Reliably Rating the CANS and ANSA

Betty Walton, PhD & John S Lyons, PhD
Indiana Division of Mental Health & Addiction
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As using information from strengths and needs assessment is being integrated into policy, basic questions have been asked. This following has been drafted in response to put aspects of ongoing training into a written document. To facilitate the reliable use the tools, relevant examples, applied practice, debriefing and coaching are needed.

Q. How do you rate the CANS and ANSA?

A. To reliably rate the Child and Adolescent Needs & Strengths Assessment (CANS) or Adult Needs and Strengths Assessment (ANSA), the rater needs a working knowledge of the six basic principles for the communimetric tools, an understanding of the scoring system, to have access to the CANS or ANSA manual for operational descriptions of circumstances which are likely to be rated at each level, use of the CANS or ANSA Glossary for additional information about the purpose of each item and to be currently certified to use the tool(s).

Six Key Principles of a Communimetric Tool

Principles	Description	Notes
1	Items are selected based on relevance to planning	The tools have item level face validity and immediate relevance for creating the treatment plan. If an item is the same for everyone, there is no purpose for having it. Similarly, if an item is not relevant to treatment planning, it is unnecessary.
2	Action level for all items	Scoring levels (0, 1, 2, 3) translate into appropriate action. See Scoring Needs & Strengths below.
3	Consider culture and development before establishing the action level	Before rating needs and strengths, consider the individual and family's culture. Treating different people differently based on cultural consideration is the core concept of cultural sensitivity. Also, a developmental perspective is taken in that expectations for a six year old are dramatically different than those for a sixteen year old.
4	Agnostic as to etiology—descriptive, no cause and effect	Most items are descriptive, with no specific cause of the need required. It is about the 'what' not the 'why'. Most individuals and families can agree on needs and strengths. Addressing the "why" is part of intervention planning.

Principles	Description	Notes
5	About the individual, not about the service.	These tools exist to represent the shared vision of the needs and strengths of the people served in the system. That vision is the health and wellbeing of the person not the health and wellbeing of the person while in services. Therefore, if services are in place that mask a need, the ratings should reflect the need not the fact that the service is masking it. The purpose is to rate the needs of an individual and caretakers, not how they are functioning with services in place. A 'discharge' ANSA from a hospital should reflect the individual's needs as they transition to community based care.*
6	Unless otherwise indicated, use past 30 days to rate needs.	However, time frames can be over-ridden if continued action is indicated. If something in the past is the basis for continued (future) action, the time-frame can be over-ridden.*

*See the following discussion of reliably rating the needs and strengths of individuals who receive intensive services.

The CANS and ANSA are easy to learn and are well liked by individuals, youth and families, providers and other partners in the services system because they are easy to understand. Each CANS or ANSA item suggests different pathways for service planning. There are four levels of each item with anchored definitions (found in the CANS and ANSA Manuals). The anchored definitions are designed to translate into the following action levels. If the manual's definitions for rating an item do not fit a particular situation, the rater must revert to the basic meaning of a level of need and the appropriate action level for each level. Different meaning is related to rating of needs and strengths as described in the following tables.

Scoring Needs

Score	Level of Need	Appropriate Action
0	No evidence of need	No action needed
1	Significant history or possible need which is not interfering with functioning	Watchful waiting/ Prevention/ Additional assessment
2	Need interferes with functioning	Action/Intervention
3	Need is dangerous or disabling	Immediate/Intensive action

Scoring Strengths

Score	Level of Strength	Appropriate Action
0	Centerpiece strength	Central to planning*
1	Strength present	Useful in planning*
2	Identified strength	Must be Built/Developed**
3	No strength identified	Strength creation or identification may be indicated

* Use/build strengths to address needs of children >13; use/build strengths to build resiliency separate from treatment for adolescents.

** It is just as beneficial to build, develop strengths as to have them. Children and youth with strengths tend to function better, in spite of significant needs.

Q. How can we reliably rate the needs of an individual who is receiving intensity services in a state hospital, a youth residential setting, ACT, Wraparound or other intensive community based services?

A. It can be challenging to accurately reflect the needs of a person residing in an intensive treatment setting. Reliably rating the ANSA involves getting to the needs of the individual, needs which may be masked by services or the setting. For youth and some adults we have been told that the ratings for individuals leaving hospitals are sometimes different from what community based providers see when individuals go home. For example, if an individual had difficulty remembering to take his medication as prescribed, shopping, paying bills and staying sober in the community, are these still issues (needs)?

Dr. Lyons talks about the best strategy involving understanding the needs that brought an individual to intensive treatment and then look for any evidence that these needs have changed...helps to determine if this is a setting effect or a treatment effect (improvement). In other words, evidence of treatment effects are different from setting effects. A setting effect is a change in behavior due to the structured environment. A treatment effect is a change in the individual that is likely to transcend environments.

For example, waking a youth and ensuring he/she goes to an on-campus school would be a setting effect for School Attendance. Identifying the factors that had led to the youth's previous School Attendance needs (e.g. undetected learning problems, social anxiety) and effectively addressing these issues would be a treatment effect.

If a need requires services to be maintained or improved in the community, keep the baseline rating. A strategy to help decide, is, when possible, to reduce the intensity of services, have home visits, etc. Another strategy is to include the individual, family, community gatekeeper and other stakeholders (probation, child welfare) in rating needs to get consensus and more accurate assessment of areas which need to be addressed in a transition plan to the community. The hospital 'discharge' plan should be an accurate transition plan to community based care.

Q. How can we ensure that the CANS and ANSA are being rated reliably?

A. Policies have been implemented and several suggestions made to ensure that the needs and strengths of individuals are being accurately rated. A few enhancements are planned for SFY2010.

1. Since July 2007, each CANS and ANSA user must be certified annually, reliably rating a vignette online as indicated by at least a 0.70 intraclass correlation coefficient. *Enhancement:* During SFY2010, modify certification requirement so that:

    - Certification test results of 0.70 - 0.74 will be valid for 6 months. These users need to review the training videos and/or work with a SuperUser to reach 0.75 reliability.
    - Certification test results of 0.75 - 0.80 reliability will be valid for 1 calendar year.
    - Certification test results greater than 0.80 reliability will be valid for 2 calendar years.

2. Develop local expertise in rating and using the CANS and ANSA through a cohort of more than 600 'SuperUsers' (SU). SU must complete in person training with Dr. John S Lyons and Dr. Betty Walton, achieving 0.75 reliability, writing and rating vignettes and role planning introductions of tools/training. Their roles include training and coaching local direct service staff to become certified, work with management and technology to integrate the tools and resulting information into practice (complete assessments as part of routine work, integrate into EMR, use resulting information to help develop intervention plans, etc. Boosters were offered with participation recommended. Four trainings for new SU are planned for SFY2101.

    Enhancement: To retain SU status, previously trained SUs must participate in one of 10 SU Boosters in SFY2010 and continue to achieve 0.75 reliability when recertified online.

3. Providers aggregate ratings will be profiled in SFY2010, identifying high and low ratings. On site reviews and targeted trainings will be provided for outliers.

4. Audits for DMHA contract providers will include a review of the CANS and ANSA. Were the assessments completed in a timely fashion? Is the assessment in the clinical record? Are the needs and strengths which were identified on the CANS and ANSA addressed in the treatment plan? Does the intensity of services received compare with what was recommended?

5. Medicaid audits may look at the reliability of ratings.

6. The Community Alternative to Psychiatric Residential Treatment Facilities Medicaid demonstration grant uses the CANS to determine eligibility, develop plans of care and to monitor progress. A SU training and targeted booster was held in spring of 2009 for 65 grant facilitators. Targeted boosters are planned for SFY2010.

7. Technology was developed to collect, analyze and report assessment information in real time, challenging the culture or a one way reporting system.

   Enhancement: Web Services are being built and enhanced to provide a direct link from the Data Assessment Registry for Mental Health and Addiction (DARMHA) to local agency's electronic clinical records.

8. Suggestion: Through SU trainings and boosters, local agencies have been encouraged to integrate information from the assessment ratings into everyday practice. Integration, actual use of the information to support decisions, to monitor progress and to improve quality increases the basic reliability of the tools.

9. Suggestion: Boosters have focused on rating challenges (rating needs when intensive services are provided), using the tools and related information in clinical supervision, developing supervisory processes before assessments are completed (closed in DARMHA) and using information to develop intervention plans.

10. Policy: Performance outcome measures are built into DMHA's SFY2010 contract with ANSA domains and targeted CANS and ANSA domains.

11. Proposed Policy: For SFY2011, MRO services will be justified by behavioral health algorithms. Proposed packages of services will be attached.

12. Department of Child Services is implementing the CANS in SFY2010, planning to use information to support team decisions about placement and services. Practice and policy about how to integrate DCS staff's use of the tools with community and residential providers is developing.

13. Consultation is provided to providers and individual users through planned boosters, email consultation, monthly technology user meetings, and as needed. The need for training and consultation to support and sustain the effective use of the tools being reviewed.

Conclusion

The gradual implementation of these tools and integration into practice and policy create meaning for the tools beyond a required form to useful tools which support a recovery, strengths based framework. Due to the complex contingency involved in the approach, the only way to "win" is to rate the needs and strengths as accurately as possible. Multiple and transparent use of the tools and resulting information makes efforts to look good or skew ratings to justify services obvious. This is an opportunity to base not only direct service, but policy and funding on the needs of individuals who are being served and to more effectively manage programs, services and the system.