you're dealing in a reality and that you might have to adjust what you do to what's feasible within those options. But, that disconnect gives the state enormous information about for its gap analysis of figuring out how do you create a system that better serves children and families because you're able to look at those distinctions and either adjust how you think about matching needs or adjust what you think about investing in new services and so forth."

Placement Complexity Chart				
Child's Level of Need	Provider's Level of Care	Placement Options		
		Foster Home	Group Home	Residential Care Center
1/2	1	Child-Specific		
	2	Basic		
3	3	Moderate Treatment	Group Home	
4	4	Specialized Treatment		
5	5	Exceptional Treatment		Residential Care Center
6	6			

This is the “Placement Complexity Chart.” It describes the recommended placement options for children based on their assessed Level of Need (LON). This does not prescribe a level of placement for a child, as you will hear in the following examples, but it illustrates options that should be able to meet the child’s identified needs and strengths.

Placement Complexity Chart				
Child's Level of Need	Provider's Level of Care	Placement Options		
		Foster Home	Group Home	Residential Care Center
	1	Child-Specific		
	2	Basic		
	3	Moderate Treatment	Group Home	
4	4	Specialized Treatment		
5	5	Exceptional Treatment		Residential Care Center
6	6			

*Example 1:* a child with a Level of Need of 3 is placed in a foster home with a Level of Care certification of 3. This provider is presumed to be able to meet the child's needs. As with any placement, the child's treatment team should create a plan with the provider to meet the identified needs of the child.

Placement Complexity Chart				
Child's Level of Need	Provider's Level of Care	Placement Options		
		Foster Home	Group Home	Residential Care Center
1 2 	1	Child-Specific		
	2	Basic		
3	3	Moderate Treatment	Group Home	
4	4	Specialized Treatment		
5	5	Exceptional Treatment		Residential Care Center
6	6			

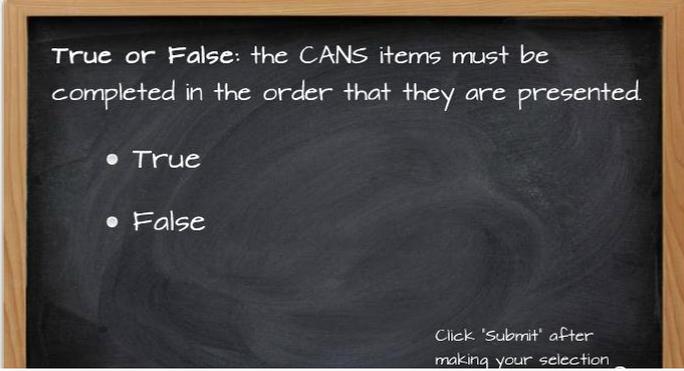
*Example 2:* a child with a Level of Need of 3 is placed in a relative foster home with a Level of Care certification of 1. Since the provider's certification level is lower than the child's LON, then the agency must document an exception in the child's CANS to describe their specific plan to support the provider in meeting the child's higher Level of Need. For instance, a young girl with significant medical needs is placed with her grandma, and her grandma gets licensed and certified at a Level 1. The plan could include a commitment from the grandma to meet with physicians and nurses to learn how to manage the medical needs, and to go to all necessary appointments for the child. In this situation, the agency may want to provide grandma with respite care to avoid caregiver burnout.

Placement Complexity Chart				
Child's Level of Need	Provider's Level of Care	Placement Options		
		Foster Home	Group Home	Residential Care Center
 2	1	Child-Specific		
	2	Basic		
3	3	Moderate Treatment	Group Home	
4	4	Specialized Treatment		
5	5	Exceptional Treatment		Residential Care Center
6	6			

*Example 3:* a child with a Level of Need of 2 is placed with a foster home with a Level of Care certification of 4. The child is being placed with their sibling who has more significant treatment needs, and requires a higher level of care. It is presumed the caregiver is able to meet the child's needs since they have a Level of Care that exceeds the child's Level of Need.

**CANS Module 2: Check Your Understanding**

Question 1 of 2



True or False: the CANS items must be completed in the order that they are presented.

- True
- False

Click 'submit' after making your selection

**PROPERTIES**  
On passing, 'Finish' button:  
On failing, 'Finish' button:  
Allow user to leave quiz:  
User may view slides after quiz:  
User may attempt quiz:

[Goes to Next Slide](#)  
[Goes to Next Slide](#)  
[At any time](#)  
[At any time](#)  
[Unlimited times](#)

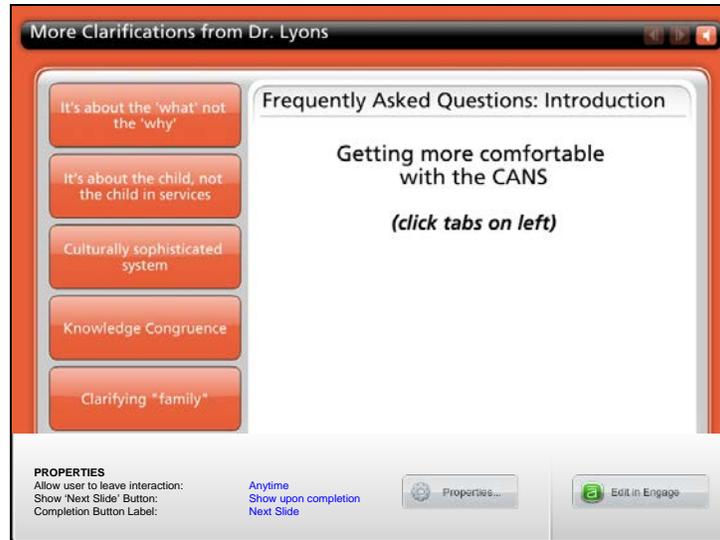
Properties...

Edit in Quizmaker



**Dr. John Lyons:**

“I think celebrating success is one of the most powerful things you can do. Now, it's scientific it's not scientific to use the CANS in celebration. You know the difference? Scientific is following the scientific method. Scientistic is looking like you're following the scientific method. And this is more scientistic. But, it communicates success differently than giving someone a buddy hug and say you're doing a good job than it does to show them a chart or a graph and say look at the progress you've made. Look at what you need to continue to work on but look at the gains you've made. So it communicates success differently. Almost everybody who works in the child serving system celebrates, and you should celebrate everything you can. Celebrate everything you can because it makes success more vivid. But, you can use the CANS in those celebrations. So, if you've never tried, I just ask you to try it once because you may be shocked at how much youth and families appreciate celebrating their success with some apparently objective information, at least consensus that information that they've gotten better on certain needs or improved on certain strengths. So, it's just a matter of when you're celebrating progress when you're wrapping up your involvement with a child and family, you go over their success on the CANS in terms of eliminating needs, reducing the intensity, or building strengths. And, use that as a part of your celebration process.”



You have learned a great deal about the CANS and how to use it with your families, but you're probably still not feeling completely confident in your use of the CANS. Don't worry, this is completely normal! Dr. Lyons always says that as you use the CANS, you'll become much more comfortable with it, and the more you do the CANS, the less time it will take you to complete it. There are several areas, though, that are often confusing or not completely clear for people, so we'll go through a few of those areas now.

The first is regarding the Key Characteristic that "it's about the what, not the why." Please listen as Dr. Lyons goes into more depth about this concept:

-----  
***It's about the 'what' not the 'why'***

Dr. Lyons:

"Yeah the key to the CANS is it's designed to be a descriptive tool. It's not designed to be a cause and effect tool. Now, there's a variety of different reasons for that. Number one, there is no unified theory of human behavior. So, and there's not a single known cause of any disorder in DSM-IV. So, if you jump to the 'why' too soon, you have a good shot of being wrong. So, it's better to start an assessment process by focusing on describing where the needs are and that's the idea. Now, there are a few items on the, your version of the CANS that do have some 'why' embedded in them. So, adjustment to trauma has a cause and affect with the trauma experience that's leading to the current adjustment problems. Intentional misbehavior has a little bit of a why because it's purposefully getting yourself in trouble. Self-injurious behavior has a little bit of a why because it's purposefully hurting yourself for self-soothing reasons. But, for the most part, the vast majority of the items are simply descriptive. So, you can have a school behavior problem because you have ADHD and you can't sit still. You've got a school behavior problem because you don't want to be in school and you're purposely getting yourself kicked out. You can have can a school behavior problem because you are being victimized by a bully and the teacher's only seeing your response and missing the bullying. You can have a school behavior problem because you remind your teacher of somebody she hated from last year and she's purposely triggering your behavior. All four of those things are actionable school behavior problems. So, it doesn't matter, the why, you're just describing the what. How you choose to intervene is going to be based on your theory of why. But, the CANS itself is just the what."

-----

***It's about the child, not the child in services***

The next Key Characteristic to review is that "it's about the child, not the child in services." Again, please listen as Dr. Lyons clarifies this idea:

"Rating the child and not the child service is really fundamentally important because you really want this to be the shared vision. And, as we discussed before, the shared vision isn't children and services it's children, all right. So, it's happy, healthy, safe, able to pursue their dreams. So, if they're in an intervention, you don't want to describe intervention, you want to describe them. So, the big factors are going to be the tension, the residential treatment kinds of settings where you need to be able to tell the difference between a setting effect and a treatment effect and then psychotropic medications. So, let's talk a little about setting effects and treatment effects. So, residential treatment is great at controlling behavior. They have a whole elaborate way of managing behavior. Sometimes that does not translate back into the community. So, let's say you've got a young person who ends up, a young lady, she ends up in residential treatment. And, part of the reason she ended up in residential treatment is she wasn't going to school. And, let's say she goes into a program that's campus based. And they wake her up in the morning, they march her to the on-campus school, at the end of the day, they march her back to the living area. Have they addressed school attendance? Well no, they've created a structure to make sure she goes to school. But, they haven't addressed school attendance. So, as she transitions back into the community, she can be a two or even a three on school attendance because what you're communicating is we were able to structure her to go to school but as she transitions, you need to be able to structure her to make sure she goes to school, still, right. So, that would be an ongoing need and that's a setting effect. Now, you could have a treatment effect in residential treatment on school attendance. Here's an example of what that might look like. So, let's say you've got that same young lady. And let's say in the course of her residential treatment, they discover that the reason she hadn't been going to school is that she had an undetected learning problem and she was humiliated. She was embarrassed by the fact that she felt stupid and so she chose not to go to school as opposed to go to school and feel dumb every day. And let's say, you know, because school's an industrial model, if you don't learn the standard way, you're in trouble, and that's what special education's about. So, let's say they come up with a plan that actually works for her and she's able to get back on track educationally because they've come up with a strategy that helps her learn, right. Well, that could be just a one on school attendance because you've figured out the problem, you've addressed it. And now, you're just saying so long as I can transfer that learning plan into her next school, I can prevent a relapse in this school attendance problem. So, that would be a treatment effect. So, with residential treatment you want to make sure you understand the difference between a treatment effect and a setting effect. And that can be a little bit challenging particularly if you have a very high intensity setting where the kids never leave, right. Because then how do you know what they're going to be like? So, what a lot of people do in those settings is they really look at what's the child like before they go in? What's the young person like before they're admitted? And then, is there any reason to believe it's going to be different than that when they come out? So, you're really starting with their admission and assuming that they're probably going to be just like they were when they in when they come out if you have no other evidence to suggest that they've made some fundamental change in their life. So, and that's probably the safest strategy to use with high end intensive settings where children never leave. If they do leave, you know, that's what lowering the intensity of the setting is about, home visits, community participation, having a job while you're still in the treatment facility, that kind of stuff. That gives you evidence of what is that young person going to be like without the structure. And that's how you determine whether you have a treatment effect or a setting effect. With the psychotropic medication, do psychiatrists use DSM-IV? Well no, they use target symptoms right. So, if you have symptoms of anxiety you get anxiolytic. If you have symptoms of depression, you get an antidepressant. If you have symptoms of psychosis you get an antipsychotic, if you have all the above, you get all the above. And that's why cocktails exist is because psychotropic medication has moved to symptom management. Now, does psychotropic medication work like an antibiotic that if you take it for ten days you're fine? No, it's, they're, you have to take them for them to work. Some of them are miraculously have great effects. But, you have to take them in order for them to be effective. So, that's still an actionable need on the target symptom. So, let me give you an example. Let's say you've got a young guy who's got severe ADHD. He just is bouncing off the walls. And, as a result, he's a behavior disaster at school. And, as a result, he's flunking everything. So, he's a three on attention, on impulse hyperactivity. He's a three on school behavior and he's a three on school attendance. Let's say you get him on stimulants. You get him to see a psychiatrist. And the psychiatrist comes up with a stimulant that works for him and his behavior comes under control. Well, school behavior could be all the way down to a zero. He's now behaving himself fine at school. His school achievement could become all the way down to a zero. Now he's back on track academically. But, his impulse hyperactivity will still be a two because what you're saying is he needs to continue to take his medication if you're going to contain those other gains, right because if you made him a zero in impulse hyperactivity you say you're done. But, you're not done. He has to take the medication in order for you to maintain those successes. So, you're communicating accurately about that child by saying he does have this need on impulse hyperactivity. We're addressing it. And, as a result, he doesn't have any sort of other functional needs. That's how this works. He might move to a one on the target symptom under one of two conditions. Either the medication management has become a routine part of his lifestyle or he's so clinically stable you're thinking about taking him off the medication even if he's not particularly compliant because some kids are noncompliant with the medication because they don't need it. All right, so, but they'd never be

a zero on the target symptom. So, every psychotropic medication has a target symptom. If they're on a medication, they're always at least a one on that target symptom because you'd never, ever give a child a powerful psychotropic medication and say "Our work is done, we're on Risperdal, now, our work is done," right because you have to monitor it at least for the side effects because every single psychotropic medication causes diseases in their own right. And so, it's at least a one because you're monitoring the side effects at minimum."

---

### **Culturally sophisticated system**

*Earlier in the training, you heard Dr. Lyons talk about the Key Characteristic of considering culture. There is often some confusion about this characteristic as well as with the cultural items. Please listen as Dr. Lyons explains this further.*

*Dr. Lyons:*

"As I mentioned before, there are three aspects of a culturally sophisticated system. The first is learning how to treat different people differently. That's cultural sensitivity and that's built in as one of the three, of one of the six pillars of a communimetric approach, that you understand somebody's culture before you intervene. The second is, sometimes people have specific cultural needs. That's what the cultural needs section in the CANS is, is do people have cultural needs that you should address as a part of your approach? The third aspect of a culturally sophisticated system, is sometimes you need to learn how to treat different people the same, right. That's what disparities, that's what disproportionate care is, is when you're treating people differently based on their culture when you should be treating them equivalently. So, a culturally sophisticated system does all three things at once. It's culturally sensitive, it identifies and address cultural needs, and it eliminates disparities and disproportionate care."

---

### **Knowledge Congruence**

The item of "Knowledge Congruence" is sometimes a confusing one. Please listen as Dr. Lyons offers some additional information on this item:

*Dr. Lyons:*

"Yeah, knowledge congruence is a new item. This is developed by Wisconsin for the Wisconsin version. It's a really rather interesting item in the cultural section because it really is capturing the notion that different people have different understanding of things. For instance, let me give you an extreme example of a colleague who's a physician in Africa. And he was telling me that kids in his region who have autism, the belief is that you take a child with autism, you cut open a live cow and put the child inside the cow, and then that will help cure the autism. Now, my guess is there's no such programs in Wisconsin, right? So, that would be a knowledge congruence issue. There's much more subtle examples of that in terms of understanding some people. Well, for instance, in Arab culture there's no concept of depression. So, if you've got a child who meets diagnostic criteria for depression, but they live in an Arab culture, well that's not going to get recognized because there is no capacity to recognize that part of the cultural dialogue within Arab culture. You might have circumstances where parents believe that there is a religious region in, you know, devil involvement with misbehavior, that would be a knowledge congruence issue. So, you're capturing all the different belief systems operating between the family and youth and the provider community in terms of what's going on. Help seeking congruence is a different kind of item. And it's really captured the notion that really it's only in Western European culture that's highly individualized. So, U.S. culture, is highly individualized that we build into our legislation all sorts of individual rights to even for fairly young youth, right. So, at 12 and at 14 you have certain rights that are unalienable. That's inconsistent with most other cultures. In many cultures, the process by which you seek help is not an individual process. So, in many tribal cultures, you go through an elder to seek help. In some Asian cultures you go through a senior and elder family member to seek help. And that's the established way you work in those cultures to seek help. You don't have an individual child coming and asking somebody for help. So, those are important considerations because you, as you look at how people access this system, you want to make sure you understand the congruence between how they're accessing it and the congruence of our common culture expectations in terms of how they might choose to access it. Some people, of course, do not believe that there's help, right. So they don't believe in the value of mental health services. So, they wouldn't seek mental health treatment because they have no sense that that would be of any value. That would be a help seeking congruence, so. Other people believe that you go and talk to your minister or rabbi, priest, and that's how you seek help. So, understanding the congruence is important in terms of being culturally sensitive."

### **Clarifying “family”**

In addition, the definition of “family” is often culturally determined, and can make rating the CANS complicated. Please listen as Dr. Lyons provides additional information on defining who should be included in rating the family items.

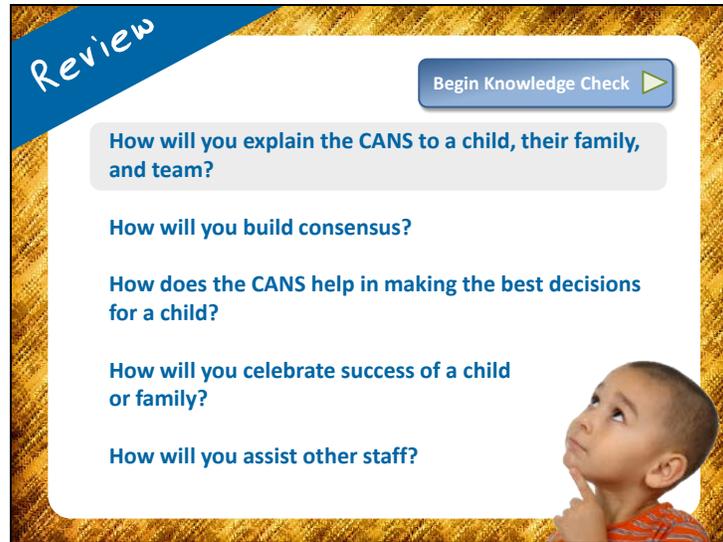
*Dr. Lyons:*

“The definition of family sometimes gets tricky. It makes family ratings some of the most difficult items. What we recommend is you, and there's all sort of cultural variations. So, what we recommend is you allow families to define themselves. So, and, different families have different perspectives about who is included. Now a nuclear family is exclusively parents and siblings. But, if you've got a young person whose grandparents have taken over raising them and are functionally parents, then it's grandparents and siblings. If it's an adopted situation, well the adopted parents become the nuclear family, right. So, it's parents and siblings but there is a little bit of flexibility about who qualifies as serving in the parental role. And, of course, you might have half siblings and that kind of stuff. So, extended family is everybody else. And, that's where it can get quite complicated potentially. If you don't know what the family's perspective is on who the family is, then it's biological relatives and their significant others with whom they're still in contact. So, particularly with the vignettes, you don't have the ability to ask people who they consider their family to be. So, you're stuck with the second definition which is biological relatives and their significant others with whom they're still in contact. So, if they're 15 and they haven't seen Dad since they were 2, Dad doesn't count for family functioning and family strengths. That doesn't mean you don't want to go find Dad and get him back involved in the life. But you're not going to send him to family therapy with Dad because Dad's not there, right. So, you're looking at biological relatives and the significant others with whom they're still in contact.”

And finally, the concept of the 30-day window often leads to some misconceptions about how to rate specific items. Please listen as Dr. Lyons helps to explain this further:

*Dr. Lyons:*

“Yeah it's really designed to be, to remind us that we've got to keep things fresh. So, if you were to become a CANS trainer, one of the things you have to do to become a CANS trainer is to do your introduction to your CANS training. You know, why should people in your training care? Why should they learn how to do this? And so I was doing a trainer program in Guam in the Chamorro culture. There's a young man there who grew up in foster care. And his introduction was something like this: He said, you know what I love about this approach, is it gives you a chance to get past your past. Just because you've done something a million times doesn't mean you have to do it a million and one times. So, you want to build in an opportunity for people to get better. That's the concept here. And so, there's a lot of risk assessments out there that are static indicators, they're combination of all risk, it's a big problem. It's a big problem in juvenile justice in particular. But, also in child welfare sometimes where you have risk models where you're just inventorying every bad thing a young person's ever done. The problem with that is once you're high risk you can't get any better. You're always going to be high risk until you age out, right. So, that's not helpful. You want to build in an opportunity for people to get better. That being said, 30 days is made up. There's all sorts of reasons why it might not be meaningful information, including the fact when a young person's in an unusual setting, like a hospital or a detention center, or jail or prison or whatever and they really can't engage in the kind of behaviors that you're concerned about when they come back out. So, there's a whole bunch of reasons. Give you an example, Philadelphia's been using the CANS for years. They had a young man who was incarcerated for four years. It's a long time for a youth to be in prison. What he'd done is, when his mother was sleeping, he poured gasoline on her and lit her up. He tried to murder his mother. So, he is in prison for four years. If you're his caseworker and you're planning for him as he emerges back into the world, are you going to plan for him as if he might be dangerous? Well that would be a good idea, right. Now, it's been four years. That's outside of the 30 day window. But, he's been in prison. And, prison isn't known as an intervention that reduces the likelihood of future violence. And frankly, you don't know what this guy's going to be like when he comes back into the community. So, what's your responsibility? Your responsibility's to him. You want to put in place a plan that protects him from screwing up and ending up back in prison, right. So, you're going to plan for him. You're probably making him a 2 on danger to others and have a safety plan in place. You may be able to fade that quickly because you discover that once he's out he's okay. Maybe he's made some fundamental changes while he's in prison. But, you really don't know until he gets out and you want a plan based on him not based on a 30 day window, right. So, you can override the timeframes with the action levels. Because at the end of the day what you want to understand is what do kids need what are their strengths. That's the items and the action levels. But again, you want to remind yourself to keep it about now. You do not want institutionalize behavior. I reviewed a chart of a 14 year old who set a fire when he was seven and he's 14 now. His chart was stamped fire setter, right, that's institutionalizing bad behavior. He'll never get better if he's always treated as he's that active fire setter even though he hadn't done anything in seven years.”

A review slide with a gold textured border. In the top left corner, a blue diagonal banner contains the word "Review" in white. In the top right corner, a blue button with a white right-pointing triangle contains the text "Begin Knowledge Check". The main content area is white and contains five blue questions. In the bottom right corner, there is a photograph of a young child with a thoughtful expression, resting their chin on their hand.

**Review**

**Begin Knowledge Check**

**How will you explain the CANS to a child, their family, and team?**

**How will you build consensus?**

**How does the CANS help in making the best decisions for a child?**

**How will you celebrate success of a child or family?**

**How will you assist other staff?**

You now have a better understanding of how to explain the CANS to a child, their family, and their treatment team, and how to build consensus on that team to accurately rate the CANS for a child. You now know how to use the CANS in making decisions for a child, and also how to use the CANS to celebrate the successes of a child or family. If you are not directly using the CANS but supervising staff who are, you have a better sense of how to assist your staff in using the CANS.

Please complete the Knowledge Check on the next slide before moving on to module 3.