

<b>Outcome Measure</b>	<b>Care and Needs Scale (CANS)</b>
<b>Sensitivity to Change</b>	Yes
<b>Population</b>	Adult
<b>Domain</b>	Global Outcome
<b>Type of Measure</b>	Clinician-rated scale
<b>ICF-Code/s</b>	d (activities and participation, except d1)
<b>Description</b>	<p>The CANS (R. L. Tate, 2004) is a clinician rating scale, designed to amalgamate information obtained from a range of sources and is to document support needs required for everyday functional activities and community living. It was developed for people with TBI and aims to capture the gamut of support needs, from very high to minimal requirements. The impetus to develop the CANS arose from the need to document support needs of people who were living in the community many years after a TBI.</p> <p>The CANS contains 2 sections: the Needs Checklist – documents the <i>type</i> of support; and Support Level – documents the <i>extent</i> of support.</p> <p>The 24-item Needs Checklist is categorized into 4 groups that are hierarchically organized according to intensity of need: (a) Group A (special needs) contains 9 items covering very high level needs, such as tracheostomy management, harmful behaviours; (b) Group B (basic activities of daily living, ADL) has 3 items covering personal hygiene, dressing, food preparation; (c) Group C (instrumental activities of daily living, IADL, and psychosocial); (d) Group D contains 2 items, informational (e.g., information, knowledge, advice) and emotional supports.</p> <p>The second section contains 8 Support Levels that are also hierarchically arranged: 0 (equivalent of does not need contact), 1 (needs intermittent contact, less than weekly), 2 (needs weekly contact), 3 (needs contact every few days), 4 (needs daily contact), 5 (can be left alone during the day, but not at night), 6 (can be left alone for a few hours), 7 (cannot be left alone).</p> <p>Can also be administered in interview format – takes around 10-15 mins to complete.</p>
<b>Properties</b>	<p>See Tate (2010) for more information regarding psychometric properties.</p> <p>Inter-rater reliability: Soo et al. (2007) 3 clinician-raters: ICC = .93-.96. Test-retest reliability: Soo et al. (2007): 1 week: ICC = .98</p> <p>Construct validity: <i>Discriminant</i>: Tate: SPRS-Good Median = 1.0 vs SPRS-Limited Median = 2.0 vs SPRS-Poor Median = 5.0; Kruskal-Wallis ANOVA <math>\chi^2 = 44.6</math> (<math>p &lt; .001</math>) – significant differences between SPRS-Good vs SPRS-Limited (<math>p &lt; .001</math>); SPRS-Limited vs SPRS-Poor (<math>p &lt; .001</math>).</p>

	Predictive Validity: Soo et al (2010) CANS at inpatient rehabilitation discharge vs 6 month follow-up on SRS ( $r = .43$ ), DRS ( $r = .64$ )
<b>Advantages</b>	Excellent psychometric properties Flexible: can be completed by a clinician based on their knowledge of a patient or by an informant. Ability to capture support requirements of higher functioning individuals whose needs are less than daily. Only sophisticated measure of how long someone can be left alone and what their needs are.
<b>Disadvantages</b>	It relies on a degree of clinical, subjective judgment in determining the support needs of a person and is thus open to concerns in reliability. Training (standardized 2 hour workshop) is advised in order to maintain high inter-rater reliability.
<b>Reviewers</b>	Jenny Fleming

### References

- Soo, C., Tate, R., Hopman, K., Forman, M., Secheny, T., Aird, V., . . . Coulston, C. (2007). Reliability of the care and needs scale for assessing support needs after traumatic brain injury. *Journal of Head Trauma Rehabilitation, 22*(5), 288-295.
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