Placing Strengths at the Center: Implementing a Trauma-Informed, Collaborative Case Planning Process for Children and Youth in Foster Care Using the Child and Adolescent Needs and Strengths (CANS) Tool

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Meet AJ: *AJ is a fictional youth who entered foster care at the age of 7 for physical abuse and neglect related to parental opioid use disorder. He experienced four foster home placements in 2 years, and each time the foster caregiver cited unmanageable behaviors as the reason for the move. AJ was angry and scared and did not have the skills to help him express these intense emotions appropriately. Fortunately, with the collaboration of a dedicated social worker and a team of professionals and caregivers, AJ was provided with the support he needed to begin to heal past trauma and build skills alongside his caregivers, which led to his adoption at 11 years old. AJ is now 17 and on his way to college, making him one of the few youth who were involved in child welfare to go on to receive a post-secondary education (Day, Riebschleger, Dworsky, Damashek, & Fogarty, 2012). Though his story is fictional, his voice represents the true potential of all children and youth to thrive when given the collaborative supports that meet their identified needs, and the opportunity to build on their strengths, talents, and interests. The goal of CANS implementation is to help realize this potential.*

Background

Across the nation, approximately 250,000 children entered foster care in 2016 (U.S. Department of Health and Human Services, Administration for Children and Families, Administration on Children, Youth and Families, Children's Bureau [USDHHS], 2017). In a way similar to AJ, too many children in foster care nationwide experience placement instability beyond initial removal from their homes (Pecora, 2010; Rubin, O'Reilly, Luan, & Localio, 2007). On average, a child or youth experiences more than three placement

moves during each stay in foster care (Child Welfare Information Gateway, 2017).

Research shows that frequent placement changes are often highly stressful for children and can impact brain development (Northern California Training Academy, 2008; Pecora, 2010) and long-term outcomes (Pecora et al., 2005). For example, a large body of literature suggests a relationship between placement instability and children's well-being, including social-emotional skills and behaviors (e.g., Newton, Litrownik, & Landsverk, 2000; Pecora et al., 2005), drug and alcohol use (e.g., Herrenkohl, Herrenkohl, & Egolf, 2003), and school stability and success (e.g., Herrenkohl et al., 2003; Pecora et al., 2006). In addition, the literature shows a consistently negative relationship between externalizing behaviors and placement stability (Koh, Rolock, Cross, & Eblen-Manning, 2014; Rubin et al., 2007), whereby children with a greater number of home placements tend to have more negative behaviors perceived by caregivers and professionals, suggesting the potential for a vicious cycle.

Although research-based trainings and interventions have been linked to improvements in placement stability (Northern California Training Academy, 2008), there is little research investigating the effectiveness of trauma-informed, collaborative, system-level interventions. Placement data point to the critical need for cross-system collaboration between families, child welfare, education, mental health, and other providers toward the early identification of children's strengths and needs (Ko et al., 2008), a process referred to as "teaming" throughout this article. By improving teaming between providers and families, it may be possible to recognize the strengths and needs of a child as soon as she or he enters foster care, and to address trauma and behavioral health needs across life domains such as school and home.

AJ's Story, Part I: Before heading off to college, AJ agreed to participate in a foster youth panel. This is his response to the statement "Tell us about your experience when you first entered DCF custody."

> *Going to college is a dream that I didn't think would come true for me…but to tell you how I got here I have to start from the beginning.*
>
> *So I guess I'll start with my birth mother who had me when she was 19 years old. I came into custody when I was 7 because she was struggling with opioids and couldn't take care of me. She was so young but was already alienated from her whole family, and all her friends were using, too. By the time I was 8, I had gone 6 months without seeing her and her parental rights were terminated. By that time, I had also been in three different foster homes in as many towns. My foster parents said things such as, "He's just a monster," "He's completely out of control," and, "I'm afraid of what he might do!" I was only 8 years old! I must have been a mess. I don't remember much of it, but imagining it makes me sad for me and my birth mother.*
>
> *I remember walking into second grade in a brand new town, not knowing anyone. I went to the shelf and picked up a toy, but another boy grabbed it out of my hands. I yelled and jumped on him and hit him. I don't remember anything else, but I know that my teachers thought I was out of control and was not "available to learn." Before I got through half the year, I was off to foster home number four in another town with another school. That fourth school was a big turning point for me.*
>
> *I had four social workers by the time I was 9! Thankfully, Amy was my last. She's the only one I remember. And she made all the difference. She understood the school system and worked with the local mental health agency using something called the Child and Adolescent Needs and Strengths (CANS) tool. The CANS was a new tool that her agency had just started using, and she really thought it would help my "team" figure out what I needed and how each of them could support me, since no one seemed to really know me or each other. . . .*

Child and Adolescent Needs and Strengths (CANS)

The CANS is a tool that brings together the voices of all of the important and influential adults in a child's

life to identify his or her unique combination of needs and strengths across contexts, thus facilitating strength-based case planning, caregiving, and targeted service provision (Praed Foundation, 1999, 2016). Furthermore, the CANS provides a format for effective communication of these strengths and needs, thereby improving communication and collaboration between cross-system service providers and caregivers (Praed Foundation, 1999). Any provider with a bachelor's degree can be certified to administer the CANS by annually completing an online training through the Praed Foundation (https://praedfoundation.org/training-and-certification/); however, there is additional education, training, and experience needed for "CANS super users" and those using "more complex versions" of the tool (Praed Foundation, 2016, p. 6). It is important to note that the CANS is a descriptive, data gathering tool that is not intended to determine, evaluate, or diagnose the *cause* of particular challenges. Rather, the tool allows for effective communication across all levels of the system. Ideally, it is completed every 6 months so that a child's progress over time can be illustrated, allowing opportunities to celebrate successes and promptly address needs (Praed Foundation, 2016).

The CANS (Praed Foundation, 1999) is organized into five domains, each of which houses several specific items related to a child's and caregiver's well-being:

1. Child Behavioral/Emotional Needs
2. Life Domain Functioning
3. Child Strengths
4. Caregiver Needs and Strengths
5. Child Risk Behaviors

Each item has been included in the CANS because it is "relevant to service/treatment planning" (Praed Foundation, 1999, p. 3). These items are scored on a 0-3 scale so that "Immediate/Intensive" needs and "Centerpiece Strengths" can be easily identified and addressed (Praed Foundation, 1999, p. 4), helping teams focus on effective, strengths-based planning.

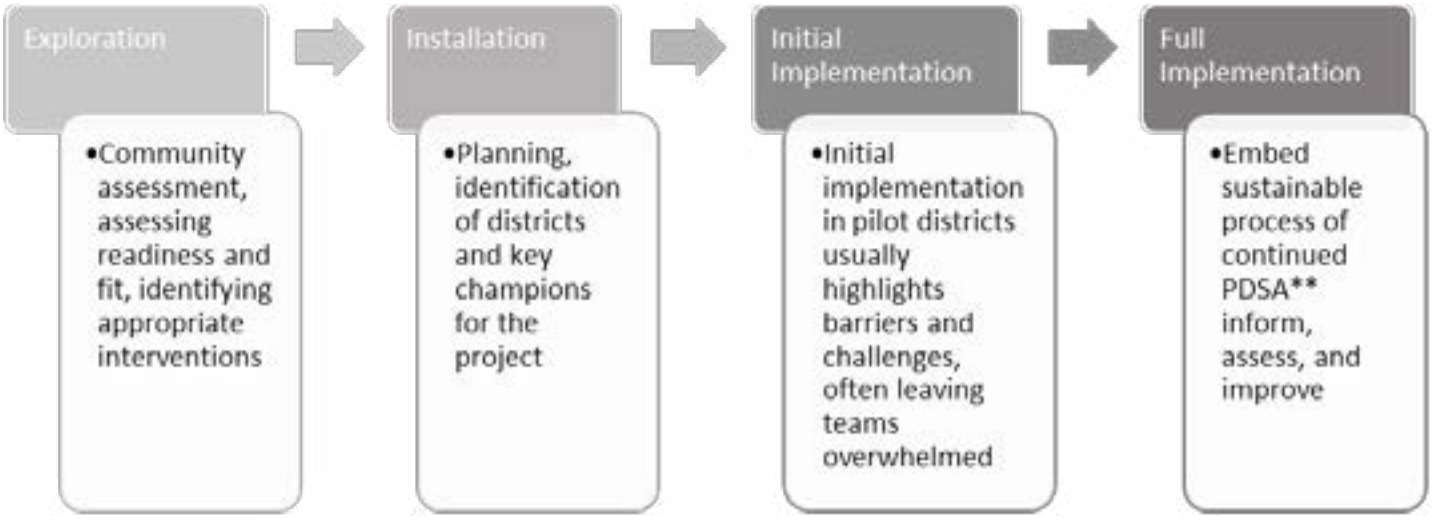
Pilot research studies conducted by CANS developers demonstrate both the reliability and validity of the CANS (Lyons, 2009; Praed Foundation, 2016), as well as the potential for improved placement stability for children in state custody (Lyons, 2009, p. 113; Lyons, 2014). These data support the potential efficacy of the CANS as a collaborative case planning tool, and one that serves the ultimate goals of all human services agencies: improving child outcomes and overall well-being.

> **AJ's Story, Part II:** *…Amy said that the most important thing that the CANS tool allowed my "team" to do was talk with me and each other about what I seemed to need the most and what was already working well. It was clear to everyone that I needed some support in school, and that I needed a family to commit to me. I didn't trust anyone and was so angry and alone. I don't remember much, but I remember thinking and feeling that I was nobody and no one cared or understood. My "team" included Amy, my child welfare social worker, my mental health clinician, my school counselor, and my foster mom, Renee. Renee kept a notebook with my schedule and habits and what made me angry and what I did when I was mad. This helped my school counselor, Drake, notice similar patterns at school. Seeing the same aggressive behaviors across settings helped my team realize that I was having "fight or flight" responses. They gave me tools for self-regulating and recommended ways that I could have the extra help I needed at school. The CANS also identified resilience as a strength and helped everyone on my team realize that art and exercise were important outlets for me that could also be used to manage my emotions. Most important, this led to finding my forever family.*
> . . .

Implementation Science

Implementation of new practice initiatives, such as teaming around the CANS, demands collaboration and commitment to arrive at a successful and productive practice. According to Fixsen, Blasé, Timbers, and Wolf (2001), there are four stages in implementation: Exploration, Installation, Initial Implementation, and Full Implementation. Each stage brings unique activities, challenges, and rewards (see Figure 1).

Figure 1. Stages of Implementation*.



*Based on work by Fixsen et al., 2001.

Initial implementation, which is the focus of this article, is the stage during which a new practice is first implemented and the biggest challenges arise. The National Implementation Research Network (NIRN) provides the following description of the initial implementation phase:

> During the Initial Implementation Stage, the new practice is first put into place and made available to consumers. The key focus of this stage is on continuous improvement. In Initial Implementation, staff are attempting to use newly learned skills (e.g., the evidence-based program) in the context of an organization, that is itself just learning how to change to accommodate and support the new ways of work. This is the most fragile Stage where the awkwardness associated with trying new things and the difficulties associated with changing old ways of work are strong motivations for giving up and going back to comfortable routines (business as usual). (2013-2017, para 1)

Initial Implementation of the CANS in a Northeastern State

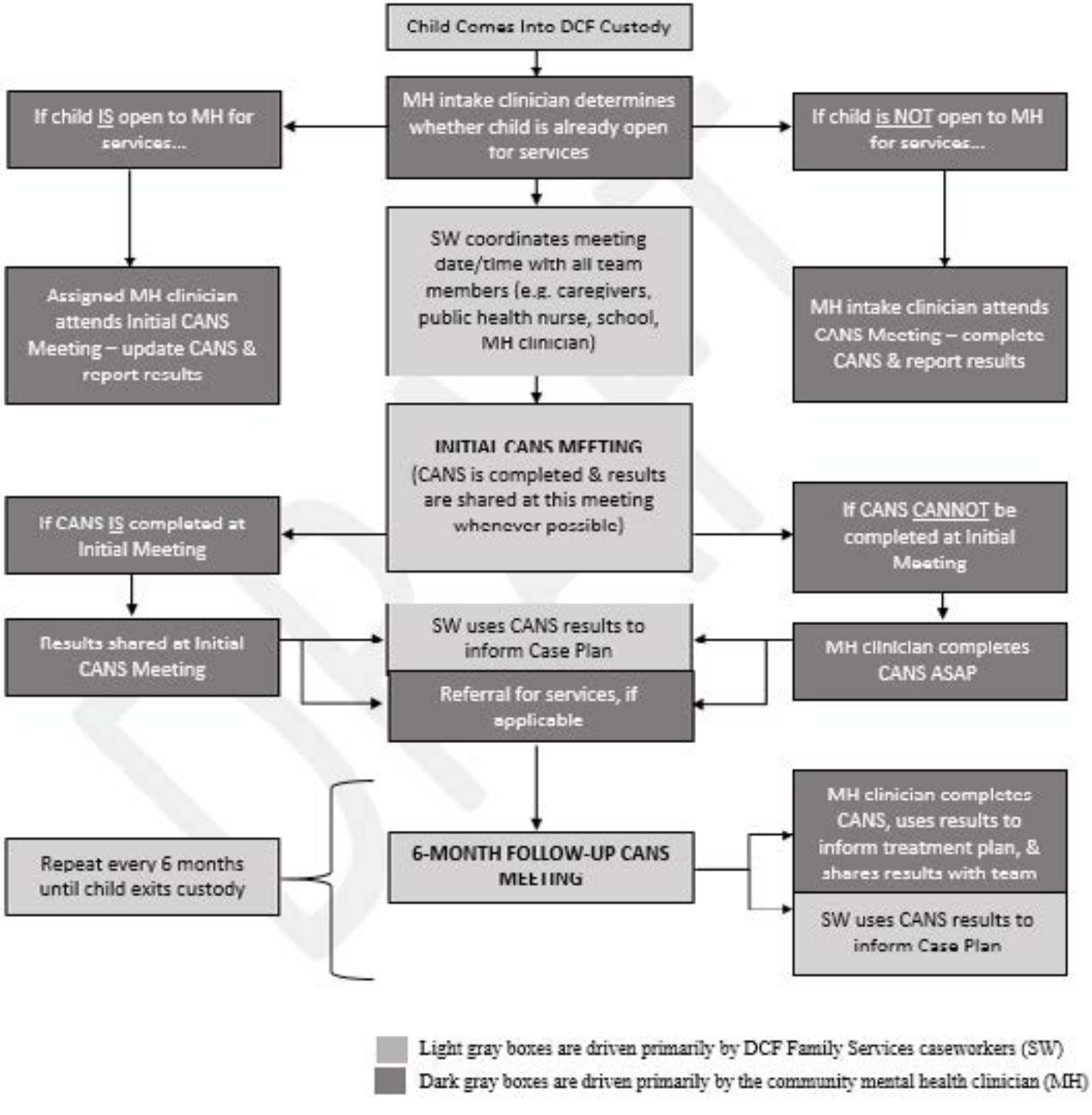
Implementation of the CANS in a Northeastern state began in 2014 with the State-Level Planning and Implementation Team, a 15-member, multidisciplinary team of local and state providers including community mental health, child welfare, and schools, which came together to identify a tool that could be utilized across disciplines to support a longstanding collaboration statute in the state. After thorough research and dialogue, the team decided to move forward with the CANS. There were a number of reasons for selecting this tool, including alignment with the state's system of care values, which emphasize a strengths-based approach to clear, cross-disciplinary communication. Ongoing leadership and oversight for implementation and fidelity of the CANS across many regions and agencies has continued to be supported by this cross-disciplinary team.

Children in state custody were quickly identified as one population that could benefit from supported implementation of the CANS, with the aim of improving placement stability through collaborative teaming and early, trauma-informed identification of needs and strengths, which informs service provision. The state has higher than average placement instability rates (USDHHS, 2013), and preliminary evidence suggests that the CANS may be a particularly powerful tool with which to improve placement stability (Lyons, 2009, 2014; Praed Foundation, 2016).

As a result, one district is piloting a cross-system collaborative case planning process using the CANS. In this district, the local implementation team comprises supervisors and clinicians from the community mental health agency, supervisors and directors in the district Family Services Division (FSD) office, and an implementation support team.

The implementation support team was funded through a 5-year federal grant that aims to improve placement stability and permanence for children and youth, by enhancing their social and emotional well-being. This goal is supported through the implementation of trauma-informed, evidence-based services and supports, such as the CANS. In this district, implementation support persons are working collaboratively alongside child welfare and mental health agencies to create a team-based CANS protocol that addresses the needs and barriers perceived across systems, while building on existing inner- and inter-agency strengths and teams. Prior to initial implementation, child welfare and mental health agencies in this district collaborated as part of a state pilot project aimed at bolstering system-level infrastructure for children, youth, and family services by supporting a continuum of integrated and consistent services for families.

Figure 2. Overview of the CANS Meeting Protocol, Working Draft.



Though the CANS protocol is still in the iterative phase of initial implementation (Fixsen et al., 2001), the flow of activities is depicted in Figure 2 (a working draft of the protocol) and outlined here, using AJ as an example. As Amy, AJ's social worker, prepared to write his case plan, she scheduled a CANS Meeting with his team, including a CANS-certified mental health clinician from the local community mental health agency, AJ's foster mother, school guidance counselor, and public health nurse. The team met to discuss AJ's strengths and needs. The clinician facilitated this conversation as she scored the CANS, using input from all of AJ's providers and caregivers. She was able to complete the CANS and share the results then and there, including recommendations for mental health service referrals. (Whenever possible, the CANS is completed at that Initial Meeting and the results are discussed with the entire team, including service recommendations; however, this is not always possible (e.g., a service provider is unable to attend the meeting and must be consulted by the clinician at a later time).) With release forms in place, a hard copy of the CANS report was shared with AJ's social worker. This report was used to inform AJ's case plan; his needs were addressed through referrals to trauma-informed services such as counseling, and his strengths were built upon by enrolling him in after-school art classes and allowing him to join the school's soccer team. Approximately five months later, Amy reached out to the team to schedule a follow-up meeting, during which an updated CANS would be completed, allowing the team to monitor AJ's progress over time and update his case and treatment plans.

Implementing any new protocol can be challenging; however, implementing cross-system practices can present multiple overlapping barriers that require the ongoing support of agency leadership (Aarons, Hurlburt, & Horwitz, 2011), as well as a committed and consistent implementation team who can flexibly adapt the protocol and support implementation efforts (NIRN, 2013-2017). Though the team continues to work toward a sustainable model, three recurring barriers have arisen during initial implementation of the CANS in this district, which have been creatively and collaboratively solved: (1) seeking input from education and healthcare providers (see Table 1), (2) workforce turnover and workload overload in both child welfare and mental health (see Table 2), and (3) lack of understanding of other professions' roles and responsibilities (see Table 3). These barriers, and the solutions addressing them, are detailed in the following three tables.

Table 1. Bringing Education and Healthcare Providers Together.

Specific Barriers	Solutions
Initial Implementation coincided with summer vacation for many schools, which may have hindered the implementation team's attempts to communicate with teachers and administrators regarding the new process of collaboration around the CANS.	The implementation team coordinated with the DCF leadership team to write and distribute a letter explaining the new initiative to teachers, and school and district leaders.
The heavy workload of pediatricians, in particular, may have precluded them from attending collaborative meetings.	Based on feedback from child welfare social workers, the protocol was revised so that the public health nurse now attends collaborative meetings, rather than each child's individual primary care physician.
In an earlier draft of the protocol, the implementation team was responsible for inviting providers to collaborative meetings; however, team members were frequently unable to gain access to the needed information prior to a child's first collaborative meeting after coming into custody.	The protocol was revised so that the child welfare social worker managing the case is responsible for inviting both school personnel and the public health nurse, as the caseworker has access to the needed information promptly after a child comes into custody.

Table 2. Workforce Turnover and Workload Overload in Child Welfare and Mental Health.

Specific Barriers	Solutions
Child welfare services and the local mental health agency experienced high staff turnover in conjunction with the onset of *Initial Implementation*.	Team leaders in the Child Protective Services (CPS) unit integrated the CANS protocol into regular training of new social workers. The mental health agency developed a CANS training for new employee orientation, and an ongoing consultation group to get mental health clinicians up to speed.
Due to a staffing shortage in the local mental health agency, only one clinician was conducting all of the CANS for new clients early in *Initial Implementation*, which resulted in a delay in CANS completion and teaming around the results.	The local mental health agency was able to increase staffing so that the assigned intake clinician is able to attend collaborative meetings and share CANS results in a timely manner. The right technology was also put in place so that CANS summary reports are now available immediately at the end of a CANS meeting.
Perhaps in part due to this delay in CANS completion, child welfare caseworkers reported that the collaborative process was not providing the information needed to inform case planning or support cross-context teaming.	The implementation team has created a "cross-walk," demonstrating the key areas of overlap between the CANS and an Initial Case Plan. Furthermore, feedback from both mental health and social workers is being monitored as CANS are completed more promptly and there are opportunities to observe change over time using a second CANS 6 months after the first.

Table 3. Lack of Understanding of Other Professions' Roles and Responsibilities.

Specific Barriers	Solutions
In early versions of the protocol, it was unclear whose role it was to initiate teaming for children who were already active clients of the local mental health agency.	The protocol was revised with this detail more clearly specified: Upon notification that a child has entered custody, the lead agency coordinator of the mental health agency collaborates with FSD supervisors to connect the social worker and assigned clinician.
At the onset of *Initial Implementation*, there was no existing mechanism for sharing this type of data regularly across agencies, nor was there a mechanism for sharing data with the implementation team that would allow for progress-monitoring. Mental health information-sharing was constrained by HIPAA protections for sharing youth substance use disorder and caregiver mental health information.	This barrier is being addressed in two stages: a) The protocol was revised to specify that all necessary parties will sign release forms before CANS results are shared with a child's team, with redaction practices in place when necessary. b) Currently, a data-sharing system is being designed and tested, which will allow child welfare and mental health agencies to share information on a child's CANS, as well as related services and outcomes, including placement stability. Furthermore, this system will allow the implementation and research team's access to de-identified data for the purposes of ongoing efficacy research

Conclusion

As depicted here, barriers to implementation have crossed systems, arising in child welfare, mental health, healthcare, and education. Yet teaming around the CANS is being used to support the work of service providers by aiding in identification of the strengths and needs of children and youth who have experienced trauma and maltreatment, as well as the adults who care for them, in order to promote the ultimate goal of improving placement stability, well-being, and positive lifetime outcomes for child welfare-involved children, youth, and families. Though there have been ongoing barriers throughout Initial Implementation, these barriers have been addressed using the same collaborative spirit that is at the heart of the implementation protocol itself. Indeed, as the team works to hone the protocol and move towards a sustainable implementation model, all members continue to approach the process with creativity, flexibility, and true collaboration. CANS implementation has helped to identify, measure, and celebrate *assets* in a way that supports the values of the state's system of care, while deepening its commitment to building resiliency and other strengths. With this powerful approach, we hope to support children like AJ who enter foster care feeling angry, scared, and alone, so that they may, with the help of trauma-informed, evidence-based services and supports, address their own barriers to happiness and success.

AJ's Story, Part III: *My forever mom was a local art teacher who had been a foster parent for many years and was ready to adopt a child of her own. Based on my identified strengths and interest in art, my team thought that we might be a good fit. Based on my needs, the team recommended that Mom attend a training on understanding and working with kids who have experienced a lot of trauma, called the Resource Parent Curriculum (Grillo, Lott, & Foster Care Subcommittee of the Child Welfare Committee, National Child Traumatic Stress Network, 2010), and that I start seeing a counselor to help me deal with my trauma. With the support of my team, Mom was able to really make a difference for me, and she knew that she wanted to be my Mom forever. The rest is history!*

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