Choosing a Consent Decree Clinical Assessment Tool

October 27, 2026

DCYF

Selection of a Clinical Assessment Tool

- Process for considering a clinical assessment tool
- Consent decree requirements
- CANS summary and work to date to update the CANS
- Comparison with other tools
- Reason for Choosing the CANS
- Appendix: More comparison info on tools



Process for Selecting and Recommending the CANS as the Clinical Assessment Tool

DCYF has been working since 2025 to update the CANS tool used within Rhode Island.

Information on the old CANS, new CANS, CALOCUS/CASII and CAFAS was discussed with the action team, as well as DCYF's rationale for wanting to use the CANS as the consent decree clinical assessment tool.

DCYF is seeking input from the Advisory Committee and will then present to the Court Monitor and Steering Committee.

1. Development of Updated CANS

2025-2026

DCYF has worked with Praed Foundation and consulted widely with involved providers to update the current version of the CANS for use in the state

2. Consultation with Action Team

August to October 2026

DCYF presented on the CANS and alternative tools to the action team and discussed concerns and thoughts.

3. Discussion with Advisory Committee

Today

DCYF would like to present on the choice of the CANS as the chosen clinical assessment tool and seek feedback.

4. Presentation to Monitor and Steering Committee

November 2026

DCYF will complete a formal memo recommending the CANS and discuss the recommendation with the Court Monitor and Steering Committee

Consent Decree Clinical Assessment Requirements

According to the Consent Decree …

A “Clinical Assessment Tool” is a standardized, validated, and evidence-based mental health assessment tool of a child’s functioning and identified needs and strengths across crucial life domains, administered by a clinician, including those performed by Bradley Hospital. The Clinical Assessment Tool will inform decisions about level of care, and the type and intensity of services.

And

The State will establish and implement policies and procedures to ensure that a timely, person-centered behavioral health assessment, using a recognized Clinical Assessment Tool, is conducted for all members of the Focus Population, as clinically indicated. The purpose of the assessment is to gather comprehensive and individualized information about the child and identify the goals, strengths, needs, preferences, and cultural factors of the child and family.

System Review Comp Assessment Findings and Recommendations

The initial System Review completed by the Innovations Institute had the following findings and recommendations:

- Assessments, clinical records, treatment and discharge plans, and placement referral forms do not consistently elevate the youth and family's goals for themselves, their interests, or their strengths.
- Referrals and reports often described the living arrangement where a youth is recommended to go instead of describing a youth's treatment needs and the types of interventions and services they would benefit from.
- To the extent feasible, the State should identify, collect, and report additional data to improve understanding of the following: Children's clinical diagnoses, functional impairments, or acuity levels at the time of inpatient admission, discharge, and repeated ED visits;
- Transition planning should be guided by a standardized framework that incorporates the child's strengths, needs, preferences, and family circumstances, and that anticipates service, placement, and court-related barriers early in the hospitalization.

**The full report is available on DCYF's Consent Decree webpage:* https://dcyf.ri.gov/programsinitiatives/consent-decree

Child and Adolescent Needs and Strengths (CANS)

What is the CANS?

- The CANS is a widely-used standardized assessment tool that has been determined to be valid and reliable
- Provides a comprehensive picture of the youth's needs and strengths
- The CANS is an information integration tool, intended to include multiple sources of information (e.g., youth and family, referral source, treatment providers, school and observation of the rater).

CANS Implementation in Rhode Island

- 2013: Roll out: Congregate Care, Specialized Foster Care, ILP, SILP
- 2016: Level of Need
- 2017: Utilization Management
- 2018: FCCP CANS Plus
- 2019: LON 0-5
- 2025: CCBHC
- 2026: Work to update the CANS in Rhode Island

Current & Future Version of the (CANS)

Current CANS Domains 0-4

- ✓ Life Functioning
- ✓ Child Strengths
- ✓ Parent/Guardian/Caregiver Strengths & Needs
- ✓ Child Behavioral/Emotional Needs
- ✓ Child Risk Factors & Behaviors

Current CANS Domains 5-21

- ✓ Life Functioning
- ✓ Child Strengths
- ✓ School
- ✓ Parent/Guardian/Caregiver Strengths & Needs
- ✓ Child Behavioral/Emotional Needs
- ✓ Child Risk Behaviors
- ✓ Trauma
- ✓ Sexual Abuse

What we're thinking the new CANS will look like….

- ✓ Life Functioning
- ✓ School
- ✓ Cultural Factors
- ✓ Strengths
- ✓ Behavioral-Emotional Health
- ✓ Risk Behaviors
- ✓ Caregiver Needs and Strengths
- ✓ Trauma
- ✓ Substance Use Module
- ✓ Violence Module
- ✓ Sexual Aggression
- ✓ Runaway
- ✓ Exploitation
- ✓ Parental Caregiving

Considerations for Tool Selection

Population & purpose: Coverage of relevant ages, needs, and life domains; alignment with consent decree requirements and intended uses.

Scientific evidence: Reliability and validity for the intended population and use; sensitivity to change if used to monitor progress.

Usability: Ease of completing, scoring, and interpreting the assessment.

Accessibility & participation: Language availability, cultural fit, and incorporation of child/caregiver perspectives.

Rater requirements: Qualifications, training, certification, and ongoing support needed for consistent ratings.

Feasibility & resources: Assessment time, workflow fit, costs, and data-system needs.

Use of results: How findings would inform care planning and service decisions.

Quality monitoring: Capacity to monitor rating consistency, assessment quality, and use of findings.

Slide uses work of Innovations Institute with Zima et al. (2019), with additional implementation considerations.

Assessment Tools Considered

Tool	Primary Purpose	Core Output
Comprehensive Assessment of Needs and Strengths (CANS)	Identify needs and strengths to guide care planning	Individual item ratings indicating action needed and strengths available
Child and Adolescent Level of Care/Service Intensity Utilization System (CALOCUS-CASII)	Determine appropriate service intensity	Dimension ratings, composite score, and recommended service intensity level
Child and Adolescent Functional Assessment Scale (CAFAS)	Assess broad functional impairment	Domain and total impairment scores

The tools have different primary purposes, but all three can inform planning and level of care decisions.

Slide uses work from Innovations Institute.

Assessment Tools Summary

	CANS	CALOCUS-CASII	CAFAS
Ages	0-5, 6-20, 21+ (Lifespan version)	6-18; ECSII for ages 0-5; LOCUS for >18	5-19*; PECFAS for ages 3-7
Primary purpose	Identify needs and strengths for individualized planning	Determine needed service intensity	Assess functional impairment across life domains
Evidence	Reliability and validity for studied versions; research on planning and change	Inter-rater reliability and validity; research on service-intensity recommendations	Reliability and validity; prediction of service use and measurement of change
Rater requirements	Training and annual certification; qualifications requirements set by state	Initial training; *additional requirements set by the state**	Training and demonstrated rating reliability; *additional requirements set by the state**
Implementation considerations	Builds on RI experience and developer partnership; adaptable, detailed item data	Standardized algorithm recommends service intensity, incorporating family and community supports; use companion tools for age coverage	Standardized ratings describe functional impairment across life domains and support monitoring change; use PECFAS for young children

Slide uses work from Innovations Institute.

Rationale for selecting the CANS as clinical assessment tool

Criteria	CANS	CALOCUS/CASII	CAFAS
Current usage w/in Rhode Island	high	minimal to none	minimal to none
Used nationally	✓	✓	✓
RI already invested in implementation	✓	✗	✗
Robust identification of strengths (in addition to needs)	✓	✗	✗
Supports identification & communication on specific needs	✓	✗	✗
Usage by non-master's level clinicians	✓	~	✗
Can support medical necessity and level of need determination	✓	✓	✓

Rationale for selecting the CANS as clinical assessment tool

DCYF is recommending the adoption of the CANS as the clinical assessment tool for the consent decree based upon …

- ✓ The state's longstanding investment in and implementation of the CANS
- ✓ The state's already completed work updating the CANS
- ✓ The CANS ability to identify strengths (and not just needs)
- ✓ The more detailed ability of the CANS to identify specific needs and serve as a tool for communication
- ✓ Well developed ability to be completed by non-clinicians
- ✓ Current use by DCYF staff



Discussion

Appendix: A Deeper Review of the Tool Options

Appendix: Comprehensive Assessment of Needs and Strengths (CANS)

- **Purpose:** Rates needs and strengths across life domains to support individualized planning, shared communication, and outcome monitoring.
- **Scoring:** Each item receives a 0–3 rating indicating the action needed or availability of a strength.
- **Decision support:** Item ratings inform care planning. Local algorithms can support decisions about service intensity and level of care.

Proposed RI Domains & Modules	
Life Functioning*	Trauma
School	Substance Use Module
Cultural Factors*	Violence Module
Strengths*	Sexual Aggression
Behavioral-Emotional Health*	Runaway
Risk Behaviors*	Exploitation
Caregiver Needs & Strengths*	Parental Caregiving

*Core to the standard CANS.

https://praedfoundation.org/tcom/tcom-tools/the-child-and-adolescent-needs-and-strengths-cans/

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Appendix: CANS Administration & Implementation

- **Ages:** Current versions cover 0–4 and 5–21
  - RI Lifespan CANS covers all ages, with versions for 0-5, 6-20, and 21+
- **Who rates it:** Trained, certified practitioners using information from youth, families, providers, schools, and records
  - Qualifications depend on program requirements
- **Time:** Depends on the version, applicable modules, and information gathering
- **Training:** Certification through the Praed Foundation, with annual recertification
- **Formats & data:** Paper and electronic formats
  - RI planned CANS entry into its new CCWIS in late 2027
- **Costs:** Training, certification, and data systems may involve costs. Instrument use is free.

https://praedfoundation.org/

Appendix: CANS Evidence & Use

- **Populations studied:** Youth in mental health, child welfare, and juvenile justice settings, using different CANS versions.
- **Reliability:** Research supports agreement between trained raters, although agreement varies across items and domains.
- **Validity:** Studies report relationships with established measures and clinical characteristics. Evidence supporting combined domain scores is mixed.
- **Use in decisions:** Studies of CANS-based algorithms support their use alongside clinical review in placement decisions; findings apply to the particular algorithm and service system studied.
- **Tracking change:** Repeated ratings can monitor needs and strengths. Longitudinal studies show improvement in some domains, but evidence is limited and findings vary.

https://praedfoundation.org/tcom/tcom-tools/the-child-and-adolescent-needs-and-strengths-cans/

Appendix: Child and Adolescent Level of Care/Service Intensity Utilization System (CALOCUS-CASII)

- **Purpose:** Assesses child and family needs across 6 dimensions to determine the appropriate intensity of services
- **Scoring:** Dimension ratings of 1-5 yield a composite score of 7-35.
- **Decision support:** A standardized algorithm combines the composite score with dimension-specific criteria to recommend a service intensity level

Dimension	Description
Risk of Harm	Risk of harm to self or others, unsafe behavior, and vulnerability to abuse or neglect
Functional Status	School, relationships, self-care, and daily functioning for age and developmental level
Co-Occurrence of Conditions	Coexisting medical, substance use, developmental, or psychiatric conditions and their impact on functioning and service needs
Recovery Environment	Child/family stressors and family/community supports (2 subscales)
Resilience and Response to Services	Coping with challenges and response to services and supports
Engagement in Services	Youth/caregiver ability and willingness to collaborate and participate in care (2 subscales)

https://calocus-casii.org/

Appendix: CALOCUS-CASII Administration & Implementation

- **Ages:** 6-18
  - Early Childhood Service Intensity Instrument (ECSII) for younger children (0-5)
  - Level of Care Utilization System (LOCUS) for those over 18
- **Who rates it:** Trained clinicians and other child-serving professionals, including care coordinators, using clinical assessment information
- **Time:** Varies depending on available information and administrator experience
- **Training:** AACAP offers online training, approximately 6 hours (manual included), and instructor-led training in person or by Zoom (manual not included)
  - Refresher training is available; no routine publisher recertification requirement identified
- **Formats & data:** Manual and electronic scoring options; data-system integration depends on the implementation arrangement
- **Costs:** Training and manuals; electronic scoring/licensing costs depend on the implementation arrangement. AACAP lists individual online training at $199

www.calocus-casii.org
https://www.aacap.org/AACAP/Member_Resources/Practice_Information/CALOCUS_CASII.aspx

Appendix: CALOCUS-CASII Evidence & Use

- **Populations studied:** Youth in mental health, child welfare, and juvenile justice settings. Most research reviewed examined earlier CALOCUS or CASII versions.
- **Reliability:** Initial vignette testing found strong agreement among raters on composite scores, with agreement varying across dimensions.
- **Validity:** Scores were associated with established measures of functioning and behavioral health needs, including CAFAS, CGAS, and CBCL.
- **Use in decisions:** Child welfare and juvenile justice studies found differences between recommended and actual levels of care.
- **Tracking change:** An outpatient CASII study found lower average scores at discharge; evidence across settings and acuity levels remains limited.

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Appendix: Child and Adolescent Functional Assessment Scale® (CAFAS)

- **Purpose:** Assesses functional impairment across 8 domains and tracks change over time.
- **Scoring:** Domain scores: 0 = minimal/none; 10 = mild; 20 = moderate; 30 = severe. Total: 0–240
- **Includes:** Two optional caregiver domains (material needs & social support); strengths & goals
- **Decision support:** Standardized scores inform planning. RI must define how scores contribute to service-intensity and level-of-care decisions.

Domain	Description
School/Work	Ability to function satisfactorily in a group educational setting; e.g., attendance, behavior
Home	Willingness to observe reasonable rules and perform age appropriate tasks
Community	Respect for the rights and property of others and conformity to laws
Behavior Toward Others	Appropriateness of youth's daily behavior
Moods/Emotions	Emotional self-regulation; e.g., anxiety, depression, or trauma-related distress
Self-Harm	Ability to cope without resorting to self-harmful behavior or verbalizations
Substance Use	Substance use and related disruption; e.g., frequency and consequences
Thinking	Ability of the youth to use rational thought processes

Appendix: CAFAS Administration & Implementation

- **Ages:** 5-19
  - Preschool and Early Childhood Functional Assessment Scale® (PECFAS) for younger children (3-7)
- **Who rates it:** Trained practitioners using info gathered through a broader clinical assessment
- **Time:** Typically about 10 minutes *once info has been gathered*
- **Training:** Self-training manual, online, and in-person options are available via MHS
  - Passing a reliability test establishes certified-rater status
  - MHS does not require recertification; states or agencies may require refresher training/recertification
- **Formats & data:** Available on paper or through FAS Outcomes (proprietary web-based system)
  - FAS Outcomes offers data exports and optional EHR integration (web services)
- **Costs:** Training materials; paper forms or online assessment fees; annual online maintenance fee

https://storefront.mhs.com/collections/cafas

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Appendix: CAFAS Evidence & Use

- **Populations studied:** Youth in mental health, child welfare, juvenile justice, and school-based mental health settings, including youth with serious emotional disturbance
- **Reliability:** Studies support agreement among trained raters, with stronger agreement on total scores and behaviorally anchored scales
- **Validity:** Scores relate to other indicators of functioning and differ across levels of care. Intake scores have predicted later service use and costs.
- **Use in decisions:** Research describes using functional profiles and progress data to identify service needs, review treatment plans, and guide program development.
- **Tracking change:** Studies have detected changes in functioning over time and differences between treatment groups, supporting use for progress monitoring and program evaluation.

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