# CANS as Psychosocial Evaluation (D&E)

## *Considerations to ensure compliance & quality*

**One psychosocial evaluation**: When someone needs to look at the psychosocial evaluation, is it obvious that the two documents (CANS Summary and CANS Psychosocial Addendum) are two parts of a single evaluation? This should be evident in the EMR and when printed for distribution. If there are two parts, these need to be clearly interconnected. Concern is that the two could be separated and thus there is no longer a comprehensive psychosocial evaluation document.

**Continuity**: Need to ensure continuity within psychosocial evaluation (D&E) document with the CANS results and other clinical information gathered, including interviews and other screening/assessment tools. Possible strategy to consider is if the EHR can auto-populate the CANS actionable items and strengths into appropriate sections of the Psychosocial Addendum and the IPC.

**Adequate detail**: Need to ensure the clinician provides the level of detail in the narrative sections of the D&E to explain/support the CANS items endorsed. E.g. Medical condition endorsed on CANS needs specific content in the narrative. It may help to map the sections of the CANS report to the sections on the D&E where the clinician needs to provide more detail; could also have pop-up prompts/elements to consider for narrative section.

The psychosocial addendum template is very dependent upon individual clinician’s skill/training to thoroughly complete the narrative, yet allows for clinician to tie together observations, CANS results, and clinical judgement. There is a risk that some addendums may lack adequate detail and be disjointed. Consider how the EHR may provide technical guidance to reduce this risk and what is needed for staff/supervisor training.

**Sources of information:** It’s important to note what the sources of information were for this psychosocial evaluation: who was interviewed, what data/reports or other info was gathered. Need to show multi-informant approach.

Spell out acronyms for any tools used to gather information. E.g. The Child & Adolescent Needs and Strengths (CANS-VT); Child Behavior Checklist (CBCL).

**Multiple Caregivers**: If the CANS was conducted with one caregiver (e.g. foster parent), need to be clear in the evaluation regarding which CANS statements are about the foster parent and which are about the bio/adoptive parent. This is especially relevant for Caregiver items such as Caregiver Knowledge, Caregiver Empathy, Family Strengths, Caregiver Supervision. Assume others reading the D&E won’t necessarily be grounded in the CANS administration, so it will be important for this to be clear throughout the psychosocial document.

**Clinical Formulation/ Interpretive Summary**: The clinical formulation and recommendations should bring together the CANS and other screening/assessment results with other clinical information into a comprehensive picture of the child and family. A developmentally sensitive clinical formulation/ interpretation should be developed, not just a summary of the details. What does all of that mean for this child & family? How does this child’s strengths and the caregiver’s strengths serve them and how can those be used going forward (**carry over into Treatment Recommendations**)?

**Treatment Recommendations** need to tie together with the information gathered and the interpretive summary. The CANS actionable items and strengths should be incorporated into the recommendations. If there are multiple caregivers, speak to the plan related to each (e.g. the bio/adoptive family and foster home).

**Continuity of psychosocial, plan of care, service delivery and progress monitoring**: The psychosocial evaluation including CANS results should clearly contribute to the development of and link to the goals, objectives and interventions on the IPC.

Incorporating the CANS into the evaluation, treatment planning and progress monitoring process provides an opportunity to focus on the child & family strengths and how those can contribute to addressing areas of concern and the achievement of goals.

## **Process going forward**

DAs share draft document template of CANS incorporated into the psychosocial evaluation (D&E) and a client sample with DMH for review.

Quality of content is key; this is driven by internal training with staff & supervisors. They should be familiar with Children’s Mental Health Minimum Standards.