

The CANS is not a form or checklist. It is a decision support tool, to be used as you **integrate and interpret** the information you have heard. The CANS items should not be asked as individual questions. Instead, a conversational approach to the Assessment process helps caregivers and children / youth feel comfortable and supported. The **9 Key Questions** below are meant to be a quick and handy reminder of the major content areas of the CANS.

9 Key Questions

A CANS 'Cheat Sheet' for Interviewers and Interviewees

This sheet lists the key areas of a child / youth's life that we will be talking about. If a child or youth has needs or strengths in any of the areas listed, we will ask for more detailed information to better understand that need or strength.

- 1. What does your child / youth do well?**
- 2. How is your child / youth doing at home, at school (attendance, behavior, performance), and with friends?**
- 3. Is your child / youth having a hard time fitting in?**
- 4. Is your child / youth having trouble with their feelings or actions?**
- 5. Is your child / youth doing things which could hurt themselves or others?**
- 6. Has your child / youth experienced any recent or historical crisis or trauma? Car accidents, major illness, community violence?**
- 7. Did your child / youth have any problems at birth or in their first few years? *Can also give parent CDQ to complete.***
- 8. Does your youth need services to prepare her/him to live on their own?**
- 9. What would help you and your family best support this child / youth and help you as a caregiver support your children? What would you say your greatest need/strength is as a caregiver?**

Scoring Challenges Making Difficult Decisions:

It is strongly recommended that the assessor refer to the CANS Manual for guidance in scoring all CANS items. The manual provides scoring guidelines and examples for each item on the CANS; however, there are several reasons why an assessor may struggle in deciding between two scoring options. Below are some common struggles and recommendations on making these sometimes difficult scoring decisions.

1. “My client’s presentation does not match the examples listed in the manual.” It is impossible for the CANS manual to list all possible symptom presentations in the examples for each item. Therefore it is not uncommon to find that your client does not match any of the examples perfectly. In these cases we strongly recommend that you refer to the action levels listed above. For instance, if your client presents with a ‘severe’ need in a particular area, or a symptom in need of immediate or intensive action then they would receive a score of “3” on that CANS item(s). You would use a score of “2” for areas where your client has a ‘moderate’ difficulty that requires intervention/inclusion in a treatment plan. If your client has only a “mild” need or you suspect your client has a need but you need more information to be sure you can rate those items as 1.

2. “I am getting conflicting information from multiple reporters and I do not know the child/family well enough to decide which is most valid.” Sometimes family members have different perspectives on the client’s needs and strengths. This is okay and can be handled in a few different ways when scoring the CANS. First, it is okay to consider all of the information you’ve received and assign a score that would reflect an average of what you know, (e.g., averaging the discrepant ratings across reporters). Second, you could decide whether a particular report is more accurate and should be considered over the other perspectives based on clinical judgment. It would also be okay to assign a 1 to a particular item, for “watchful waiting” so that you can keep an eye on this particular need while you get to know the client. Once you know the client well, it is okay to use your clinical opinion to move a score in one direction or another and give one rating more salience than the other based on what seems most clinically accurate. Finally, you can always choose to use another assessment measure to gather more symptom specific information.

- For example, dissociation is an area where there may be differing reports. The clinician may see signs of dissociation in therapy but get denial of such symptoms from the child’s caregiver (who might instead report inattention and/or opposition) or the child’s teacher (who might report laziness or excessive daydreaming) with no report of dissociation. This would be a good opportunity for further clinical assessment of the child, the administration of a dissociation scale based on some evidence of dissociative symptoms.

3. Overlapping Needs: “The symptom(s) reported by my client seem to fit into more than one item on the CANS.” Sometimes assessors wonder about what to do when a client has overlapping needs, co-morbid and related symptoms or a single type of symptom that can be recorded in multiple CANS items. Below are guidelines in how to handle these situations:

The assessor should score as many CANS items as is necessary to capture the client’s full symptom presentation and plan for treatment.

- The cause, or etiology, of a particular symptom is not always clear, and does not need to be known to score the CANS which reflect the current needs and strengths of the child. In these cases, until clarity is achieved either with further assessment or responses to treatment, it is okay to rate as many different items as need be on the CANS to reflect the child’s current (potential) needs. Please see examples below:
 - If a child presents with frequent crying before bed and the clinician does not yet have sufficient information to know whether this is anxiety related, depression related or trauma related; he or she might consider rating a “1” for all of the items that are potentially related: depression, anxiety, sleep and adjustment to trauma items on the CANS, while s/he gathers more information.
 - Nightmares, loss of interest in previously enjoyable activities, moodiness/irritability, and fear can be symptoms of anxiety disorders, mood disorders and/or traumatic stress symptoms. You can rate the anxiety, depression, and adjustment to trauma items at a low level until you are able to determine the etiology of these symptoms.
 - A child who is unable to focus, hyperactive in their behavior and speech, who seems to ‘zone out’ at times could be suffering from biologically based Attention Deficit Hyperactivity Disorder or this child may be reacting in a hypervigilant way to reminders of his/her trauma and using dissociation as a coping mechanism. It is OK to initially rate all of these items at a low level as they all reflect the behavioral needs of the child.