

## **RESEARCH ABSTRACT**

### **Foster Family-based Treatment Association's 17<sup>th</sup> Annual Conference on Treatment Foster Care July 2003**

#### **Use of the CANS-CW for planning Treatment Foster Care in Philadelphia, PA**

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#### **THE TFC REDESIGN PROCESS IN PHILADELPHIA**

In November 2001, PMHCC's Best Practices Institute (BPI) was contracted by the Philadelphia Department of Human Services to conduct a Needs Assessment as well as National Research of Best Practices in the field of Treatment Foster Care (TFC).

After researching the literature and connecting with various national experts, BPI presented the National TFC Program Standards developed by the FFTA to the leadership team of Philadelphia's Child Welfare and Behavioral Health System (BHS), who made the joint decision to adopt the FFTA standards for Philadelphia.

Although some Philadelphia providers were already providing some form of intense or therapeutic foster care, several key changes were needed in order to align existing services with the national standards. For example, DHS needed to restructure its intake, assessment and referral process, which was in part accomplished by bringing the Child and Adolescent Needs and Strengths (CANS) assessment tool to Philadelphia.

In March 2002, a Request for Qualifications (RFQ) was issued to Philadelphia's providers of Mental Health Foster Care to contract with DHS in providing TFC services that meet FFTA standards. 15 providers were selected to provide TFC according to the new model.

On September 1, 2002, the new daily rate and the program standards became effective. In October 2002, the Monthly Administrative Report Form was implemented and DHS began gathering administrative data specific to each agency's TFC program. In addition, BPI was able to coordinate training on the new model as well as the ABC model (People Places, Inc.) through People Places trainers for all TFC providers.

To address challenges on a systems level, BPI was asked to convene a TFC Steering Committee that has been meeting at least every 6 weeks since its inception in October 2002. This committee includes representatives from the TFC providers, behavioral health providers and system

representatives from both DHS and BHS. The goal is to identify and report systemic issues and possible solutions back to the DHS/BHS leadership.

DHS' Contract Administration and Program Evaluation (CAPE) Division centralized its role in TFC by appointing one TFC Program Analyst that conducts weekly check-ins (via phone) with TFC Program Directors and site visits for technical assistance and monitoring purposes. CAPE is also essential in the implementation of the step-down process once a child has been determined for step-down to a lower level of care.

### **CANS – CW Use in Philadelphia**

It was decided to use the CANS as a decision-support tool to determine eligibility for Treatment Foster Care (TFC) and to track and monitor outcomes for all children/youth in TFC and determine continued necessity for TFC services.

Through a RFP process, DHS identified a community-based provider agency to administer all CANS assessments and make level of care recommendations to DHS. Internally at DHS, a position (CANS Coordinator) was created that will receive and process all requests for a CANS.

- New Cases (Child never known to DHS; Re-entry to DHS)
- Level of Placement Changes (Step-Up from General Foster Care, SCOH or Family Preservation or Step-Down from Hospital Inpatient Unit, RTF, Institution, Group Home)
- Six-Month Reviews In accordance with DHS Family Service Plan cycle

### **DEVELOPMENT OF A DECISION SUPPORT ALGORITHM**

In order to establish an initial clinical model for the rational assignment of children to Treatment Foster Care (TFC) for Philadelphia Department of Human Services (DHS), the records of all children currently placed in TFC placements were reviewed. The primary review instrument was the Child and Adolescent Needs and Strengths Assessment (CANS; Lyons, 1999), child welfare version modified for use within the DHS system of care. Data on 349 cases with sufficient data to generate a valid CANS profile were analyzed. Cases were reviewed both in terms of their status at admission into TFC and on their current status. Based on an analysis of these data and experiences in other settings the following algorithm was tested for these data:

Criterion 1: Presence of Symptoms Associated with a Serious Emotional/ Behavioral Disorder  
A rating of '2' or '3' on at least one of the following CANS items:

- Psychosis
- Attention Deficit/Impulse
- Depression/Anxiety
- Anger Control
- Oppositional Behavior
- Antisocial Behavior
- Adjustment to Trauma
- Attachment
- Severity of Substance Abuse

At admission into TFC 90.5% of cases met this criterion. At current assessment, 84% of cases still met this criterion.

Criterion 2: Notable Impairment in Functioning in at least one area

A rating of '2' or '3' on at least one of the following CANS items:

- Motor
- Sensory
- Intellectual
- Communication
- Developmental
- Self Care
- Physical/Medical
- Sexual Development

At admission into TFC placements, 30.9% met this criterion. At current assessment, 26.1% of cases still met this criterion.

Criterion 3: Notable Impairment in School Functioning

A rating of '2' or '3' on at least one of the following CANS items:

- School Achievement
- School Behavior
- School Attendance

At admission into TFC placements, 67% of cases met this criterion. At current assessment, 51.3% of cases still met this criterion.

Criterion 4: Notable Risk Behaviors in at least one area

A rating of a '2' or '3' on the following CANS items:

- Danger to Self
- Violence
- Fire Setting
- Runaway
- Social Behavior
- Seriousness of Criminal Behavior
- Sexually Abusive Behavior

At admission into TFC placements, 45% of cases met this criterion. At current assessment, 32.1% of cases still met this criterion.

To be deemed eligible for TFC level of care a child would need to meet Criterion 1 AND either Criterion 2 OR Criterion 3 OR Criterion 4. In other words, the child would have to have symptom presentations consistent with the presence of a Serious Emotional/Behavioral Disorder and either notable functional impairment or the presence of significant risk behaviors.

Using these criteria, at admission into TFC, 257 (78.6%) of the 327 rated cases meet these criteria, meaning that 70 cases (21.4%) were below this threshold for placement. At current status, 212 (60.7%) of 349 rated cases continued to meet these criteria, meaning that 137 cases (39.3%) of cases no longer meet this threshold for continued placement.

In order to assess whether children were placed in TFC who might be too challenging for this level of care, a second algorithm was tested that involved the presence of at least one mental health need (see Criterion 1 for list) rated as a '3' AND at least one risk behavior (see Criterion 4 for list) rated as a '3' OR Attachment rated as a '3'. At admission, eight children (2.4%) met these criteria. At current assessment, only five children (1.4%) met these criteria.

To provide some initial validity for this model, cases who were deemed eligible at admission to TFC were compared to those deemed not eligible (using the above criteria) and compared on outcomes across from admission to current status. Eligible children had significantly greater improvement on mental health needs ( $t=-2.57$ ,  $p=.01$ ), functioning ( $t=-2.21$ ,  $p=.03$ ), school ( $t=-3.33$ ,  $p=.001$ ) and risk behaviors ( $t=3.43$ ,  $p=.001$ ). These findings indicated that children defined as eligible based on the above algorithm receive more benefit from TFC placements than do children whose needs do not rise to the eligibility level.

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