

Trauma-Informed Treatment Planning with the CANS: What is it, How to do it and Why it's worth the effort.

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Introductions

- How long have you been using the CANS?
- Does “your CANS” have trauma items?
- What professional roles are represented?
- What percentage of the time do you share CANS scores with families?
- What percentage of the time do the children or families have a role in using the CANS scores to develop service or treatment plans?



Objectives:

Introduce the CANS Trauma, with an emphasis on the trauma domains;

Discuss and practice approaches for gathering the sensitive information needed to score trauma items;

Highlight and practice steps for writing trauma-informed goals with a trauma case.

Part I:

Introducing the CANS-Trauma

History & Development of the CANS:

- CANS-TEA: Trauma domains first developed in 2002 in conjunction with NCTSN
- CANS-Trauma Comprehensive, developed in 2011
- CANS-Trauma updated in March, 2013:
cctasp.northwestern.edu
- CANS-Trauma, an official NCTSN product : www.nctsn.org and <http://learn.nctsn.org/>



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The Center for Child Trauma Assessment
and Service Planning (CCTASP)

Northwestern University Feinberg School of Medicine

CANS TRAUMA MANUAL



Child and Adolescent Needs and Strengths (CANS)-Trauma Comprehensive Version Manual

**A Comprehensive Information Integration Tool for
Children and Adolescents Exposed to Traumatic
Events**

Updated March 2013

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Trauma CANS: 110 Items, 10 Domains

1. Traumatic Experiences
2. Traumatic Stress Related Symptoms
3. Child Strengths
4. Life Domain Functioning
5. Acculturation
6. Child Behavioral and Emotional Needs
7. Child Risk Behaviors
8. Children 5 and Younger
9. Transition to Adulthood (17 and older)
10. Caregiver Needs and Strengths

Trauma Exposure Domain:

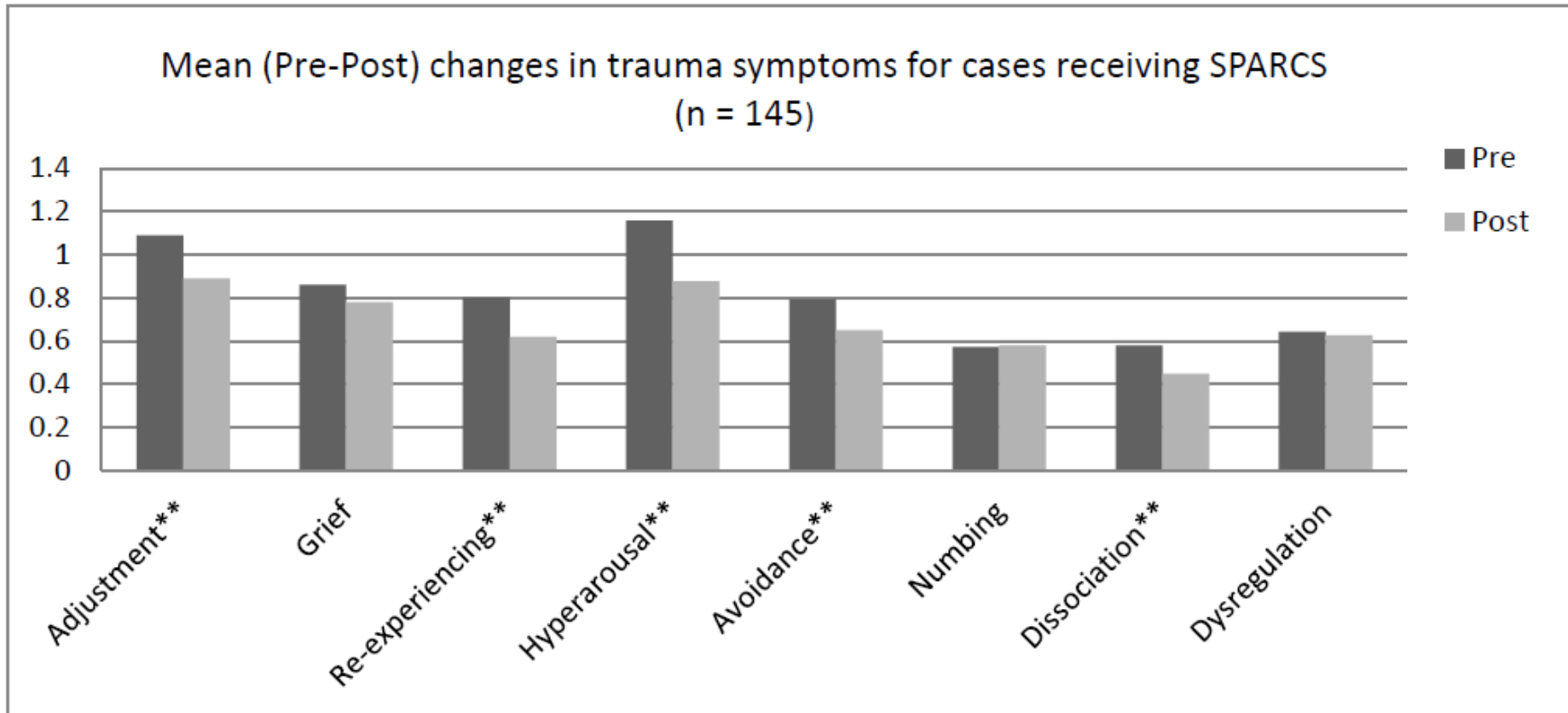
lifetime exposure to potentially traumatic events and other adverse childhood experiences

1. Sexual Abuse
2. Physical Abuse
3. Emotional Abuse
4. Neglect
5. Medical Trauma
6. Family Violence
7. Community Violence
8. School Violence
9. Natural or Manmade Disasters
10. War Affected
11. Terrorism Affected
12. Witness to Criminal Activity
13. Parental Criminal Behavior
14. Disruption in Caregiving

Symptoms Related to Traumatic or Adverse Childhood Experiences

1. Adjustment to Trauma
2. Affective/Physiological Dysregulation
3. Re-experiencing
4. Dissociation
5. Traumatic Grief
6. Hyperarousal
7. Avoidance
8. Numbing

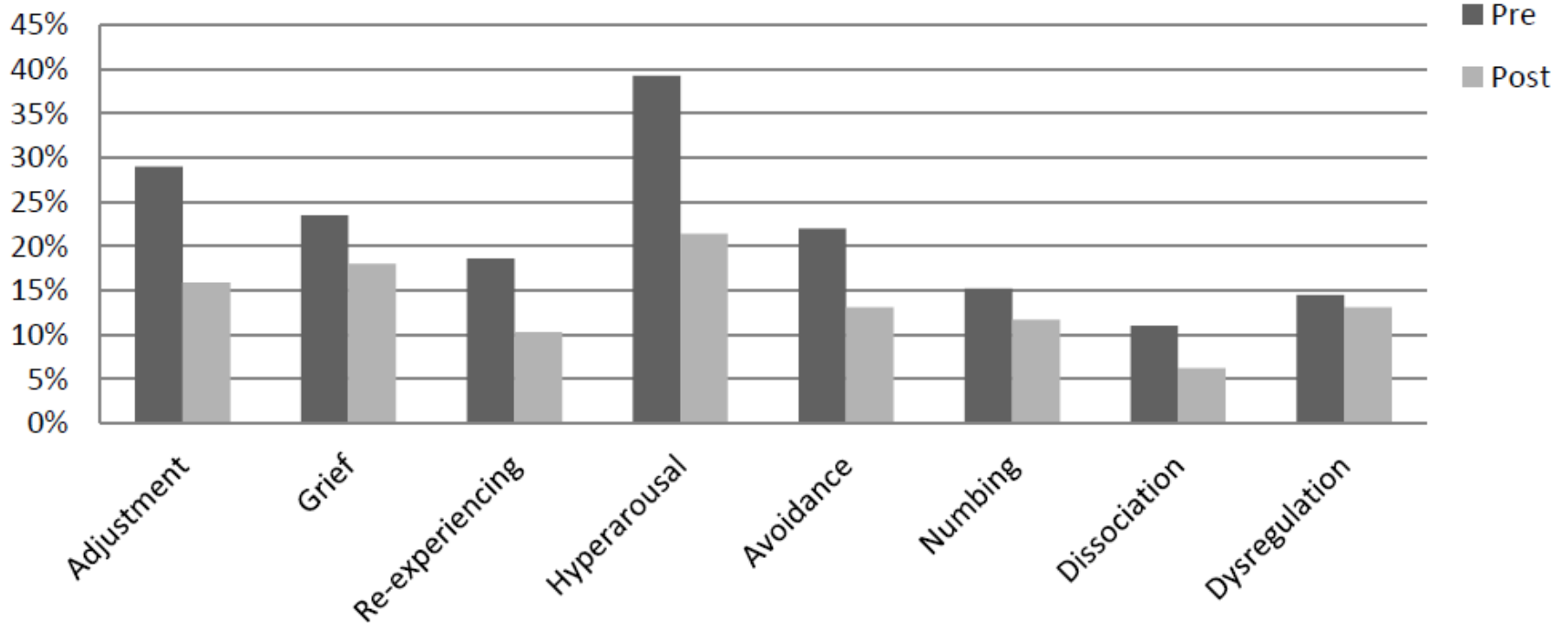
CANS Data



** $p < .01$ and * $p < .05$

CANS Data

Percent Actionable (Pre-Post) changes in trauma symptoms for cases receiving SPARCS (n = 145)



** $p < .01$ and * $p < .05$

Scores: Trauma Exposure Domain

Assesses Lifetime History

0 = No evidence of any trauma of this type

1 = Single incident or suspicion of trauma or ACE.

2 = “Moderate” exposure... multiple incidents or a moderate degree of this trauma or ACE.

3 = “Severe” exposure...repeated and severe incidents of this trauma or ACE.

CANS-Trauma: Adjustment to Trauma Item

ADJUSTMENT TO TRAUMA - *This item covers the youth's reaction to any potentially traumatic or adverse childhood experience. This item should be rated as 1 – 3 for children who are exhibiting any symptoms related to a traumatic or adverse childhood experience, even if this experience was in their past. This item will be a 0 for any youth who has never been exposed to potentially traumatic events/situations.*

NOTE: This item allows you to rate the overall severity of the broad range of trauma-related symptoms the child may be experiencing. The remaining items on the CANS will allow you to also rate each of the specific types of symptoms.

Meet Julia



CANS-Trauma: Sexual Abuse Item

SEXUAL ABUSE – *This rating describes the child’s experience of sexual abuse.*

0	There is no evidence that child has experienced sexual abuse.
1	There is a suspicion that the child has experienced sexual abuse with some degree of evidence <u>or</u> the child has experienced “mild” sexual abuse including but not limited to direct exposure to sexually explicit materials . Evidence for suspicion of sexual abuse could include evidence of sexually reactive behavior as well as exposure to a sexualized environment or Internet predation . Children who have experienced secondary sexual abuse (e.g., witnessing sexual abuse, having a sibling sexually abused) also would be rated here.
2	Child has experienced one or a couple of incidents of sexual abuse that were not chronic or severe. This might include a child who has experienced molestation without penetration on a single occasion .
3	Child has experienced severe or chronic sexual abuse with multiple episodes or lasting over an extended period of time . This abuse may have involved penetration, multiple perpetrators, and/or associated physical injury .

CANS-Trauma: Adjustment to Trauma Item

0	Child has not experienced any significant trauma <u>or</u> has adjusted well to traumatic/adverse child experiences.
1	Child has some mild problems with adjustment due to trauma exposure . These symptoms are expected to ease with the passage of time and therefore no current intervention is warranted. Child 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	Child presents with a moderate level of trauma-related symptoms . Symptoms can vary widely and may include sleeping or eating disturbances, regressive behavior, behavior problems or problems with attachment. Child may have features of one or more diagnoses and may meet full criteria for a specific DSM diagnosis including but not limited to diagnoses of Post-Traumatic Stress Disorder (PTSD) and Adjustment Disorder .
3	Child has severe symptoms as a result of exposure to traumatic or adverse childhood experiences that require intensive or immediate attention. Child likely meets criteria for more than one diagnosis (which may/may not include PTSD), OR may have several symptoms consistent with complex trauma (e.g., problems with affect and behavioral dysregulation, attachment, cognition/learning, etc.)

CANS-Trauma: Dissociation item

DISSOCIATION - *Symptoms included in this dimension are daydreaming, spacing or blanking out, forgetfulness, fragmentation, detachment, and rapid changes in personality often associated with traumatic experiences. This dimension may be used to rate dissociative disorders (e.g., Dissociative Disorder NOS, Dissociative Identity Disorder) but can also exist when other diagnoses are primary (e.g., PTSD, depression). (Please see the CANS glossary for more information on this item and/or other CANS items).*

CANS-Trauma: Dissociation Item

0	This rating is given to a child with no evidence of dissociation.
1	This rating is given to a child with minor dissociative problems , including some emotional numbing, avoidance or detachment, and some difficulty with forgetfulness, daydreaming, spacing or blanking out .
2	This rating is given to a child with a moderate level of dissociation. This can include amnesia for traumatic experiences or inconsistent memory for trauma (e.g., remembers in one context but not another), more persistent or perplexing difficulties with forgetfulness (e.g., loses things easily, forgets basic information), frequent daydreaming or trance-like behavior , depersonalization and/or derealization. This rating would be used for someone who meets criteria for Dissociative Disorder Not Otherwise Specified or another diagnosis that is specified “with dissociative features.”
3	This rating is given to a child with severe dissociative disturbance . This can include significant memory difficulties associated with trauma that also impede day to day functioning . Child is frequently forgetful or confused about things he/she should know about (e.g., no memory for activities or whereabouts of previous day or hours). Child shows rapid changes in personality or evidence of distinct personalities. Child who meets criteria for Dissociative Identity Disorder or a more severe level of Dissociative Disorder NOS would be rated here.

Part II:

Talking about Trauma

Talking about Trauma with Kids and Caregivers: Why?

- Because our job is to “protect children and keep them safe as best as we can.”
- So we can address trauma as the underlying cause when it is.
- You might be the first person to ask.
- What message does it send if you ask about everything except the trauma experiences?

Common Barriers to ‘Talking About’ (Assessing) Trauma



1. Wanting to “wait” until you get to know the child or until you build rapport
2. Trying to get the information without having to “say” the words
3. Fear of getting an inconsistent story from multiple reporters
4. Fear of hurting your relationship by bringing it up later
5. Fear of upsetting / triggering / retraumatizing the client

Talking about Trauma with Kids and Caregivers: who, how and when?

Do I need special training? How should I respond?

- Be “prepared to handle” what they tell you...
- Will it trigger me?
- How much detail is enough?
- What if they are being “resistant”?
- What if they lie, exaggerate or minimize?
- When’s the right time to ask?

Trauma-Informed Practice

The trauma-informed professional:

- Understands the impact of trauma on a child or adult's behavior, development, relationships, and survival strategies
- Can integrate that understanding into planning for the child, adult, and family
- Understands his or her role in responding to child traumatic stress

*NCTSN Child Welfare Trauma
Training Toolkit, 2008*

What does it mean to use a Trauma Lens?

Ask about trauma...
assess,
assess,
assess.

Label
traumatic
situations
when you
see them.

Try to
identify the
“role” of
the trauma
...including
resilience.

Talk openly
and
sensitively
about
trauma.

Trauma
informed
services
matched to
specific
needs

Using a Trauma Lens for Julia's Case

Please work individually or in pairs to complete questions 5 – 9 on the back of the Julia handout.

TIPS on *Client Engagement* with the CANS

You MIGHT want to try....

- Using the CANS as a starting place for conversation.
- SHOWING the CANS and other assessment paperwork to the client.
- Let the client know exactly what will happen with the information they give you.
- Keep your communication honest and simple using common language.
- Acknowledge it is difficult to share personal information with someone you don't know well.

You can let them know that it's also uncomfortable asking about personal things.

- Take your time...if you feel like it is a good use of your time, he/she is more likely to feel the same.

Talking to Kids About Trauma



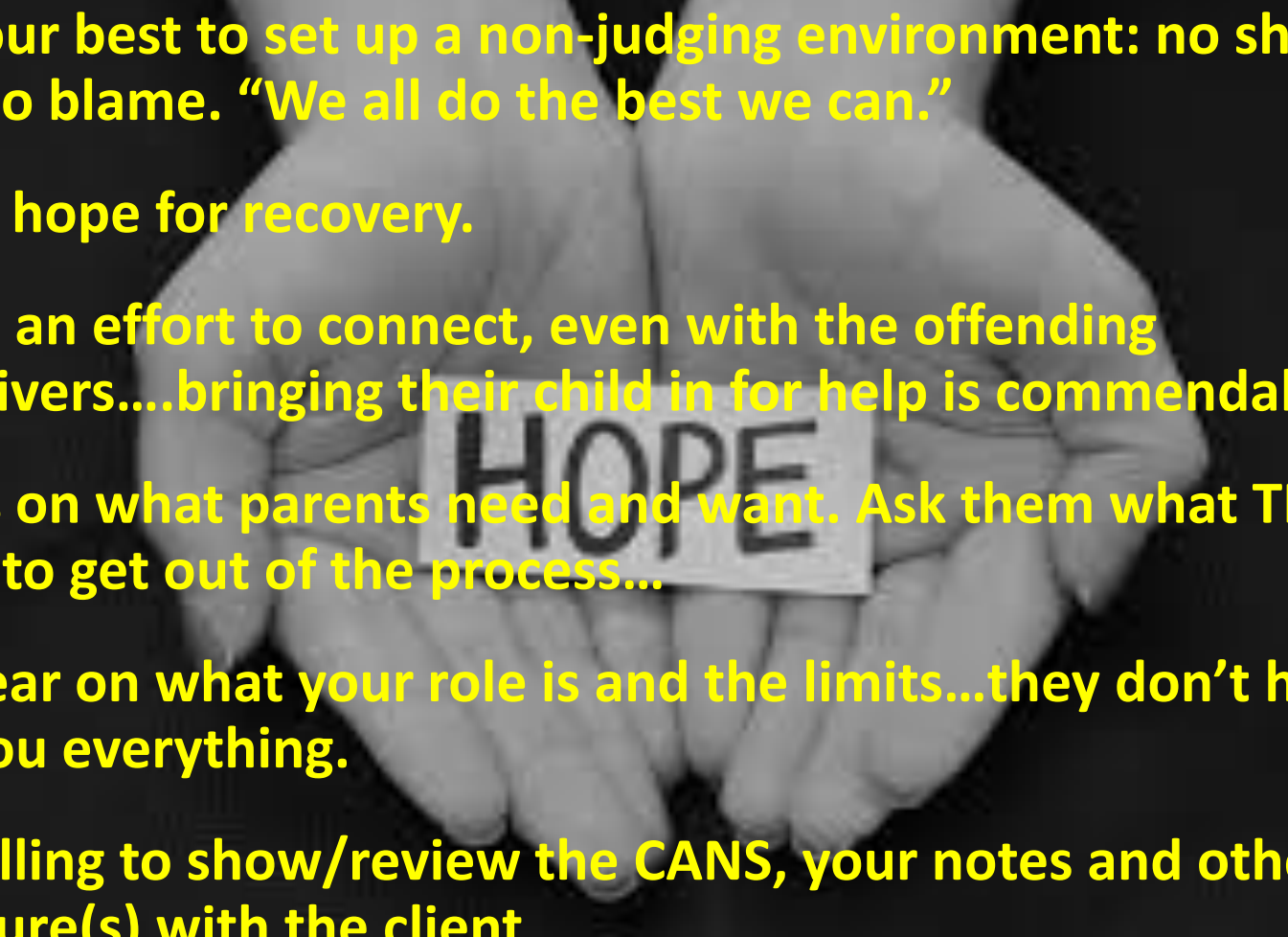
Talking to Kids About Trauma

You might want to let them know that....



- All kids deserve to be safe and protected no matter what.
- Part of your job is to keep kids safe and this means you will ask lots of questions, some of which may be hard to answer.
- You won't need all the details; how about starting by saying yes or no and go from there...
- It's OK to let you know when they don't want to say any more.
- You will write down much of what they tell you so that they don't have to repeat everything again right away (e.g., if they begin therapy).

Talking to Caregivers About Trauma

- 
- **Do your best to set up a non-judging environment: no shame and no blame. “We all do the best we can.”**
 - **Instill hope for recovery.**
 - **Make an effort to connect, even with the offending caregivers....bringing their child in for help is commendable.**
 - **Focus on what parents need and want. Ask them what THEY hope to get out of the process...**
 - **Be clear on what your role is and the limits...they don't have to tell you everything.**
 - **Be willing to show/review the CANS, your notes and other measure(s) with the client.**

Psychoeducation with the CANS

- Talk about WHY you are asking for certain types of information, especially sensitive information. Explain your role.
- NORMALIZE the child and parent's reactions ...

When something scary or traumatic happens, it might change the way we feel, think or act...

- Demonstrate that it is OK to talk about difficult things / memories. Don't skim over difficult terms on the CANS. Describe trauma terms in using every day language and keep it matched to the developmental stage of the youth.
- Have youth and parent trauma-focused resources on hand to share.

*Have you ever experienced....uhhh....well,
have you ever....well, sometimes....um....*

Conversation Starters :

Traumatic Stress Exposure and Symptoms

Gathering Information to Score the Trauma Exposure Items

- 1) How would you gather information about Julia's trauma history or symptoms in order to score the CANS? WHAT would you say? WHO would you ask?
- 2) What barriers might you run into?
- 3) What strategies can you use to overcome these barriers in a way that is respectful and safe for the youth/family and professional?

Work in pairs of 2-3, Document your ideas
Pick the ones you like best to report out

BONUS POINTS: *incorporate education into your conversation starters*

Part III:

Trauma-Informed Treatment Planning: Writing Service or Treatment Goals...

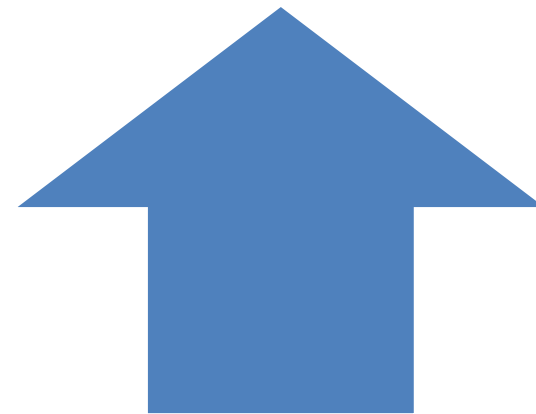
Ideally done collaboratively with the youth and his/her family

TIPS for T-I-P with the CANS



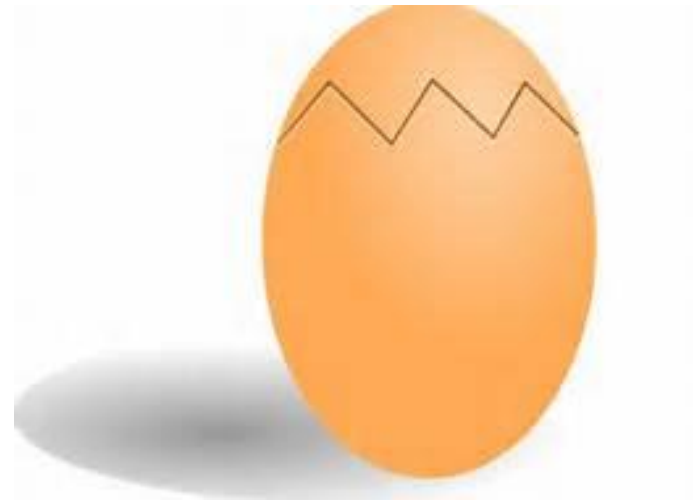
Step #1:
Recognize
**Trauma-Related
Needs**

Assess the relationship
between a child's
trauma experiences
and his/her needs –
both traumatic stress
and “other” needs.



Which Came First?

Sometimes determining if a need is related to the child's trauma is like...



Is this a trauma-related need?

What was the child's functioning like in this area before the trauma?

Does the child have a history of chronic exposure to multiple traumas?

Does the child/family see a connection?

Does child have a family history of MH problems?

Is the need consistent or does it seem to come and go with some pattern (e.g., depending on the situation)?

Is this a trauma-related need?

How common is this type of need in traumatized youth?

What types of support has the child had since the trauma?

What treatments has the child had and are they working?

Has the child ever received trauma focused services?

What needs are changing during the course of trauma-informed treatment?

TIPS for T-I-P with the CANS

Step #2. CONSIDER ALL of the child's needs and strengths: nothing in trauma-informed treatment planning suggests that traumatic stress symptoms 'trump' the other needs in the child's life.

TIPS for T-I-P with the CANS

Step #3: Collaborate and Share Information with other professionals serving the child.
When planning for treatment, all resources in the child's life should be considered.

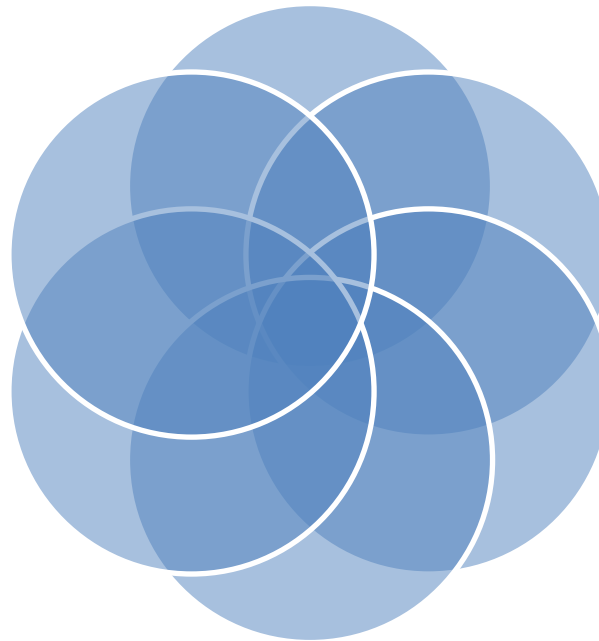
Remember that you can rely on other professionals working with the child (e.g., case worker) to address some of the needs identified in the CANS

TIPS for T-I-P with the CANS

Step #4: Ask yourself how the items scored 2 or 3 may be related:

Which might be related to the youth's current perception of their own safety?

Which are related to difficulty with emotional regulation?



Which of these needs may be coping responses?

Which are surfacing with trauma triggers?

Which have to do with the youth's difficulty in forming or maintaining healthy relationships?

TIPS for T-I-P with the CANS



Step #5: What role do / can strengths play in this plan?

Can existing child or caregiver strengths be used to address the needs?

Can building specific strengths be highlighted in the plan as a method for recovery / building post-trauma resilience?

Activity: Goal Writing

Work individually or in pairs of 2-3
to write 1+
“trauma informed”
treatment or service goal for Juila.

TIPS for T-I-P with the CANS

- ✓ **Only include the number of needs you can realistically address in a service/treatment plan initially**
- These should ALWAYS include items rated 3.
- ✓ Update the CANS and revise the plan on a frequent and regular basis, especially if you are unable to include all of the actionable needs in the plan.

TIPS for T-I-P with the CANS

Step #6:

Keep the Plan Alive

Reassess, Revise

Reassess, Revise

Reassess, Revise

Reassess, Revise

Reassess, Revise

Guidelines for Trauma-Informed Assessment, Treatment Planning and Treatment with the Trauma CANS

Three Parts:

1. CANS in Trauma-Focused Assessment
2. CANS in Trauma-Informed Treatment Planning
3. Trauma-Focused Treatment



Guidelines for Using the CANS in Trauma-Informed Planning

Scoring Challenges, Making Difficult Decisions:

Below are some common struggles and recommendations on making difficult scoring decisions...

1. “My client’s presentation does not match the examples listed in the manual.”
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.”
3. “The symptom(s) reported by my client seem to fit into more than one item on the CANS.”

Utilizing a Trauma-informed Perspective involves...

- Routinely screening for trauma exposure and related symptoms
- Using culturally appropriate, evidence-based assessment and treatment
- Making resources available to children, families, adults and providers on trauma exposure, its impact and treatment
- Engaging in efforts to strengthen the resilience and protective factors of children/families and adults impacted by and vulnerable to trauma
- Addressing parent trauma and its impact on the family system
- Emphasizing continuity of care and collaboration across child or adult service systems
- Maintain an environment of care that addresses and minimizes secondary trauma and increases staff resilience

www.nctsn.org

Utilizing a Trauma Framework in Treatment and Service Planning with Clients and Caregivers

- After conducting comprehensive assessment on needs and strengths, *SHARE* information with family members as appropriate
- Translate information with family members/ youth in a way that makes sense – helping them ‘connect the dots’ across various needs.
- Utilize information to educate, communicate, and advocate for client’s needs across settings– using a complex trauma ‘lens’
- If the child or adult has multiple needs or diagnoses, help family members and other systems make sense of these using a broader trauma framework
- *Regardless of specific intervention approach*, ensure that you are identifying and responding to the range of complex needs and building upon strengths that exist

*For more
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