# Child and Adolescent Needs and Strengths (CANS-SCREEN)

A Washington State
**Intensive Mental Health Services Screening Tool**

Children and Adolescents 5-20
With Mental Health Challenges

2018
REFERENCE
GUIDE

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# ACKNOWLEDGEMENTS

A large number of individuals have collaborated in the development of the Child and Adolescent Needs and Strengths. Along with the CANS, versions for developmental disabilities, juvenile justice, and child welfare, this information integration tool is designed to support individual case planning and the planning and evaluation of service systems. The CANS is an open domain tool for use in multiple child-serving systems that address the needs and strengths of children, youth, and their families. The copyright is held by the Praed Foundation to ensure that it remains free to use. Training and annual certification is expected for appropriate use.

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# INTRODUCTION

## THE CANS

The **Child and Adolescent Needs and Strengths (CANS)** is a multiple purpose information integration tool that is designed to be the output of an assessment process. The purpose of the CANS is to accurately represent the shared vision of the child/youth serving system—children, youth, and families. As such, completion of the CANS is accomplished in order to allow for the effective communication of this shared vision for use at all levels of the system. Since its primary purpose is communication, the CANS is designed based on communication theory rather than the psychometric theories that have influenced most measurement development. There are six key principles of a communimetric measure that apply to understanding the CANS.

## SIX KEY PRINCIPLES OF THE CANS

1. **Items were selected because they are each relevant to action planning.** An item exists because it might lead you down a different pathway in terms of planning actions.

2. **Each item uses a 4-level rating system that translates into action**. Different action levels exist for needs and strengths. For a description of these action levels please see below.

3. **Rating should describe the child/youth, not the child/youth in services.** If an intervention is present that is masking a need but must stay in place, this should be factored into the rating consideration and would result in a rating of an "actionable" need (i.e. '2' or '3').

4. **Culture and development should be considered prior to establishing the action levels.** Cultural sensitivity involves considering whether cultural factors are influencing the expression of needs and strengths. Ratings should be completed considering the child/youth's developmental and/or chronological age depending on the item. In other words, anger control is not relevant for a very young child but would be for an older youth or youth regardless of developmental age. Alternatively, school achievement should be considered within the framework of expectations based on the child/youth's developmental age.

5. **The ratings are generally "agnostic as to etiology."** In other words, this is a descriptive tool; it is about the "what" not the "why." While most items are purely descriptive, there are a few items that consider cause and effect; see individual item descriptions for details on when the "why" is considered in rating these items.

6. **A 30-day window is used for ratings in order to make sure assessments stay relevant to the child/youth's present circumstances.** However, the action levels can be used to over-ride the 30-day rating period.

## HISTORY AND BACKGROUND OF THE CANS

The CANS is a multi-purpose tool developed to support care planning and level of care decision-making, to facilitate quality improvement initiatives, and to allow for the monitoring of outcomes of services. The CANS was developed from a communication perspective in order to facilitate the linkage between the assessment process and the design of individualized service plans including the application of evidence-based practices.

The CANS gathers information on the child/youth's and parents/caregivers' needs and strengths. Strengths are the child/youth's assets: areas life where they are doing well or have an interest or ability. Needs are areas where a child/youth requires help or intervention. Care providers use an assessment process to get to know the child or youth and the families with whom they work and to understand their strengths and needs. The CANS helps care providers decide which of a child/youth's needs are the most important to address in action planning (e.g., services, treatment, crisis and/or care planning. The CANS also helps identify strengths, which can be the basis of a treatment or service plan. By working with the child/youth and family during the assessment process and talking together about the CANS, care providers can develop a treatment or service plan that addresses a child/youth's strengths and needs while building strong engagement.

The CANS is made of domains that focus on various areas in a child/youth's life, and each domain is made up of a group of specific items. There are domains that address how the child/youth functions in everyday life, on specific emotional or behavioral concerns, on risk behaviors, on strengths and on skills needed to grow and develop. There is also a domain that asks about the family's beliefs and preferences, and about general family concerns. The care provider, along with the child/youth and family as well as other stakeholders, gives a number rating to each of these items. These ratings help the provider, child/youth and family understand where intensive or immediate action is most needed, and also where a child/youth has assets that could be a major part of the treatment or service plan.

The CANS ratings, however, do not tell the whole story of a child/youth's strengths and needs. Each section in the CANS is merely the output of a comprehensive assessment process and is documented alongside narratives where a care provider can provide more information about the child/youth.

## HISTORY

The Child and Adolescent Needs and Strengths grew out of John Lyons' work in modeling decision-making for psychiatric services. To assess appropriate use of psychiatric hospital and residential treatment services, the Childhood Severity of Psychiatric Illness (CSPI) tool was created. This measure assesses those dimensions crucial to good clinical decision-making for intensive mental health service interventions and was the foundation of the CANS. The CSPI tool demonstrated its utility in informing decision-making for residential treatment (Lyons, Mintzer, Kisiel, & Shallcross, 1998) and for quality improvement in crisis assessment services (Lyons, Kisiel, Dulcan, Chesler & Cohen, 1997; Leon, Uziel-Miller, Lyons, Tracy, 1998). The strength of this measurement approach has been that it is face valid and easy to use, yet provides comprehensive information regarding clinical status.

The CANS assessment builds upon the methodological approach of the CSPI, but expands the assessment to include a broader conceptualization of needs and an assessment of strengths – both of the child/youth and the caregiver, looking primarily at the 30-day period prior to completion of the CANS. It is a tool developed with the primary objective of supporting decision making at all levels of care: children, youth and families, programs and agencies, child/youth-serving systems. It provides for a structured communication and critical thinking about children/youth and their context. The CANS is designed for use either as a prospective assessment tool for decision support and recovery planning or as a retrospective quality improvement device demonstrating an individual child/youth's progress. It can also be used as a communication tool that provides a common language for all child/youth-serving entities to discuss the child/youth's needs and strengths. A review of the case record in light of the CANS assessment tool will provide information as to the appropriateness of the recovery plan and whether individual goals and outcomes are achieved.

Annual training and certification is required for providers who administer the CANS and their supervisors. Additional training is available for CANS super users as experts of CANS assessment administration, scoring, and use in the development of service or recovery plans.

## MEASUREMENT PROPERTIES

**Reliability**

Strong evidence from multiple reliability studies indicates that the CANS can be completed reliably by individuals working with children/youth and families. A number of individuals from different backgrounds have been trained and certified to use the CANS assessment reliably including health and mental health providers, child welfare case workers, probation officers, and family advocates. With approved training, anyone with a bachelor's degree can learn to complete the tool reliably, although some applications or more complex versions of the CANS require a higher educational degree or relevant experience. The average reliability of the CANS is 0.78 with vignettes across a sample of more than 80,000 trainees. The reliability is higher (0.84) with case records, and can be above 0.90 with live cases (Lyons, 2009). The CANS is auditable and audit reliabilities demonstrate that the CANS is reliable at the item level (Anderson et al., 2001). Training and certification with a reliability of at least 0.70 on a test case vignette is required for ethical use. In most jurisdictions, re-certification is annual. A full discussion on the reliability of the CANS assessment is found in Lyons (2009) *Communimetrics: A Communication Theory of Measurement in Human Service Settings*.

**Validity**

Studies have demonstrated the CANS' validity, or its ability to measure children/youth's and their caregiver's needs and strengths. In a sample of more than 1,700 cases in 15 different program types across New York State, the total scores on the relevant dimensions of the CANS-Mental Health retrospectively distinguished level of care (Lyons, 2004). The CANS assessment has also been used to distinguish needs of children in urban and rural settings (Anderson & Estle, 2001). In numerous jurisdictions, the CANS has been used to predict service utilization and costs, and to evaluate outcomes of clinical interventions and programs (Lyons, 2004; Lyons & Weiner, 2009; Lyons, 2009). Five independent research groups in four states have demonstrated the reliability and validity of decision support algorithms using the CANS (Chor, et al., 2012, 2013, 2014; Cordell, et al., 2016; Epstein, et al., 2015; Israel, et al., 2015; Lardner, 2015).

# RATING NEEDS & STRENGTHS

The CANS is easy to learn and is well liked by children, youth and families, providers and other partners in the services system because it is easy to understand and does not necessarily require scoring in order to be meaningful to the youth and family.

- ★ Basic core items – grouped by domain – are rated for all individuals.
- ★ Individual assessment module questions provide additional information in a specific area.

Each CANS rating suggests different pathways for service planning. There are four levels of rating for each item with specific anchored definitions. These item level definitions, however, are designed to translate into the following action levels (separate for needs and strengths):

**Basic Design for Rating Needs**

| Rating | Level of Need | Appropriate Action |
|---|---|---|
| 0 | No evidence of need | No action needed |
| 1 | Significant history or possible need that is not interfering with functioning | Watchful waiting/prevention/additional assessment |
| 2 | Need interferes with functioning | Action/intervention required |
| 3 | Need is dangerous or disabling | Immediate action/Intensive action required |

**Basic Design for Rating Strengths**

| Rating | Level of Strength | Appropriate Action |
|---|---|---|
| 0 | Centerpiece strength | Central to planning |
| 1 | Strength present | Useful in planning |
| 2 | Identified strength | Build or develop strength |
| 3 | No strength identified | Strength creation or identification may be indicated |

The rating of 'N/A' for 'not applicable' is available for a few items under specified circumstances (see reference guide descriptions). For those items where the 'N/A' rating is available, it should be used only in the rare instances where an item does not apply to that particular child/youth.

To complete the CANS, a CANS trained and certified care coordinator, case worker, clinician, or other care provider should read the anchor descriptions for each item and then record the appropriate rating on the CANS form (or electronic record). This process should be done collaboratively with the child/youth, family and other stakeholders.

Remember that the item anchor descriptions are examples of circumstances which fit each rating ('0', '1', '2', or '3'). The descriptions, however, are not inclusive and the action level ratings should be the primary rating descriptions considered (see page 6). The rater must consider the basic meaning of each level to determine the appropriate rating on an item for an individual.

The CANS is an information integration tool, intended to include multiple sources of information (e.g., child/youth and family, referral source, treatment providers, school, and observation of the rater). As a strength-based approach, the CANS supports the belief that children, youth, and families have unique talents, skills, and life events, in addition to specific unmet needs. Strength-based approaches to assessment and service or treatment planning focus on collaborating with children/youth and their families to discover individual and family functioning and strengths. Failure to demonstrate a child/youth's skill should first be viewed as an opportunity to learn the skill as opposed to the problem. Focusing on the child/youth's strengths instead of weaknesses with their families may result in enhanced motivation and improved performance. Involving the family and child/youth in the rating process and obtaining information (evidence) from multiple sources is necessary and improves the accuracy of the rating. Meaningful use of the CANS and related information as tools (for reaching consensus, planning interventions, monitoring progress, psychoeducation, and supervision) support effective services for children, youth and families.

As a quality improvement activity, a number of settings have utilized a fidelity model approach to look at service/treatment/action planning based on the CANS assessment. A rating of '2' or '3' on a CANS need suggests that this area must be addressed in the action plan. A rating of a '0' or '1' identifies a strength that can be used for strength-based planning and a '2' or '3' a strength that can be the focus on strength-building activities, when appropriate. It is important to remember that when developing service and treatment plans for healthy children and youth trajectories, balancing the plan to address risk behaviors/needs and protective factors/strengths is key. It has been demonstrated in the literature that strategies designed to develop child and youth capabilities are a promising means for development, and play a role in reducing risky behaviors.

Finally, the CANS can be used to monitor outcomes. This can be accomplished in two ways. First, CANS items that are initially rated a '2' or '3' are monitored over time to determine the percent of individuals who move to a rating of '0' or '1' (resolved need, built strength). Dimension scores can also be generated by summing items within each of the domains (Behavioral/Emotional Needs, Risk Behaviors, Functioning, etc.). These scores can be compared over the course of treatment. CANS dimension/domain scores have been shown to be valid outcome measures in residential treatment, intensive community treatment, foster care and treatment foster care, community mental health, and juvenile justice programs.

The CANS is an open domain tool that is free for anyone to use with training and certification. There is a community of people who use the various versions of the CANS and share experiences, additional items, and supplementary tools.

# HOW IS THE CANS USED?

The CANS is used in many ways to transform the lives of children, youth, and their families and to improve our programs. Hopefully, this guide will help you to also use the CANS as a multi-purpose tool.

## IT IS AN ASSESSMENT STRATEGY

When initially meeting clients and their caregivers, this guide can be helpful in ensuring that all the information required is gathered. Most items include "Questions to Consider" which may be useful when asking about needs and strengths. These are not questions that must be asked, but are available as suggestions. Many clinicians have found this useful during initial sessions either in person or over the phone (if there are follow up sessions required) to get a full picture of needs before treatment or service planning and beginning therapy or other services.

## IT GUIDES CARE AND ACTION PLANNING

When an item on the CANS is rated a '2' or '3' ('action needed' or 'immediate action needed') this indicates that it is a serious need for our client, and one that should be offered to be addressed during the course of our treatment. As such, when working with the youth and family to create an action plan (i.e., service, treatment, crisis or care plan), you should do your best to address any needs, impacts on functioning, or risk factors that you rate as a 2 or higher in that document.

## IT FACILITATES OUTCOMES MEASUREMENT

The CANS is often completed every 6 months to measure change and transformation. We work with children, youth, and families and their needs tend to change over time. Needs may change in response to many factors including quality clinical support provided. One way we determine how our supports are helping to alleviate suffering and restore functioning is by re-assessing needs, adjusting treatment or service plans, and tracking change.

## IT IS A COMMUNICATION TOOL

When a client leaves a treatment program, a closing CANS may be completed to define progress, measure ongoing needs and help us make continuity of care decisions. Doing a closing CANS, much like a discharge summary, integrated with CANS ratings, provides a picture of how much progress has been made, and allows for recommendations for future care which ties to current needs. And finally, it allows for a shared language to talk about our child/youth and creates opportunities for collaboration. It is our hope that this guide will help you to make the most out of the CANS and guide you in filling it out in an accurate way that helps you make good clinical decisions.

# CANS: A BEHAVIOR HEALTH CARE STRATEGY

The CANS is an excellent strategy in addressing children and youth's behavioral health care. As it is meant to be an outcome of an assessment, it can be used to organize and integrate the information gathered from clinical interviews, records reviews, and information from screening tools and other measures.

It is a good idea to know the CANS and use the domains and items to help with your assessment process and information gathering sessions/clinical interviews with the child/youth and family. This will not only help the organization of your interviews, but will make the interview more conversational if you are not reading from a form. A conversation is more likely to give you good information, so have a general idea of the items. The CANS domains can be a good way to think about capturing information. You can start your assessment with any of the sections—Life Domain Functioning or Behavioral/Emotional Needs, Risk Behaviors or Child/Youth Strengths, or Caregiver Needs & Resources—this is your judgment call. Sometimes, people need to talk about needs before they can acknowledge strengths. Sometimes, after talking about strengths, then they can better explain the needs. Trust your judgment, and when in doubt, always ask, "We can start by talking about what you feel that you and your child/youth need, or we can start by talking about the things that are going well and that you want to build on. Do you have a preference?"

Some people may "take off" on a topic. Being familiar with the CANS items can help in having more natural conversations. So, if the family is talking about situations around the youth's anger control and then shift into something like---"you know, he only gets angry when he is in Mr. S's classroom," you can follow that and ask some questions about situational anger, and then explore other school related issues.

## MAKING THE BEST USE OF THE CANS

Children and youth have families involved in their lives, and their family can be a great asset to their treatment. To increase family involvement and understanding, it is important to talk to them about the assessment process and describe the CANS and how it will be used. The description of the CANS should include teaching the child/youth and family about the needs and strengths rating scales, identifying the domains and items, as well as how the actionable items will be used in treatment or serving planning. When possible, share with the youth and family the CANS domains and items (see the CANS Core Item list on page 12) and encourage the family to look over the items prior to your meeting with them. The best time to do this is your decision—you will have a sense of the timing as you work with each family. Families often feel respected as partners when they are prepared for a meeting or a process. A copy of the completed CANS ratings should be reviewed with each family. Encourage families to contact you if they wish to change their answers in any area that they feel needs more or less emphasis.

## LISTENING USING THE CANS

Listening is the most important skill that you bring to working with the CANS. Everyone has an individual style of listening. The better you are at listening, the better the information you will receive. Some things to keep in mind that make you a better listener and that will give you the best information:

★ **Use nonverbal and minimal verbal prompts.** Head nodding, smiling and brief "yes," "and"—things that encourage people to continue.

★ **Be nonjudgmental and avoid giving person advice.** You may find yourself thinking "If I were this person, I would do x" or "That's just like my situation, and I did x." But since you are not that person, what you would do is not particularly relevant. Avoid making judgmental statements or telling them what you would do. It's not really about you.

★ **Be empathic.** Empathy is being warm and supportive. It is the understanding of another person from their point of reference and acknowledging feelings. You demonstrate empathetic listening when you smile, nod, maintain eye contact. You also demonstrate empathetic listening when you follow the person's lead and acknowledge when something may be difficult, or when something is great. You demonstrate empathy when you summarize information correctly. All of this demonstrates to the child or youth that you are with them.

★ **Be comfortable with silence.** Some people need a little time to get their thoughts together. Sometimes, they struggle with finding the right words. Maybe they are deciding how they want to respond to a question. If you are concerned that the silence means something else, you can always ask "Does that make sense to you?" Or "Do you need me to explain that in another way?"

★ **Paraphrase and clarify—avoid interpreting.** Interpretation is when you go beyond the information given and infer something—in a person's unconscious motivations, personality, etc. The CANS is not a tool to come up with causes. Instead, it identifies things that need to be acted upon. Rather than talk about causation, focus on paraphrasing and clarifying. Paraphrasing is restating a message very clearly in a different form, using different words. A paraphrase helps you to (1) find out if you really have understood an answer; (2) clarify what was said, sometimes making things clearer; and (3) demonstrate empathy. For example, you ask the questions about health, and the person you are talking to gives a long description. You paraphrase by saying "Ok, it sounds like . . . is that right? Would you say that is something that you feel needs to be watched, or is help needed?"

## REDIRECT THE CONVERSATION TO PARENTS'/CAREGIVERS' OWN FEELINGS AND OBSERVATIONS

Often, people will make comments about other people's observations such as "Well, my mother thinks that his behavior is really obnoxious." It is important to redirect people to talk about their observations: "So your mother feels that when he does x that is obnoxious. What do YOU think?" The CANS is a tool to organize all points of observation, but the parent or caregiver's perspective can be the most critical. Once you have their perspective, you can then work on organizing and coalescing the other points of view.

## ACKNOWLEDGE FEELINGS

People will be talking about difficult things and it is important to acknowledge that. Simple acknowledgement such as "I hear you saying that it can be difficult when ..." demonstrates empathy.

## WRAPPING IT UP

At the end of the assessment, we recommend the use of two open-ended questions. These questions ask if there are any past experiences that people want to share that might be of benefit to planning for their young person, and if there is anything that they would like to add. This is a good time to see if there is anything "left over"—feelings or thoughts that they would like to share with you.

Take time to summarize with the individual and family those areas of strengths and of needs. Help them to get a "total picture" of the individual and family, and offer them the opportunity to change any ratings.

Take a few minutes to talk about what the next steps will be. Now you have information organized into a framework that moves into the next stage—planning.

So you might close with a statement such as: “OK, now the next step is a “brainstorm” where we take this information that we’ve organized and start writing a plan—it is now much clearer which needs must be met and what we can build on. So, let’s start. . .”

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# CANS BASIC STRUCTURE

The Child and Adolescent Needs and Strengths basic core items are noted below.

## CORE ITEMS

**Life Functioning Domain**
- Family Functioning
- Living Situation
- School
- Interpersonal Functioning
- Crime/Delinquency
- Developmental/Intellectual
- Medical/Physical
- Sexual Development

**Behavioral/Emotional Needs Domain**
- Psychosis
- Attention Deficit/Impulse Control
- Mood Disturbance
- Anxiety
- Disruptive Behavior
- Substance Use
- Adjustment to Trauma
- Emotional Control

**Risk Behaviors Domain**
- Suicide Risk
- Non-Suicidal Self-Injurious Behavior
- Danger to Others
- Runaway
- Decision Making
- Medication Management

**Caregiver Resources & Needs**
- Caregiver Capacity
- Family Stress
- Safety

**Remember, this is not a "form" to be completed, but the reflection of a story that needs to be heard.**

The Washington CANS User Guide was formulated with the Certified Assessor in mind. It was developed over the course of many months and reflects the knowledge gained from CANS training sessions provided by several other states to thousands of clinicians, in preparation for CANS certification. The CANS User Guide contains useful information for rating each item in the CANS and also offers questions to consider that may help when rating an item. Each item contains the item definition, the definition for each rating, as well as questions to consider when scoring each item, and supplemental information. The CANS User Guide is intended to provide a clinician with adequate guidance to rate each item in a domain as accurately as possible, in one single document.

Youth's Name: _____ DOB: __ __|__ __| __ __ __ __ P1 ID: __|__|__|__|__|__|__|__|__|__WA
M M D D Y Y Y Y

Gender: ☐ M ☐ F ☐ Unknown Completed by *(name)*: _____ Phone: (_ _ _) _ _ _|_ _ _ _

Assessment reason: ☑ Initial

Assessment date: ___ ___|___ ___| 2 0 ___ ___
M M D D Y Y

Agency Name: _____

Participant County: _____

Caregiver Name: _____

Relationship: _____

## REFERRAL SOURCE INFORMATION

Referral source: _____

Date contacted by referral source: ___ ___|___ ___|2 0 ___ ___
M M D D Y Y

Referral source recommended: O WISe O Outpatient O BRS O CLIP *(Medicaid)* O CLIP *(Non-Medicaid)*

O Other *(specify)*:

_____

**SCREENING OUTCOME**

*Referred to:*

O Outpatient
O WISe
O BRS
O CLIP
O Other

*(specify)*:

_____

_____

_____

_____

| **CROSS SYSTEM INVOLVEMENT:** *When was youth's **most recent** involvement with the following?* | | | | | | |
|---|---|---|---|---|---|---|
| Current | Past 30 days | Past 12 months | More than 12 months ago | Never | Don't know | Most recent involvement in . . . |
| O | O | O | O | O | O | Behavioral Rehabilitation Services |
| O | O | O | O | O | O | Foster Care |
| O | O | O | O | O | O | Other Children's Administration Services *(CPS, FRS, Child Welfare)* |
| O | O | O | O | O | O | Juvenile Justice *(Arrests, Probation, Detention)* |
| O | O | O | O | O | O | Juvenile Rehabilitation *(JJ&RA Institution, Parole, Dispositional Alternatives)* |
| O | O | O | O | O | O | Special Education |
| O | O | O | O | O | O | Developmental Disabilities Administration |
| O | O | O | O | O | O | Substance Abuse – Outpatient Treatment |
| O | O | O | O | O | O | Substance Abuse – Inpatient Treatment |
| O | O | O | O | O | O | Substance Abuse – Detox |
| O | O | O | O | O | O | Mental Health – Outpatient Treatment – **Non-DBHR Medicaid** |
| O | O | O | O | O | O | Mental Health – Outpatient Treatment – **DBHR Medicaid** |
| O | O | O | O | O | O | Mental Health – CLIP |
| O | O | O | O | O | O | Mental Health – Other Inpatient Treatment *(Psychiatric Hospitalizations, State Hospitals)* |
| O | O | O | O | O | O | Mental Health – Crisis Service |
| O | O | O | O | O | O | School-Based Behavioral Health Services |
| O | O | O | O | O | O | Tribal Behavioral Health Services |

| **PSYCHIATRIC PRESCRIPTION MEDICATIONS:** *When did the youth **most recently** take prescription medications for the following conditions?* | | | | |
|---|---|---|---|---|
| Current | Past 12 months | More than 12 months ago or never | Don't know | Most recently receiving medication for . . . |
| O | O | O | O | Psychotic symptoms such as hallucinations or delusions *(such as, Chlorpromazine [Thorazine], Haloperidol [Haldol], Perphenazine, Fluphenazine, Risperidone [Risperdal], Olanzapine [Zyprexa])* |
| O | O | O | O | Mood disorders *(such as, Fluoxetine [Prozac], Citalopram [Celexa], Sertraline [Zoloft], Paroxetine [Paxil], Escitalopram [Lexapro], Venlafaxine [Effexor], Lithium)* |
| O | O | O | O | Anxiety *(such as, Clonazepam [Klonopin], Lorazepam [Ativan], Alprazolam [Xanax])* |
| O | O | O | O | ADHD *(such as, Methylphenidate [Ritalin, Metadate, Concerta, Daytrana], Amphetamine [Adderall], Dextroamphetamine [Dexedrine, Dextrostat])* |
| O | O | O | O | Other mental health condition *(specify)*_____ |

**EVENTS:** *Please report how many of the following events the youth has experienced in the **past 12 months.***

Number of arrests: ☐ None ☐ One ☐ Two ☐ Three or more

Number of convictions: ☐ None ☐ One ☐ Two ☐ Three or more

Number of times youth went to a hospital emergency room about his or her health:
*(This includes emergency room visits that resulted in a hospital admission.)* ☐ None ☐ One ☐ Two ☐ Three or more

- *If at least one, was mental health a primary factor in any of these ER visits?* ☐ Yes ☐ No
- *If at least one, was substance abuse a primary factor in any of these ER visits?* ☐ Yes ☐ No

# I. LIFE FUNCTIONING DOMAIN

Life domains are the different arenas of social interaction found in the lives of children, youth, and their families. This domain rates how they are functioning in the individual, family, peer, school, and community realms. This section is rated using the needs scale and therefore will highlight any struggles the individual and family are experiencing.

**Question to Consider for this Domain:** How is the child/youth functioning in individual, family, peer, school, and community realms?

For the **Life Functioning Domain,** use the following categories and action levels:

| | |
|---|---|
| 0 | No current need; no need for action or intervention. |
| 1 | History or suspicion of problems; requires monitoring, watchful waiting, or preventive activities. |
| 2 | Problem is interfering with functioning; requires action or intervention to ensure that the need is addressed. |
| 3 | Problems are dangerous or disabling; requires immediate and/or intensive action. |

**FAMILY FUNCTIONING**

This item rates the child/youth's relationships with those who are in their family. It is recommended that the description of family should come from the child/youth's perspective (i.e. who the child/youth describes as their family). In the absence of this information, consider biological and adoptive relatives and their significant others with whom the child/youth is still in contact. Foster families should only be considered if they have made a significant commitment to the child/youth. For children/youth involved with child welfare, family refers to the person(s) fulfilling the permanency plan. When rating this item, take into account the relationship the child/youth has with their family as well as the relationship of the family as a whole.

Questions to Consider

- Is there conflict in the family relationship that requires resolution?
- Is treatment required to restore or develop positive relationship in the family?

Ratings and Descriptions

| | |
|---|---|
| 0 | No current need; no need for action or intervention.<br>No evidence of problems in relationships with family members, and/or child/youth is doing well in relationships with family members. |
| 1 | History or suspicion of problems; requires monitoring, watchful waiting, or preventive activities.<br>History or suspicion of problems. Child/youth might be doing adequately in relationships with family members, although some problems may exist. For example, some family members may have problems in their relationships with child/youth. Arguing may be common but does not result in major problems. |
| 2 | Problem is interfering with functioning; requires action or intervention to ensure that the need is addressed.<br>Child/youth is having problems with parents, siblings and/or other family members that are impacting the child/youth's functioning. Frequent arguing, difficulty maintaining positive relationships may be observed. |
| 3 | Problems are dangerous or disabling; requires immediate and/or intensive action.<br>Child/youth is having severe problems with parents, siblings, and/or other family members. This would include problems of domestic violence, absence of any positive relationships, etc. |

**LIVING SITUATION**

This item refers to how the child/youth is functioning in the child/youth's current living arrangement, which could be with a relative, in a foster home, etc. This item should exclude respite, brief detention/jail, and brief medical and psychiatric hospitalization.

Questions to Consider

- How has the child/youth been behaving and getting along with others in the current living situation?

Ratings and Descriptions

| | |
|---|---|
| 0 | No current need; no need for action or intervention.<br>No evidence of problem with functioning in current living environment. Child/youth and caregivers feel comfortable dealing with issues that come up in day-to-day life. |
| 1 | History or suspicion of problems; requires monitoring, watchful waiting, or preventive activities.<br>Child/youth experiences mild problems with functioning in current living situation. Caregivers express some concern about child/youth's behavior in living situation, and/or child/youth and caregiver have some difficulty dealing with issues that arise in daily life. |
| 2 | Problem is interfering with functioning; requires action or intervention to ensure that the need is addressed.<br>Child/youth has moderate to severe problems with functioning in current living situation. Child/youth's difficulties in maintaining appropriate behavior in this setting are creating significant problems for others in the residence. Child/youth and caregivers have difficulty interacting effectively with each other much of the time. |
| 3 | Problems are dangerous or disabling; requires immediate and/or intensive action.<br>Child/youth has profound problems with functioning in current living situation. Child/youth is at immediate risk of being removed from living situation due to problematic behaviors. |

**SCHOOL**

This item rates the child/youth's overall functioning at school and may include attendance, behavior and achievement.

Questions to Consider

- How is the child/youth doing in school?
- Are they having difficulty with any subjects? At risk of failing any classes?
- Have they had any behavioral problems?
- Has the child/youth had any difficulty with getting to or staying in school?

Ratings & Descriptions

| | |
|---|---|
| 0 | No current need; no need for action or intervention.<br>Child/youth is performing well in school. |
| 1 | Identified need requires monitoring, watchful waiting, or preventive activities.<br>Child/youth is performing adequately in school although some problems may exist. |
| 2 | Action or intervention is required to ensure that the identified need is addressed; need is interfering with child/youth's functioning.<br>Child/youth is experiencing moderate problems with school attendance, behavior, and/or achievement. |
| 3 | Problems are dangerous or disabling; requires immediate and/or intensive action.<br>Child/youth is experiencing severe problems in school with school attendance, behavior and/or achievement. |

**INTERPERSONAL FUNCTIONING**

This item refers to the social functioning and interpersonal skills of the child/youth both with peers and adults.

Questions to Consider

- Currently, how well does the child/youth get along with others?
- Does the child/youth have the ability to engage friendships?
- Has there been an increase in peer conflicts?
- Does the child/youth have unhealthy friendships?
- Does the child/youth tend to change friends frequently?

Ratings and Descriptions

0 No current need; no need for action or intervention.
No evidence of interpersonal problems. Child/youth is seen as well-liked by others and has significant ability to form and maintain positive relationships with both peers and adults. Child/youth has multiple close friends and is friendly with others.

1 History or suspicion of problems; requires monitoring, watchful waiting, or preventive activities.
Some evidence of interpersonal strengths. Child/youth has formed positive interpersonal relationships with peers and/or other non-caregivers. Child/youth may have one friend, if that friendship is a healthy "best" friendship model.

2 Problem is interfering with functioning; requires action or intervention to ensure that the need is addressed.
Some evidence of need in interpersonal strengths. Child/youth has some social skills that facilitate positive relationships with peers and adults but may not have any current relationships. Child/youth may have a history of making and maintaining health friendships with others.

3 Problems are dangerous or disabling; requires immediate and/or intensive action.
This level indicates a child/youth with no known interpersonal strengths. Child/youth currently does not have any friends nor have they had friends in the past. Child/youth does not have positive relationships with adults.

**CRIME/DELINQUENCY**

This item includes both criminal behavior and status offenses that may result from child/youth failing to follow required behavioral standards (e.g., truancy, curfew violations, driving without a license). Sexual offenses should be included as delinquent behavior. If caught, child/youth could be arrested for this behavior. *Note: The standard name for this item is Delinquent Behavior.*

Questions to Consider

- Do you know of laws that the child/youth has broken (even if they have not been charged or caught)?
- Has the child/youth ever been arrested?

Ratings and Descriptions

0 No current need; no need for action or intervention.
No evidence or no history of delinquent behavior.

1 History or suspicion of problems; requires monitoring, watchful waiting, or preventive activities.
History or suspicion of delinquent behavior, but none in the recent past. Status offenses would generally be rated here.

2 Problem is interfering with functioning; requires action or intervention to ensure that the need is addressed.
Currently engaged in delinquent behavior (e.g., vandalism, shoplifting, etc.) that puts the child/youth at risk.

3 Problems are dangerous or disabling; requires immediate and/or intensive action.
Serious recent acts of delinquent activity that place others at risk of significant loss or injury, or place the child/youth at risk of adult sanctions. Examples include car theft, residential burglary and gang involvement.

**DEVELOPMENTAL/INTELLECTUAL**

This item describes the child/youth's development as compared to standard developmental milestones, as well as rates the presence of any developmental (motor, social and speech) or intellectual disabilities. It includes Intellectual Developmental Disorder (IDD) and Autism Spectrum Disorders. Rate the item depending on the significance of the disability and the related level of impairment in personal, social, family, school, or occupational functioning.

Questions to Consider

- Does the child/youth's growth and development seem healthy?
- Has the child/youth reached appropriate developmental milestones (such as walking, talking)?
- Has anyone ever mentioned that the child/youth may have developmental problems?
- Has the child/youth developed like other same age peers?

Ratings and Descriptions

0 No current need; no need for action or intervention.
No evidence of developmental delay and/or child/youth has no developmental problems or intellectual disability.

1 History or suspicion of problems; requires monitoring, watchful waiting, or preventive activities.
There are concerns about possible developmental delay. Child/youth may have low IQ, a documented delay, or documented borderline intellectual disability (i.e. FSIQ 70-85). Mild deficits in adaptive functioning are indicated.

2 Problem is interfering with functioning; requires action or intervention to ensure that the need is addressed.
Child/youth has mild developmental delays (e.g., deficits in social functioning, inflexibility of behavior causing functional problems in one or more settings) and/or mild to moderate Intellectual Disability/Intellectual Disability Disorder. (If available, FSIQ 55-69.) IDD impacts communication, social functioning, daily living skills, judgment, and/or risk of manipulation by others.

3 Problems are dangerous or disabling; requires immediate and/or intensive action.
Child/youth has severe to profound intellectual disability (FSIQ, if available, less than 55) and/or Autism Spectrum Disorder with marked to profound deficits in adaptive functioning in one or more areas: communication, social participation and independent living across multiple environments.

**MEDICAL/PHYSICAL**

This item describes both health problems and chronic/acute physical conditions or impediments.

Questions to Consider

- Does the child/youth have anything that limits their physical activities?
- How much does this interfere with the child/youth's life?

Ratings and Descriptions

0 No current need; no need for action or intervention.
No evidence that the child/youth has any medical or physical problems, and/or they are healthy.

1 History or suspicion of problems; requires monitoring, watchful waiting, or preventive activities.
Child/youth has mild, transient or well-managed physical or medical problems. These include well-managed chronic conditions like juvenile diabetes or asthma.

2 Problem is interfering with functioning; requires action or intervention to ensure that the need is addressed.
Child/youth has *serious* medical or physical problems that require medical treatment or intervention. Or child/youth has a *chronic* illness or a physical challenge that requires *ongoing* medical intervention.

3 Problems are dangerous or disabling; requires immediate and/or intensive action.
Child/youth has *life-threatening* illness or medical/physical condition. Immediate and/or intense action should be taken due to imminent danger to child/youth's safety, health, and/or development.

**Supplemental Information:** Included in this item will be conditions which limit activity, such as impaired hearing, vision and asthma. A rating of '2' includes sensory disorders such as blindness and deafness.

**SEXUAL DEVELOPMENT**

This item looks at broad issues of sexual development including developmentally inappropriate sexual behavior or sexual concerns, and the reactions of others to any of these factors. The child/youth's sexual orientation, gender identity and expression (SOGIE) could be rated here only if they are leading to difficulties. Sexually abusive behaviors are rated elsewhere.

Questions to Consider

- Are there concerns about the child/youth's healthy sexual development?
- Is the child/youth sexually active?
- Does the child/youth have less/more interest in sex than other same age peers?

Ratings and Descriptions

| | |
|---|---|
| 0 | No current need; no need for action or intervention.<br>No evidence of issues with sexual development. |
| 1 | History or suspicion of problems; requires monitoring, watchful waiting, or preventive activities.<br>History or suspicion of problems with sexual development, but does not interfere with functioning in other life domains. May include the child/youth's concerns about sexual orientation, gender identity and expression (SOGIE), or anxiety about the reaction of others. |
| 2 | Problem is interfering with functioning; requires action or intervention to ensure that the need is addressed.<br>Moderate to serious problems with sexual development that interferes with the child/youth's life functioning in other life domains. |
| 3 | Problems are dangerous or disabling; requires immediate and/or intensive action.<br>Severe problems with sexual development. This would include very frequent risky sexual behavior or victim of sexual exploitation. |

# 2. BEHAVIORAL/EMOTIONAL NEEDS DOMAIN

This section identifies the behavioral health needs of the child/youth. While the CANS is not a diagnostic tool, it is designed to be consistent with diagnostic communication. In the DSM, a diagnosis is defined by a set of symptoms that is associated with either dysfunction or distress. This is consistent with the ratings of '2' or '3' as described by the action levels below.

**Question to Consider for this Domain:** What are the presenting social, emotional, and behavioral needs of the child/youth?

For the **Behavioral/Emotional Needs Domain,** use the following categories and action levels:

| | |
|---|---|
| 0 | No current need; no need for action or intervention. |
| 1 | History or suspicion of problems; requires monitoring, watchful waiting, or preventive activities. |
| 2 | Problem is interfering with functioning; requires action or intervention to ensure that the need is addressed. |
| 3 | Problems are dangerous or disabling; requires immediate and/or intensive action. |

**PSYCHOSIS (THOUGHT DISORDER)**

This item rates the symptoms of psychiatric disorders with a known neurological base, including schizophrenia spectrum and other psychotic disorders. The common symptoms of these disorders include hallucinations (i.e. experiencing things others do not experience), delusions (i.e. a false belief or an incorrect inference about reality that is firmly sustained despite the fact that nearly everybody thinks the belief is false or proof exists of its inaccuracy), disorganized thinking, and bizarre/idiosyncratic behavior.

Questions to Consider

- Does the child/youth exhibit behaviors that are unusual or difficult to understand?
- Does the child/youth engage in certain actions repeatedly?
- Are the unusual behaviors or repeated actions interfering with the child/youth's functioning?

Ratings and Descriptions

| | |
|---|---|
| 0 | No current need; no need for action or intervention.<br>No evidence of psychotic symptoms. Both thought processes and content are within normal range. |
| 1 | History or suspicion of problems; requires monitoring, watchful waiting, or preventive activities.<br>Evidence of disruption in thought processes or content. Child/youth may be somewhat tangential in speech or evidence somewhat illogical thinking (age-inappropriate). This also includes a child/youth with a history of hallucinations but none currently. Use this category for children/youth who are below the threshold for one of the DSM diagnoses listed above. |
| 2 | Problem is interfering with functioning; requires action or intervention to ensure that the need is addressed.<br>Evidence of disturbance in thought process or content that may be impairing the child/youth's functioning in at least one life domain. Child/youth may be somewhat delusional or have brief intermittent hallucinations. Speech may be at times quite tangential or illogical. |
| 3 | Problems are dangerous or disabling; requires immediate and/or intensive action.<br>Clear evidence of dangerous hallucinations, delusions, or bizarre behavior that might be associated with some form of psychotic disorder that places the child/youth or others at risk of physical harm. |

**ATTENTION DEFICIT/IMPULSE CONTROL**

This item rates behavioral symptoms associated with hyperactivity and/or impulsiveness, e.g., loss of control of behaviors, ADHD and disorders of impulse control.

| Questions to Consider | Ratings and Descriptions | |
|---|---|---|
| • Is the child/youth unable to sit still for any length of time?<br>• Does the child/youth have trouble paying attention for more than a few minutes?<br>• Is the child/youth able to control their behavior, talking?<br>• Does the child/youth report feeling compelled to do something despite negative consequences? | 0 | No current need; no need for action or intervention.<br>No evidence of attention/hyperactivity problems. |
| | 1 | History or suspicion of problems; requires monitoring, watchful waiting, or preventive activities. This rating is used to indicate a child/youth with evidence of mild problems with attention/ hyperactivity or impulse control. Child/youth may have some difficulties staying on task for an age-appropriate time period. |
| | 2 | Problem is interfering with functioning; requires action or intervention to ensure that the need is addressed.<br>Moderate attention/hyperactivity or impulse control problems. A child/youth who meets DSM diagnostic criteria for ADHD or an impulse control disorder would be rated here. |
| | 3 | Problems are dangerous or disabling; requires immediate and/or intensive action.<br>Severe impairment of attention or impulse control. Frequent impulsive behavior is observed or noted that carries considerable safety risk (e.g., running into the street, dangerous driving or bike riding). A child/youth with profound symptoms of ADHD would be rated here. |

**MOOD DISTURBANCE**

This item rates displayed symptoms of a change in emotional state and can include symptoms of depressed mood, hypomania or mania.

| Questions to Consider | Ratings and Descriptions | |
|---|---|---|
| • Do parents feel that the child/ youth is depressed or irritable?<br>• Has the child/ youth withdrawn from normal activities?<br>• Does the child/youth seem lonely or not interested in others? | 0 | No current need; no need for action or intervention.<br>No evidence of mood problems. |
| | 1 | History or suspicion of problems; requires monitoring, watchful waiting, or preventive activities. Mild mood problems. Brief duration of depression, irritability, or impairment of peer, family or academic function that does not lead to gross avoidance or inappropriate behavior. |
| | 2 | Problem is interfering with functioning; requires action or intervention to ensure that the need is addressed.<br>Moderate level of mood disturbance. This would include anhedonia, episodes of mania, depression, social withdrawal or school avoidance. |
| | 3 | Problems are dangerous or disabling; requires immediate and/or intensive action.<br>Severe level of mood disturbance. This would include a child/youth whose emotional symptoms prevent appropriate participation in school, friendship groups, or family life. |

**ANXIETY**

This item rates symptoms associated with DSM-5 Anxiety Disorders characterized by excessive fear and anxiety and related behavioral disturbances (including avoidance behaviors). Panic attacks can be a prominent type of fear response.

Questions to Consider

- Does the child/youth have any problems with anxiety or fearfulness?
- Is the child/youth avoiding normal activities out of fear?
- Does the child/youth act frightened or afraid?

Ratings and Descriptions

| | |
|---|---|
| 0 | No current need; no need for action or intervention.<br>No evidence of anxiety symptoms. |
| 1 | History or suspicion of problems; requires monitoring, watchful waiting, or preventive activities.<br>There is a history, suspicion, or evidence of mild anxiety associated with a recent negative life event. This level is used to rate either a mild phobia or anxiety problem that is not yet causing the child/youth significant distress or markedly impairing functioning in any important context. |
| 2 | Problem is interfering with functioning; requires action or intervention to ensure that the need is addressed.<br>Clear evidence of anxiety associated with either anxious mood or significant fearfulness. Anxiety has interfered in the child/youth's ability to function in at least one life domain. |
| 3 | Problems are dangerous or disabling; requires immediate and/or intensive action.<br>Clear evidence of debilitating level of anxiety that makes it virtually impossible for the child/youth to function in any life domain. |

**DISRUPTIVE BEHAVIOR**

This item is intended to capture whether the child/youth's behavior is disruptive to their environment or relationships. Oppositional behavior is different from conduct disorder in that the emphasis of the behavior is on non-compliance to authority rather than on seriously breaking social rules, norms and laws. *Note: The standard name for this item is Oppositional.*

Questions to Consider

- Is the child/youth seen as dishonest?
- Does the child/youth follow their parents' rules?
- Have teachers or other adults reported that child/youth does not follow rules or directions?
- Does the child/youth argue with adults when they try to get child/youth to do something?

Ratings and Descriptions

| | |
|---|---|
| 0 | No current need; no need for action or intervention.<br>This rating indicates that the child/youth has no known problems with disruptive behavior. |
| 1 | History or suspicion of problems; requires monitoring, watchful waiting, or preventive activities.<br>This rating indicates that the child/youth has mild problems with disruptive behavior. |
| 2 | Problem is interfering with functioning; requires action or intervention to ensure that the need is addressed.<br>This rating indicates that the child/youth has moderate problems with disruptive behavior. Child/youth's behavior is resulting in notable functioning problems. |
| 3 | Problems are dangerous or disabling; requires immediate and/or intensive action.<br>This rating indicates that the child/youth has severe problems with disruptive behavior. Child/youth may be always noncompliant or engaging in behavior that is a community safety risk. |

**SUBSTANCE USE**

This item describes problems related to the use of alcohol and illegal drugs, the misuse of prescription medications, and the inhalation of any chemical or synthetic substance by a child/youth. This rating is consistent with DSM-5 Substance-Related and Addictive Disorders. This item does not apply to the use of tobacco or caffeine.

Questions to Consider

- Has the child/youth used alcohol or drugs on more than an experimental basis?
- Do you suspect that the child/youth may have an alcohol or drug use problem?
- Has the child/youth been in a recovery program for the use of alcohol or illegal drugs?

Ratings and Descriptions

| | |
|---|---|
| 0 | No current need; no need for action or intervention.<br>Child/youth has no notable substance use difficulties at the present time. |
| 1 | History or suspicion of problems; requires monitoring, watchful waiting, or preventive activities.<br>Child/youth has substance use problems that occasionally interfere with daily life (e.g., intoxication, loss of money, reduced work/school performance, parental concern). History of substance use problems without evidence of current problems related to use is rated here. |
| 2 | Problem is interfering with functioning; requires action or intervention to ensure that the need is addressed.<br>Child/youth has a substance use problem that consistently interferes with the ability to function optimally, but does not completely preclude functioning in an unstructured setting. |
| 3 | Problems are dangerous or disabling; requires immediate and/or intensive action.<br>Child/youth has a substance use problem that represents complications to functional issues that may result in danger to self, public safety issues, or the need for detoxification of the child/youth. |

**ADJUSTMENT TO TRAUMA**

This item is used to describe the child/youth who is having difficulties adjusting to a traumatic experience, as defined by the child/youth. This is one item where speculation about *why* a person is displaying a certain behavior is considered. There should be an inferred link between the trauma and behavior.

Questions to Consider

- What was the child/youth's trauma?
- How is it connected to the current issue(s)?
- What are the child/youth's coping skills?
- Who is supporting the child/youth?

Ratings and Descriptions

| | |
|---|---|
| 0 | No current need; no need for action or intervention.<br>No evidence that child/youth has experienced a traumatic life event, OR child/youth has adjusted well to traumatic/adverse experiences. |
| 1 | History or suspicion of problems; requires monitoring, watchful waiting, or preventive activities.<br>The child/youth has experienced a traumatic event and there are some changes in their behavior that are managed or supported by caregivers. These symptoms are expected to ease with the passage of time and therefore no current intervention is warranted. Child/youth may be in the process of recovering from a more extreme reaction to a traumatic experience, which may require a need to watch these symptoms or engage in preventive action. |
| 2 | Problem is interfering with functioning; requires action or intervention to ensure that the need is addressed.<br>Clear evidence of adjustment problems associated with traumatic life event(s). Symptoms can vary widely and may include sleeping or eating disturbances, regressive behavior, behavior problems or problems with attachment. Adjustment is interfering with child/youth's functioning in at least one life domain. |
| 3 | Problems are dangerous or disabling; requires immediate and/or intensive action.<br>Clear evidence of debilitating level of trauma symptoms that makes it virtually impossible for the child/youth to function in any life domain including symptoms such as flashbacks, nightmares, significant anxiety, intrusive thoughts, and/or re-experiencing trauma (consistent with PTSD). |

**EMOTIONAL CONTROL**

This item describes the child/youth's ability to manage their emotions and frustration tolerance.

| Questions to Consider | Ratings and Descriptions | |
|---|---|---|
| • How does the child/ youth control their emotions?<br>• Does the child/youth get upset or frustrated easily?<br>• Does the child/youth overreact if someone criticizes or rejects the child/youth?<br>• Does the child/youth seem to have dramatic mood swings? | 0 | No current need; no need for action or intervention.<br>No evidence of any emotional control problems. |
| | 1 | History or suspicion of problems; requires monitoring, watchful waiting, or preventive activities.<br>Some problems with controlling emotions. Peers and family may be aware of and may attempt to avoid stimulating outbursts. |
| | 2 | Problem is interfering with functioning; requires action or intervention to ensure that the need is addressed.<br>Moderate emotional control problems. Child/youth's labile mood and/or extreme mood swings have gotten them in significant trouble with peers, family and/or school. Others are likely quite aware of unstable emotions. |
| | 3 | Problems are dangerous or disabling; requires immediate and/or intensive action.<br>Severe emotional control problems. Child/youth's temper makes them unable to regulate their emotions. Others likely fear them. |

# 3. RISK BEHAVIORS DOMAIN

This section focuses on behaviors that can get children and youth in trouble or put them in danger of harming themselves or others. Time frames in this section can change (particularly for ratings '1' and '3') away from the standard 30-day rating window.

Note that these items will not replace a detailed risk assessment.

**Question to Consider for this Domain**: Does the child/youth's behaviors put them at risk for serious harm?

For the **Risk Behaviors Domain,** use the following categories and action levels:

| | |
|---|---|
| 0 | No current need; no need for action or intervention. |
| 1 | Need that requires monitoring, watchful waiting, or preventive action. This may have been a risk behavior in the past. |
| 2 | Action or intervention is required to ensure that the identified need is addressed. |
| 3 | Intensive and/or immediate action is required to address the need or risk behavior. |

**SUICIDE RISK**

This item is intended to describe the presence of thoughts or behaviors aimed at taking one's life. This rating describes both suicidal and significant self-injurious behavior. This item rates overt and covert thoughts, and efforts on the part of a child or youth to end their life. A rating of '2' or '3' would indicate the need for a safety plan. Notice the specific time frames for each rating.

Questions to Consider

- Has the child/youth ever talked about a wish or plan to die or to kill themselves?
- Has the child/youth ever tried to commit suicide?

Ratings and Descriptions

| | |
|---|---|
| 0 | No current need; no need for action or intervention.<br>No evidence of suicidal ideation. |
| 1 | Need that requires monitoring, watchful waiting, or preventive action. This may have been a risk behavior in the past.<br>History of suicidal ideation, but no recent ideation or gesture. History of suicidal behaviors or significant ideation but none during the recent past. |
| 2 | Action or intervention is required to ensure that the identified need is addressed.<br>Recent, but not acute, suicidal ideation or gesture. |
| 3 | Intensive and/or immediate action is required to address the need or risk behavior.<br>Current suicidal ideation and intent OR command hallucinations that involve self-harm. |

**NON-SUICIDAL SELF-INJURIOUS BEHAVIOR**

This item includes repetitive, physically harmful behavior that generally serves as a self-soothing function to the child/youth (e.g., cutting, carving, burning self, face slapping, head banging, etc.). *Note: This item was previously called Non Suicidal Self Injury.*

Questions to Consider

- Does the behavior serve a self-soothing purpose (e.g., numb emotional pain, move the focus of emotional pain to the physical)?
- Does the child/youth ever purposely hurt themselves (e.g., cutting)?

Ratings and Descriptions

| | |
|---|---|
| 0 | No current need; no need for action or intervention.<br>No evidence of any forms of self-injury. |
| 1 | Need that requires monitoring, watchful waiting, or preventive action. This may have been a risk behavior in the past.<br>A history or suspicion of self-injurious behavior. |
| 2 | Action or intervention is required to ensure that the identified need is addressed.<br>Engaged in self-injurious behavior (e.g., cutting, burns, piercing skin with sharp objects, repeated head banging) that does not require medical attention. |
| 3 | Intensive and/or immediate action is required to address the need or risk behavior.<br>Engaged in self-injurious behavior requiring medical intervention (e.g., sutures, surgery) and that is significant enough to put the child/youth's health at risk. |

**DANGER TO OTHERS**

This item rates the child/youth's violent or aggressive behavior. The intention of this behavior is to cause significant bodily harm to others. A rating of '2' or '3' would indicate the need for a safety plan. Reckless behavior that may cause physical harm to others is not rated on this item.

Questions to Consider

- Has the child/youth ever injured another person on purpose?
- Does the child/youth get into physical fights?
- Has the child/youth ever threatened to kill or seriously injure others?

Ratings and Descriptions

| | |
|---|---|
| 0 | No current need; no need for action or intervention.<br>No evidence or history of aggressive behaviors or significant verbal threats of aggression towards others (including people and animals). |
| 1 | Need that requires monitoring, watchful waiting, or preventive action. This may have been a risk behavior in the past.<br>History of aggressive behavior or verbal threats of aggression towards others. History of fire setting would be rated here. |
| 2 | Action or intervention is required to ensure that the identified need is addressed.<br>Occasional or moderate level of aggression towards others. Child/youth has made verbal threats of violence towards others. |
| 3 | Intensive and/or immediate action is required to address the need or risk behavior.<br>Acute homicidal ideation with a plan, frequent or dangerous (significant harm) level of aggression to others. Child/youth is an immediate risk to others. |

**RUNAWAY**

This item describes the risk of running away or actual runaway behavior.

Questions to Consider

- Has the child/youth ever run away from home, school, or any other place?
- If so, where did the child/youth go? How long did they stay away? How was the child/youth found?
- Does the child/youth ever threaten to run away?

Ratings and Descriptions

0 No current need; no need for action or intervention.
Child/youth has no history of running away or ideation of escaping from current living situation.

1 Need that requires monitoring, watchful waiting, or preventive action. This may have been a risk behavior in the past.
Child/youth has no recent history of running away but has expressed ideation about escaping current living situation. Child/youth may have threatened running away on one or more occasions or has a history of running away but not in the recent past.

2 Action or intervention is required to ensure that the identified need is addressed.
Child/youth has run from home once or run from one treatment setting. Also rated here is a child/youth who has runaway to home (parental or relative).

3 Intensive and/or immediate action is required to address the need or risk behavior.
Child/youth has run from home and/or treatment settings in the recent past and present an imminent flight risk. A child/youth who is currently a runaway is rated here.

**DECISION MAKING**

This item describes the child/youth's age-appropriate decision making process and understanding of choices and consequences.

Questions to Consider

- How is the child/youth's judgment and ability to make good decisions?
- Does the child/youth typically make good choices for the youth?
- Do their choices ever result in harm to the child/youth or others?

Ratings and Descriptions

0 No current need; no need for action or intervention.
No evidence of problems with judgment or decision making that result in harm to development and/or well-being.

1 Need that requires monitoring, watchful waiting, or preventive action. This may have been a risk behavior in the past.
There is a history or suspicion of problems with judgment in which the child/youth makes decisions that are in some way harmful to their development and/or well-being.

2 Action or intervention is required to ensure that the identified need is addressed.
Problems with judgment in which the child/youth makes decisions that are in some way harmful to their development and/or well-being. As a result, more supervision is required than expected for their age.

3 Intensive and/or immediate action is required to address the need or risk behavior.
Child/youth makes decisions that would likely result in significant physical harm to self or others. Therefore, child/youth requires intense and constant supervision, over and above that expected for child/youth's age.

**MEDICATION MANAGEMENT**

This item focuses on the child/youth's level of willingness or ability to collaborate and participate in taking prescribed medications.

Questions to Consider

- Is the child/youth taking prescribed medication?
- Is the child/youth willing to participate in taking the medication?
- Do they take the medication as planned?
- Do they take responsibility for taking their medication as prescribed?
- Do they feel that their opinion about the medication is considered in med plans?

Ratings and Descriptions

0 No current need; no need for action or intervention.
Not currently on any medication. Or, there is no evidence of unwillingness or noncompliance to taking medications as prescribed and without reminders. Or, the child/youth collaborates in taking medication as prescribed.

1 Need that requires monitoring, watchful waiting, or preventive action. This may have been a risk behavior in the past.
Child/youth collaborates and will take prescribed medications routinely, but sometimes needs reminders to take medication regularly. Also, a history of inability or unwillingness to take medication as prescribed, but no current problems would be noted here.

2 Action or intervention is required to ensure that the identified need is addressed.
Child/youth is periodically unable or unwilling to collaborate or take medication as prescribed. Child/youth may be resistant to taking prescribed medications, or may tend to overuse their medications. The child/youth might adhere to prescription plans for periods of time (1-2 weeks) but generally does not sustain taking medication following the prescribed dose or protocol.

3 Intensive and/or immediate action is required to address the need or risk behavior.
Child/youth does not collaborate and has refused to take prescribed medications during the past 30-day period. A person who has abused their medications to a significant degree (e.g., overdosing or over using medications to a dangerous degree) would be noted here.

# 4. CAREGIVER RESOURCES & NEEDS DOMAIN

This section focuses on the strengths and needs of the caregiver. Caregiver ratings should be completed by household. If multiple households are involved in the planning, then this section should be completed once for each household under consideration. If the child/youth is in a foster care or out-of-home placement, please rate the identified parent(s), other relative(s), adoptive parent(s), or caretaker(s) who is planning to assume custody and/or take responsibility for the care of this child/youth. If child/youth does not have an identified permanent caregiver at this time, please rate all items a 0.

**Question to Consider for this Domain:** What are the resources and needs of the child/youth's caregiver(s)?

For the **Caregiver Resources & Needs Domain,** use the following categories and action levels:

| | |
|---|---|
| 0 | No evidence of any needs. This could be a potential resource for the child/youth. |
| 1 | Identified need requires monitoring, watchful waiting, or preventive activities. The caregiver may require help or resources in this area. |
| 2 | Action or intervention is required to ensure that the identified need or risk behavior is addressed, as it is currently interfering with the caregiver's ability to parent or support the child/youth. |
| 3 | Identified need requires immediate or intensive action, as it is currently preventing the caregiver from effectively parenting or supporting the child/youth. |

**CAREGIVER CAPACITY**
This item refers to the caregiver's capacity to provide the parenting needed by the child/youth.

Questions to Consider

- How is the caregiver's health?
- Do caregivers have any substance use needs, developmental problems, physical and/or mental health needs that make parenting difficult?
- Does anyone else in the family have serious needs that the caregiver is taking care of?

Ratings and Descriptions

| | |
|---|---|
| 0 | No evidence of any needs. This could be a potential resource for the child/youth.<br>No evidence of caregiver mental, physical, developmental or substance use issues. No concerns about the family/caregiver's capacity to meet the needs of the child/youth. |
| 1 | Identified need requires monitoring, watchful waiting, or preventive activities. The caregiver may require help or resources in this area.<br>Mild concerns about the family/caregiver's abilities to fully meet the needs of the child/youth. |
| 2 | Action or intervention is required to ensure that the identified need or risk behavior is addressed, as it is currently interfering with the caregiver's ability to parent or support the child/youth.<br>Caregiver circumstance in which notable challenges exist for the family/caregiver to meet the needs of the child/youth. |
| 3 | Identified need requires immediate or intensive action, as it is currently preventing the caregiver from effectively parenting or supporting the child/youth.<br>Caregiver circumstance in which the family/caregiver is currently unable to meet basic needs of the child/youth. |
| NA | There is no permanent caregiver known at this time. |

**FAMILY STRESS**

This item is used to describe the impact of managing the child/youth's behavioral and emotional needs on the family's stress level.

Questions to Consider

- Are the family members able to deal with their family stresses?
- Are there marital difficulties or sibling issues that increase family stress?
- Has stress led to other problems within the family?

Ratings and Descriptions

| | |
|---|---|
| 0 | No evidence of any needs. This could be a potential resource for the child/youth.<br>No evidence of caregiver having difficulty managing the stress of the child/youth's needs and/or caregiver is able to manage the stress of child/youth's needs. |
| 1 | Identified need requires monitoring, watchful waiting, or preventive activities. The caregiver may require help or resources in this area.<br>There is a history or suspicion and/or caregiver has some problems managing the stress of child/youth's needs. |
| 2 | Action or intervention is required to ensure that the identified need or risk behavior is addressed, as it is currently interfering with the caregiver's ability to parent or support the child/youth.<br>Caregiver has notable problems managing the stress of child/youth's needs. This stress interferes with their capacity to provide care. |
| 3 | Identified need requires immediate or intensive action, as it is currently preventing the caregiver from effectively parenting or supporting the child/youth.<br>Caregiver is unable to manage the stress associated with child/youth's care. This stress prevents caregiver from parenting. |

**SAFETY**

This item describes the caregiver's ability to maintain the child/youth's safety within the household. It does not refer to the safety of other family or household members based on any danger presented by the assessed child/youth.

Questions to Consider

- Is the caregiver able to protect the child/youth from harm in the home?
- Are there individuals living in the home or visiting the home that may be abusive to the child/youth?

Ratings and Descriptions

| | |
|---|---|
| 0 | No evidence of any needs. This could be a potential resource for the child/youth.<br>No evidence of safety issues. Household is safe and secure. Child/youth is not at risk from others. |
| 1 | Identified need requires monitoring, watchful waiting, or preventive activities. The caregiver may require help or resources in this area.<br>Household is safe but concerns exist about the safety of the child/youth due to history or others who might be abusive. |
| 2 | Action or intervention is required to ensure that the identified need or risk behavior is addressed, as it is currently interfering with the caregiver's ability to parent or support the child/youth.<br>Child/youth is in some danger from one or more individuals with access to the home. |
| 3 | Identified need requires immediate or intensive action, as it is currently preventing the caregiver from effectively parenting or supporting the child/youth.<br>Child/youth is in immediate danger from one or more individuals with unsupervised access. |

****All referents are legally required to report suspected child abuse or neglect.****

# 5. DIAGNOSIS AND PROGNOSIS

The CANS form for Washington includes a section that allows for the communication of DSM diagnoses. It is important to document who gave the diagnosis and when it was given. Diagnosis should be established as consistent with the guidelines of the most up to date edition of DSM. Clinicians will also rate the certainty with which the clinician has diagnosed and the estimated prognosis.

| DIAGNOSES (DX) |
|---|
| Mental Health Conditions: |
| |
| |
| |
| |

**DIAGNOSTIC CERTAINTY**

This item refers to the degree to which the symptoms are clear and consistent with a specific psychiatric diagnosis or diagnoses. Concerns regarding certainty could revolve around issues such as inconsistent symptom presentation, the presence of behavioral health or medical rule outs, etc.
Determining a diagnosis is an intricate process that can be complicated by the presence of multiple overlapping conditions or different conditions that share symptoms and signs. Some diagnoses are clearer than others. Some diagnoses require a response to treatment to confirm that they are correct. This item allows the individual performing the CANS evaluation to specify the degree to which the diagnosis is clear and certain.

Questions to Consider

- How clear are the symptoms?
- Is there ambiguity regarding diagnosis due to substance use or withdrawal?
- Are there rule outs being considered?

Ratings and Descriptions

| | |
|---|---|
| 0 | The child/youth's behavioral health diagnoses are clear and there is no doubt as to the correct diagnoses. Symptom presentation is clear. |
| 1 | Although there is some confidence in the accuracy of the child/youth's diagnoses, the child/youth's symptom presentation is sufficiently complex, raising concerns that the diagnoses may not be accurate. |
| 2 | There is substantial concern about the accuracy of the child/youth's diagnoses due to the complexity of the child/youth's presentation of symptoms. |
| 3 | It is currently not possible to accurately diagnose the child/youth's behavioral health condition(s). |

**PROGNOSIS**

This item refers to the expected trajectory of the recovery of the child/youth based on their current diagnosis, symptoms and functioning when compared with children/youth having similar diagnostic, symptomatic, and functioning presentations.
All diagnoses include some consideration of expectations for recovery. This item is designed to communicate the perception of an expected trajectory of recovery given that the child/youth is involved in the treatment system. For example, problems that result from adjustments to life events often have a better prognosis than do a chronic or degenerative disorder.

| Questions to Consider | Ratings and Descriptions | |
|---|---|---|
| • How long do you anticipate this child/ youth will need to be in treatment? | 0 | Behavioral health problems began during the past six months, and there is a clear stressor to which they can be attributed. |
| | 1 | Behavioral health problems have been ongoing, but can be anticipated to be resolved within the next year. |
| | 2 | Behavioral health problems have been ongoing and are anticipated to continue to be a problem for at least another year. |
| | 3 | Behavioral health problems have been ongoing and are anticipated to continue through to adulthood. |