



State of South Carolina

Department of Social Services

Policies and Guidelines: Child Welfare Services

Subject	Child and Adolescent Needs and Strengths Assessments
Document No.	1650
Amendment No.	1650-26.1
Authority	Family First Prevention Services Act (P.L. 115-123)
Standards	Guiding Principles and Standards (GPS) Practice Model
Application	All Child Welfare Services Staff
Purpose	
To guide child welfare case managers and team leaders in completing the Child and Adolescent Needs and Strengths (CANS) tool to complete fact-based assessments that reflect strengths-based, trauma informed, culturally responsive, and family centered practice, grounded in the interpersonal skills of genuineness, empathy, and respect for the family in accordance with the Guiding Principles and Standards (GPS) Practice Model .	
Policy Statement	
Child welfare case managers shall complete fact-based assessments of children and families using the Child and Adolescent Needs and Strengths (CANS) tool within the designated timeframes outlined in this policy. Assessment results must be used to identify and respond to the child's needs and strengths. If a case manager is unable to complete the assessment, the team leader shall assume responsibility for its timely completion.	
Policy Administration	
The Division of Child Welfare Services' Office of Safety is the owner of this policy. The Safety Director, or designee, shall review this policy annually from the date published in the Child Welfare Services Policy Manual, or as needed due to changes in law or practice.	
Policy Guidelines	
A. CANS Assessments for Children Receiving Foster Care, Adoption, and Transition Services and Support	1. The following personnel may utilize the Child and Adolescent Needs and Strengths (CANS) to either complete assessments or gather case specific information: a. Case managers and team leaders across all child welfare programs shall utilize CANS to evaluate the strengths and needs of children under the care of foster care, adoptions, or Transition Services and Support (TSS); b. Regional Assessment and Planning Coordinators; c. DSS Therapeutic Services Coordinators (TSC) or Regional Clinical Specialists (RCS) to evaluate clinical service needs for children; d. DSS Nurse Care Coordinators to evaluate medical needs for children;

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	e. Transitional Youth Advocates to assess independent living skills for 18-21 year olds, who partner with DSS to continue receiving services and support to foster a successful transition to adulthood; f. Child and Family Team (CFT) Facilitators to submit requests and utilize information found in an assessment, to prepare for a 90-Day Child and Family Team Meeting (CFTM); and g. Placement staff to submit requests and utilize information found in the assessment to identify instances in which a child may need trauma-responsive services to address their individualized needs. 2. Case managers may utilize DSS Form 37673: CANS Field Guide as a reference when completing the comprehensive assessment; however, the CANS must be fully completed and entered in CAPSS.
B. CANS Assessment Domain Groups	Basic core indicators/items are grouped by domain. Each CANS domain consists of indicators/items that case managers must rate when completing the assessment. 1. The South Carolina CANS assessment domains are: a. Behavioral/Emotional Needs; b. Risk Behaviors; c. Life Functioning; d. Cultural Factors; e. Strengths; f. Caregiver Resources and Needs; g. Potentially Traumatic/Adverse Childhood Experiences; h. Early Childhood (Ages 0-5); and i. Independent Living (Ages 14 -17; Ages 18 – 20 for young adults receiving extended foster care services from TSS). 2. Case managers must complete the Early Childhood Domain for children in foster care who are between the ages of 0 and 5. a. Case managers are not required to complete the Early Childhood Domain, but must complete all the other domains listed, for children in foster care over the age of 5. 3. Case managers shall utilize the Independent Living CANS (IL – CANS) Module to assess children starting at age 14 to identify and provide monthly independent living skills that help towards the goal of a successful transition to adulthood.
C. CANS Assessment Indicator/Item Rating	1. Basic core indicators/items are rated for all individuals. The CANS assessment uses a Likert scale (0, 1, 2, and 3) to identify and rate a child's "Needs" and "Strengths"; except for the Potentially Traumatic/Adverse Childhood

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	Experiences Domain, which is rated using “Yes” or “No”. 2. Non-Actionable indicators/items have a rating of 0 or 1, and result in one of the following outcomes: a. 0 – No action needed; or b. 1 – Watchful waiting, prevention, and/or additional assessment. 3. Actionable indicators/items have a rating of 2 or 3, and result in one of the following outcomes: a. 2 – Action/intervention required, opportunity for strength building; or b. 3 – Immediate, intensive, action required, strength creation or identification may be indicated. Note: <i>Individual assessment module questions provide additional information in specific areas (e.g., a rating of 1, 2, or 3 on the Victimization/Exploitation and Medical/Physical indicator/item necessitate the completion of the Commercially Sexually Exploited (CSE) Module and Medical Health Module, respectively).</i> 4. Case managers shall provide written justification for every: a. Strength indicator/item regardless of rating; and b. Need indicator/item rated a 1, 2, or 3. 5. Case managers may rate an indicator/item “Not Applicable, N/A” only in rare instances when no indicator/item applies to an individual’s current circumstances or situation. 6. Refer to the CANS Reference Guide for an exhaustive list of CANS indicators/items that case managers must assess and rate as part of the comprehensive assessment.
D. Writing Rationale	1. The rationale section is a narrative section of the assessment that provides: a. A clear and concise justification of the need for an intervention or service; b. An explanation of the rating, behaviors, current intervention(s), and concerns contributing to the rating; c. Information on the occurrence and severity; d. Discussion of whether another indicator/item contributes to another concern causing the severity to increase more; and e. Any individual(s) who may negatively impact the occurrence and severity. 2. Case managers shall provide written justification, in the Rationale section, for every: a. Need indicator/item rated a 1, 2, or 3; and b. Strength indicator/item regardless of rating. 3. Only the rationale of actionable indicators/items section, auto-populates into the Family Permanency Plan (FPP).

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E. Timeframes for CANS Assessment Initiation and Updates	1. Case managers shall complete the Initial CANS within 48 hours after the 25-Day CFTM. 2. Team leaders shall complete a Full Review of the CANS by Day 30 of the foster care line opening. 3. The below items reflect additional points in time when a Full Review of the CANS must be completed: a. A minimum of every 90 days; b. Before any FPP revision; c. Before all CFTM's; d. Transitional Periods; and e. Five (5) days before a child exits care.
F. Foster Care Entries	1. Upon a child entering foster care, foster care case managers shall utilize the Behavioral/Mental Health Needs, School, and Risk Behavior Module information from previous Family Advocacy and Support Tool (FAST) assessments to determine the level of care needed. 2. After a child's fifth day in care, foster care case managers shall collaborate with case managers from investigations or family preservation to gather information and begin the process of completing the CANS assessment. 3. Foster care case managers shall complete and submit the initial CANS within the first 48 business hours following the 25-Day CFTM, regardless of whether DSS recommends the child remain in foster care, return home, or exit foster care. a. Foster care case managers shall notify the Regional Clinical Specialist (RCS) when a child scores a 1, 2, or 3 on Behavioral/Emotional Needs or Risk Behaviors indicators/items in order to discuss the next steps regarding both identified and potential needs. 4. Within 72 hours of receipt, team leaders shall review and approve, or reject and return, submitted assessments to case managers for corrections. All resubmissions shall be reviewed within 72 hours of receipt. 5. Approved assessments are then reviewed and approved, or rejected for revision, by an Assessment and Planning Coordinator within five (5) business days of receipt.
G. Caregiver Assessment	1. When completing the Caregiver Assessment portion of the CANS, case managers shall consider assessing the following items: a. Biological parents whose parental rights have not been terminated; b. Noncustodial parents; c. Foster parents whose foster children have a plan of Another Planned Permanent Living Arrangement (APPLA)

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	and are going to remain in the foster parent's home after attaining age 18; and d. Foster parents who are considered pre-adoptive or adoptive parents who have signed pre-adoptive or adoptive placement agreements. 2. Case managers shall rate foster parents, who do not wish to adopt and who will not serve as long-term placement for a child after the child attains age 18, in the Life Functioning Domain under the Living Situation indicator/item. 3. Case managers shall refer regulatory concerns to the DSS Foster Family and Licensing Support Office. 4. The CANS assessment cannot be completed if a case manager has not made initial contact with the parent or caregiver and reliable documentation from a professional entity (e.g., law enforcement, medical organizations, educational institutions, and any in-state agencies) is not available. 5. Case managers may complete and finalize the CANS assessment using evidence and information obtained from an outside professional entity provided the entity documents the evidence and information in writing and it is clear the entity is the source of the documentation. 6. Case managers may rely on evidence and information that is received from an out-of-state public child welfare agency to complete and finalize a CANS assessment. However, the information must be in writing, and it must be clear that the out-of-state public child welfare agency is the source of the documentation. The documentation must address the following: - Specific questions provided by DSS, related to the CANS indicators/items; - Caregiver domains including: - Strengths; - Needs; - Advocacy and Capacity; and - Caregiver.
H. Initial CANS Assessment and Gathering Information	1. Case managers shall initiate a CANS assessment after foster care entry and repeat the assessment if a child exits and re-enters foster care. 2. Case managers shall complete the CANS assessment if a child exits care via a court order after the 25-Day CFTM. 3. The CFTM shall be utilized to: Obtain additional information that is useful for ratings by asking follow-up questions and conducting a follow-up conversation with the child and family to further expand on what was discussed; and

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	b. Aid the completion of the CANS assessment. 4. Case managers shall complete the CANS assessment with the child and family. 5. Case managers shall complete the CANS to assess the strengths and needs of the child and family. Information may be gathered by way of: a. Interviews; b. Observations; c. Record reviews (CLEAR, criminal history, and Title IV-E Eligibility checklist); d. Collateral reports; e. Evaluations; and f. Pictorial tools (genogram, timeline, family map). Note: <i>This is not an exhaustive list. The case manager may need to explore other means of gathering information by consulting with their team leader for guidance.</i>
I. Reassessment CANS	1. Case managers shall complete CANS assessments prior to any FPP revision and CFTM. 2. Case managers shall update/complete CANS assessments, at a minimum of every 90 days. 3. Team leaders shall approve, or reject, the submitted CANS assessment within 72 hours of receiving the assessment. 4. Assessment and Planning Coordinators approve or reject the CANS assessment for revision within five (5) business days of receipt.
J. Transition CANS Reviews	1. Case managers shall review and update CANS assessments at major transitional periods during the custodial episode. These transitions include: a. Placement change; b. Placement dissolution; c. Change in permanency plan; and d. Transitioning out of foster care, to include returning home to parents and kinship care placement. 2. Team leaders review and approve CANS assessments and route the CANS assessments to Assessment and Planning Coordinators. 3. Assessment and Planning Coordinators approve or reject the CANS assessment for revision within five (5) business days of receipt. Note: <i>If the Assessment and Planning Coordinator approves an updated CANS assessment within 30 days of a placement change, that CANS assessment serves as both the baseline CANS assessment at the new provider</i>

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	<i>agency and an Exit CANS assessment for the discharging agency.</i>
K. Independent Living CANS Module for Young Adults Receiving Extended Foster Care Services	1. Transitional Youth Advocates shall collaborate with young adults to complete the IL-CANS Module through the utilization of the Core Practice Skill of Teaming if a young adult remains in care under a Voluntary Services and Support Agreement. 2. DSS Form 37674: IL-CANS Field Guide may be utilized when rating indicators/items; however, the IL-CANS Module must be fully completed and entered in CAPSS. 3. The IL-CANS Module consists of Domains in: a. Safe and Stable Housing; b. Financial Stability; c. Health and Personal Care; d. Education and Employment; and e. Positive Connections. 4. Ratings of 1, 2, or 3 on any "Parenting/Caregiver Roles" indicator/item necessitates the need to complete the Parenting/Caregiving Module. 5. Transitional Youth Advocates shall update the IL-CANS Module to reflect the changes if indicator/item rating change significantly due to case circumstances. 6. Transitional Youth Advocates shall provide a finalized copy of the completed IL-CANS Module to young adults.
L. Foster Care Exit CANS Assessment	1. Case managers shall complete an Exit CANS assessment no later than 10 business days prior to a planned exit from custody. 2. Team leaders shall: a. Review and approve the Exit CANS assessment within three (3) business days of receipt; and b. Notify the Assessment and Planning Coordinator to expedite the review of the Exit CANS assessment. 3. The Assessment and Planning Coordinator approves or rejects the CANS assessment and requests revision within 24 business hours of receipt. 4. If the child is ordered to exit custody unexpectedly, case managers must: a. Complete the Exit CANS assessment; and b. Notify their Assessment and Planning Coordinator.
M. CANS Approval Process	1. CANS assessment approval consists of an "Initial Team Leader Review" and a "Full Team Leader Review". Prior to approval, team leaders may reject CANS assessments and request corrections.

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	2. The “Initial Team Leader Review” consists of the team leader reviewing the CANS assessment within 72 hours of receiving the CANS from the case manager to approve or determine if modifications are needed. 3. If modifications are needed, case managers will receive a notification via CAPSS indicating the assessment was not approved and changes are needed. 4. Case managers shall amend CANS assessments, incorporating the suggested corrections, and submit the assessment for “Full Team Leader Review”. 5. “Full Team Leader Review” consists of the following: a. Team leaders approve CANS assessments within 72 hours of receiving the assessment from the case manager; b. Team leaders check the box in CAPSS that “Full Team Leader Review” is ready for final approval by an Assessment and Planning Coordinator; and c. Approval at this level will trigger a notification to an Assessment and Planning Coordinator notifying them the assessment is ready for review. 6. Assessment and Planning Coordinators must provide final approval or provide disapproval with recommended corrections within five (5) business days of receiving the notification. 7. If Assessment and Planning Coordinators disapprove of a CANS assessment with noted corrections: a. A detailed email shall be sent to the case manager and team leader noting instructions for correcting the assessment; b. Case managers amend the assessments accordingly and send to the team leader within three (3) calendar days of receiving the disapproved assessment from the Assessment and Planning Coordinator; c. Using the “Full Team Leader Review”, team leaders review and approve the amended CANS assessment within two (2) calendar days of the case manager submitting the amended assessment; and d. Assessment and Planning Coordinators approve or disapprove the amended CANS assessment within two (2) calendar days of receiving the amended assessment from team leaders.
N. Determining Level of Care	1. Upon completion, CANS assessments provide recommendations regarding the following levels of care: a. Regular Foster Care (RFC); b. Therapeutic Foster Care (TFC); and c. Group Care (GC).

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	Note: Group care may include moderate and enhanced levels of care, Qualified Residential Treatment Programs and Psychiatric Residential Treatment Facilities. - Case managers/team leaders shall request a CFTM to be conducted. A CFTM is conducted to include the applicable Child Health and Well-Being staff, child, family, case manager, and team leader to discuss and determine whether the recommended level of care is: - Appropriate; and - Considered the least restrictive placement environment. - Once a level of care is agreed upon by the CFT, case managers or team leaders shall notify the family placement unit to begin the search for placement.
O. Service Decision Support Model – Determining Recommended Services to be Received by Children and Families	- Upon completion, CANS assessments provide the following service recommendation types: - Assessment and Testing; - Psychotherapy Services; - Applied Behavioral Analysis (ABA); - Other Behavioral Interventions; - Psychosexual Dysfunction Services; - Concrete Services; and/or - Parenting Services. - Case managers shall utilize DSS Resource 37679: CANS Service Types and Determination and consult with team leaders, children (when age and developmentally appropriate), and family to determine specific service(s) based on the recommended service type. - Case managers shall make service referrals immediately after consulting with team leaders, but not later than 48 hours after the consultation. - Service referrals shall not be limited to the specific services, outlined in DSS Resource 37679, that accompany the service recommendation types: - Case managers may need to explore other service referral options, based upon availability of services, extenuating circumstances or identified needs, or the caregiver's preference(s) for appropriate service referrals, through consultation with team leaders. - If additional consultation, support, or services are needed, case managers and team leaders shall consult with the Well-Being Team, and any other appropriate individuals, to discuss and determine the next steps.
P. CANS Assessment Level of Care	- The need for a higher or lower level of care may be evidenced by: - Changes in behaviors; and

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Recommendations for Existing Foster Care Episode	b. The current caregiver being unable to meet the needs of the child; or c. The current caregiver expresses a concern regarding helping the child manage the behaviors. 2. Case managers shall complete assessments by updating all pertinent information related to the child's current needs and strengths. 3. Upon completion of updated assessments, the child's recommended level of care will be generated based on the Service Decision Support Model. 4. The Child and Family Team, including placement staff, county case managers and team leaders, Child Health and Well-Being staff, and any other external partners, shall consider the recommended level of care and determine whether the child's placement needs can be met in the identified placement setting or if an alternative level of care needs to be explored. 5. If any of the above criteria are met, the team shall utilize this information to determine if the child's needs are best met in TFC I, II, or III, or Group Care Moderate or Enhanced. 6. If the team decides on a placement level that differs from the level that CANS assessment recommends, case managers shall document the team's decision in: a. The Placement CFTM Summary, under the Placement CFTM CAPSS action code; and b. The FPP.
Q. Children with Medically Therapeutic Needs	1. The need for a higher level of care may be evidenced by a child having "medically therapeutic" needs. 2. Case managers shall complete assessments by utilizing the CANS tool to update all pertinent information related to the child's current needs and strengths. 3. Upon completion of updated assessments, the CANS will generate the child's recommended level of care based on the decision support model. 4. When a therapeutic level of care is recommended AND the child has a rating of 2 or 3 on the Medical/Physical indicator/item AND at least one (1) rating of 2 or 3 on the following Life Functioning indicator/items, case managers and team leaders shall notify the DSS Nurse Care Coordinator and submit all medical paperwork, including: a. Family Functioning; b. Living Situation; c. Social Functioning; d. Decision Making; e. School Attendance;

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	f. School Behavior; g. Sexual Development; or h. Sleep. 5. ADSS Nurse Care Coordinator reviews the Medically Therapeutic Foster Home Service (MTFHS) application to approve or deny it. 6. If approved, placement can proceed with identifying a medically therapeutic foster home. Note: Please refer to Work Aid 512.1: Medically Therapeutic Foster Home Services Eligibility Determination for further practice guidance.
R. Qualified Residential Treatment Program Needs	The need for a higher level of care may be evidenced by a child having serious and persistent mental health needs requiring placement in a Qualified Residential Treatment Program (QRTF). 1. Case managers complete an assessment by updating all pertinent information related to the child's current needs and strengths. 2. Upon completion of updated assessments, the CANS generates the child's recommended level of care based on the decision support model. 3. When a QRTF is recommended, please refer to Policy 590: Placement in a Qualified Residential Treatment Program. 4. Regional Clinical Specialists provide service recommendations and inform the Therapeutic Services Coordinators of the decision.
S. Psychiatric Residential Treatment Facility Needs	The need for a higher level of care may be evidenced by a child having serious and persistent mental health needs requiring placement in a Psychiatric Residential Treatment Facility (PRTF). 1. Regional Clinical Specialists may recommend a PRTF; however, a completed certificate of need must be submitted to a Licensed Practitioner of the Healing Arts (LPHA) for approval. 2. Regional Clinical Specialists cannot provide placement approval. Only the LPHA has the authority to provide signed placement approval or disapproval.
T. CANS Assessment Training and Certification	1. Child welfare case managers and team leaders responsible for completing the CANS assessment must be trained and certified. 2. Case managers must score a 70 or above on the training vignette to be certified to complete the CANS assessment.

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	3. Team leaders must score a 70 or above on the training vignette to be certified to complete and/or approve the CANS assessment. 4. Case managers, team leaders, team coordinators, and any other individuals responsible for completing or approving the CANS assessment must be re-certified annually.
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Forms and Related Documents	DSS Form 37673: CANS Field Guide DSS Form 37674: IL-CANS Field Guide DSS Form 37679: CANS Service Types and Determination CANS Reference Guide IL-CANS Reference Guide FAST and CANS CAPSS User Instructions
Related Management Reports	CANS100-R01 – Foster Care CANS Assessment – Detail – Daily CANS100-R02 – Foster Care CANS Assessment – Summary – Weekly CANS100-R03 – Foster Care CANS Assessment Region – Summary Weekly

Glossary
Child: a person under the age of 18 Child and Adolescent Needs and Strengths (CANS): a multipurpose information integration tool which best exemplifies strength-based, culturally responsive, and family focused casework practice and: - Produces the least stigma or label for the children and families served; - Provides a collaborative communication means for understanding the treatment needs of children and making decisions about care; and - Assesses the needs of children to assist with matching services to needs. Child and Family Team (CFT): a group of family members, fictive kin, friends, professionals, and other invested stakeholders, chosen by the family and includes the child when age and developmentally appropriate, who join together to support a family, provide protection, and develop a FPP for the child to achieve safety, permanency and well-being. Child and Family Team Meeting (CFTM): a family-centered, trauma-informed, individualized, strengths-based, and culturally responsive meeting, planned ahead of time to provide more opportunity for meaningful participation by all members, with goal orientation and problem-solving processes that bring together the CFT to make decisions about the safety, permanency, and well-being of children through the development of an individualized FPP. CLEAR®: an investigative tool used to locate individuals to include current/previous addresses, social security numbers, telephone numbers, email addresses, criminal history, relatives, associates, etc. Family Permanency Plan (FPP): the sole plan developed collaboratively with the family to describe the reasons for DSS involvement, actions and services required to

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change behaviors and reduce safety concerns and risks, and promote the safety, permanency, and well-being of the child and family.

Psychiatric Residential Treatment Facility (PRTF): a structured, supportive, and therapeutic residential program for a child in need of treatment

Qualified Residential Treatment Program (QRTF): a group care facility that has a trauma-informed treatment model designed to address the needs, including clinical needs as appropriate, of children with serious emotional or behavioral disorders or disturbances and is able to implement the treatment identified for the child in the required 30-day assessment of the appropriateness of the QRTF placement:

- a. To the extent appropriate and in accordance with the child's best interest;
- b. Facilitates participation of family members in the child's treatment program;
- c. Facilitates outreach to the family members of the child, including siblings, and documents information for any known biological family and fictive kin of the child;
- d. Documents how family members are integrated into the treatment process for the child, including post-discharge planning and family-based aftercare support for at least six (6) months post-discharge;
- e. Is licensed by DSS and accredited by an approved independent, non-profit organization;
- f. Has registered or licensed nursing staff and other licensed clinical staff who provide care within the scope of their practice, are on-site according to the treatment model, and are available 24 hours a day and seven (7) days a week;
- g. Is not a detention facility, forestry camp, training school, or any other facility operated primarily for the detention of children who are determined to be delinquent; and
- h. Is not a PRTF

Young Adult: individuals aged 18-21 years old

Youth: individuals aged 14-17 years old