Use of the CANS in Trauma-Informed Treatment and Service Planning*

The Center for Child Trauma Assessment and Service Planning at Northwestern University focuses on the application of the Child and Adolescent Needs and Strengths (CANS) as a trauma-informed assessment and treatment/service planning tool in relation to delivery of treatment or services.

There are three important areas to consider when using a comprehensive approach to identify and address the needs of traumatized children. These include: 1) Trauma-informed Assessment, 2) Trauma-informed Treatment and Service Planning, and 3) Trauma-focused Treatment or Services. The resource called "Guidelines for Using the CANS in Trauma-Informed Assessment, Treatment, and Service Planning, and Delivery of Services" encompasses each of these areas. This resource in particular focuses on area (2): Trauma-informed Treatment and Service Planning.

Note: throughout this document the CANS tool is referred to in a general manner, with the understanding that versions of the CANS that incorporate one or both trauma modules (i.e., Trauma Experiences, Traumatic Stress Symptoms) such as the CANS-Trauma Comprehensive (or "CANS-Trauma") version, will be most suitable when utilizing this approach. Note that this resource has been updated but is still in progress and we appreciate any feedback and suggestions.

Primary Developers of This Resource

This resource was developed by **The Center for Child Trauma Assessment and Service Planning (CCTASP)** at Northwestern University– with Cassandra Kisiel, Ph.D., Tracy Fehrenbach, Ph.D. and other team members. CCTASP is a partner in the National Child Traumatic Stress Network (NCTSN). For additional resources, please visit http://cctasp.northwestern.edu/

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A PARTNER IN NCTSN The National Child Traumatic Stress Network

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I. General Guidelines for Use of the CANS in Trauma-Informed Treatment and Service Planning

The purpose of this resource is to highlight ways the CANS can be used in trauma-informed treatment and service planning. Please see the recommendations below. As you review, please also consider how you use and integrate CANS scores in the setting where you work. The concept of **trauma-informed treatment and service planning** can take on a variety of meanings:

- It involves the consideration of the child's trauma history and trauma-related mental health symptoms in conjunction with the child's other needs and strengths in planning for intervention and services.
- It is meant to be a flexible process based on the particular needs and strengths of a child and caregiving system.
- It recognizes that children may change with regard to their needs, strengths, readiness and ability to engage in different aspects of trauma-focused treatment or services over time.
- Trauma-informed treatment and service planning, like all ethical and effective planning, should always reflect the best clinical judgment of the clinician or caseworker and his/her supervisor.

Trauma-informed treatment and service planning, as informed by the CANS-Trauma, is meant to ensure the following:

- The assessor/clinician/caseworker does not overlook a child's history of exposure to traumatic events; and
- The assessor/clinician/caseworker considers and rates the impact that trauma experiences may have across areas of a child's functioning or adjustment. This is achieved by comprehensively assessing all of the following areas, as captured by domains on the CANS:
  - ✓ Trauma Experiences
  - ✓ Traumatic Stress Symptoms
  - ✓ Child Behavioral and Emotional Needs
  - ✓ Child Risk Behaviors
  - ✓ Life Domain Functioning

- It also prompts the assessor/clinician/caseworker to consider and rate Strengths or protective factors in the child, his/her caregiver, family context and environment, all of which can provide a buffer to the on-going impact of trauma and integrated into interventions.

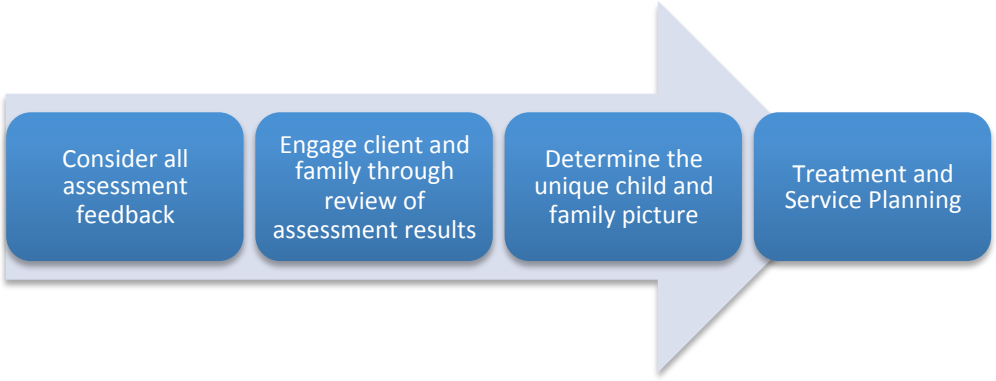
The CANS tool and scores can be used:

- To facilitate communication between different professionals working with the child;
- To both "educate" and collaborate with youth, family members, and other providers in determining why we want to focus on certain areas in treatment or services and engage them in the process of treatment or service delivery;

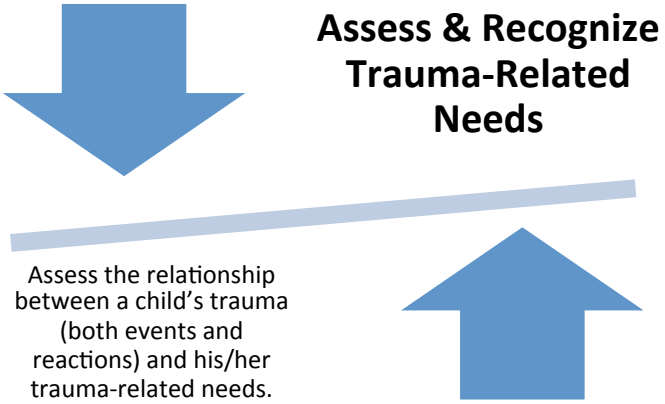
- To decide the best type of treatment, services, or placement for a child based on child/caregiver's needs;
- To monitor a child's progress in treatment or services over time.

Recommended Steps for Trauma-Informed Treatment and Service Planning using the CANS

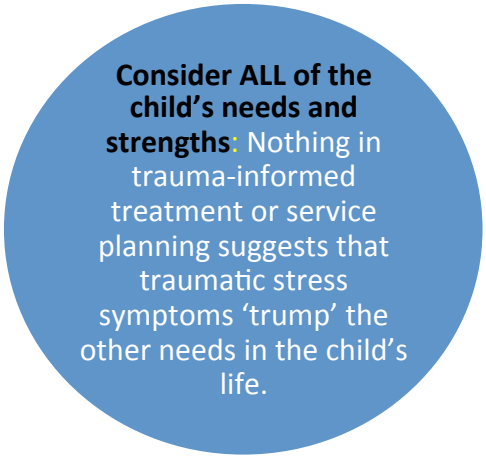
Overview of Trauma-Informed Treatment and Service Planning



- STEP 1: Assess for both traumatic events and reactions, and recognize trauma-related needs.

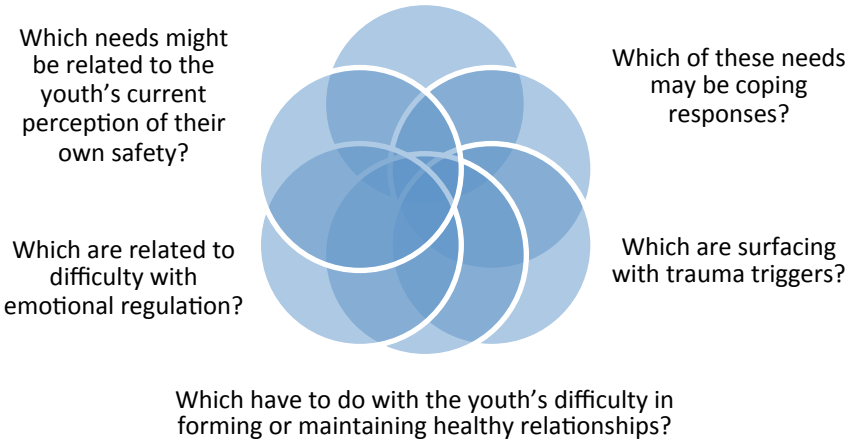


- STEP 2: Consider all of a child's needs and strengths when creating trauma-informed plans.



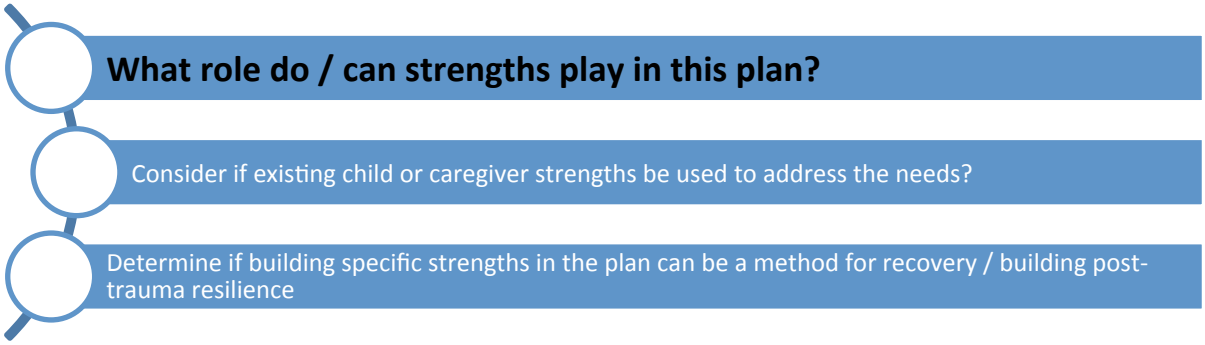
- STEP 3: Connect the dots between elevated needs and trauma experiences on the CANS using a trauma lens; share these connections with youth/families in a way that makes sense*.

Ask yourself how the "dots can be connected" between CANS needs items scored 2 or 3 and trauma experiences:



*Note this process is also described further below

- STEP 4: Integrate Strengths in trauma-informed treatment and service planning.

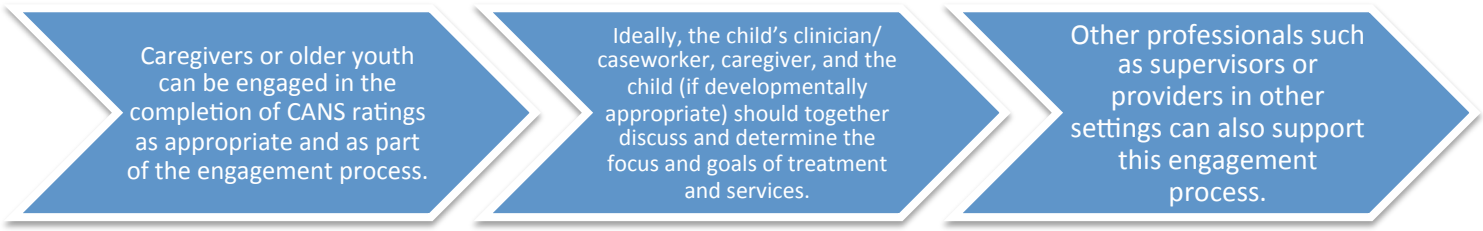


- STEP 5: Educate and collaborate with families and other providers about the potential role of trauma in relation to the child's identified needs/presenting problems.

Psychoeducation regarding the impact of trauma, traumatic stress, and trauma-related symptoms is often critical for helping families and other providers to understand the "full story" of the child and his/her adaptation to trauma and establishing goals that address these needs.

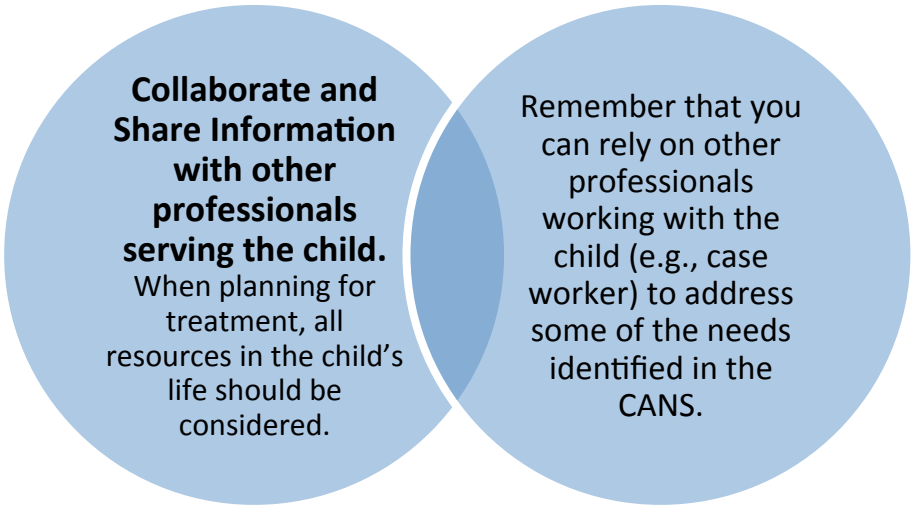
- STEP 6: Throughout the assessment process, engage youth and family members! Include the child and family in the treatment/service planning process at various stages and in meaningful ways. Once the CANS has been completed, the clinician/caseworker and child's family should work collaboratively to determine an appropriate course for treatment and service planning.

Integrate Youth and Family Engagement throughout the Process!



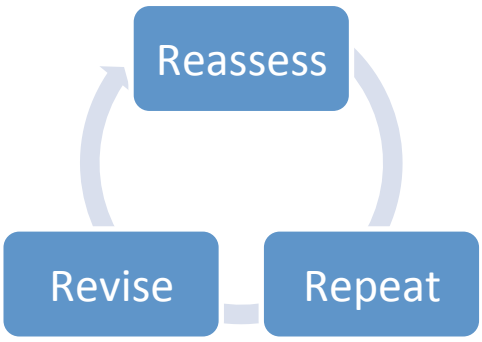
- STEP 7: Collaborate with other professionals serving the child.

When planning for treatment and services, all resources in the child's life should be considered. For instance, the clinician should consider what roles the other professionals in the child's life (e.g., caseworker, teachers, school counselors, coaches) can have in helping the child address some of the needs identified on the CANS, or increasing some of the child's strengths in need of development.



- STEP 8: Make recommendations for treatment or services that will in one way or another address trauma.

- STEP 9: Keep the plan alive!
  Reassess as often as necessary.



II. Use of the CANS Scores in Developing Trauma-Informed Treatment and Service Planning Goals

Key Questions for Linking & Clustering CANS Items in Trauma-Informed Planning:

Many traumatized children, especially those with chronic histories of trauma, will present with various types of needs. Given there will likely be too many elevated scores (i.e., scores of 2 or 3) to address separately, we encourage you to consider these key questions when developing trauma-informed plans using the CANS in order to group these needs together. These may also represent ways that CANS items may be related in useful and meaningful ways:

- ✓ Does the child have a history of exposure to chronic or multiple traumas?
- ✓ Which needs represent the youth's coping responses/efforts to cope with trauma?
- ✓ Which symptoms or difficulties were evident prior to trauma exposure? Did they worsen or change after the exposure?
- ✓ Which of these needs surface or worsen when the child is faced with trauma triggers?
- ✓ Which of these needs are related to the youth's difficulty with emotional regulation (e.g., difficulty in controlling or modulating emotions or identifying emotional states)?
- ✓ Which of these needs are related to the youth's difficulty in forming/maintaining relationships?
- ✓ Which of these needs might be related to youth's current perception of his/her own safety?

- ❖ By grouping the needs together in these ways, you are able to formulate plans that address several needs at once.
- ❖ By grouping needs together, you can also help youth, caregivers and other adults in the child's life see the connection between trauma experiences and emotional and behavioral issues.
- ❖ Consider also relying on other professionals working with the child (e.g., caseworker or clinician) to address some of the needs identified in the CANS based on the services offered in different settings.
- ❖ Consider only including the number of needs that can actually be addressed in the treatment or service plan (as appropriate); or consider sequencing these goals based on priority of needs (see below).

Key Questions & Explanations to Guide Development of Trauma-Focused Plans:

Below are key questions and explanations that may facilitate rating a child appropriately the on CANS, grouping CANS items together, developing trauma-informed plans, and prioritizing interventions.

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

If the child has a history of chronic exposure to multiple traumas (i.e., rated as a 2 or 3 on two or more CANS Trauma Experiences items), especially if the traumas were interpersonal in nature, s/he may display a wide range of CANS needs or complex trauma responses which fall outside of traditional PTSD or Traumatic Stress Symptoms on the CANS. Symptoms which are trauma-related but broader than PTSD symptoms can and should be addressed using trauma-focused interventions.

✓ Do the child's needs represent his/her efforts to cope?

This question is essential to working with traumatized children. Symptoms such as dissociation, avoidance, substance use, and other CANS Risk Behaviors are often adaptive coping responses in the face of a trauma, but maladaptive if the child uses them in everyday, non-traumatic situations. It is important for the provider to understand the "role" that such symptoms can play in the youth's attempts to cope with other stressors and trauma reminders. Before a child is able to stop engaging in unhealthy coping techniques, they must learn to use alternative coping strategies, they may also need to focus on building affect tolerance and regulation skills as part of this work in treatment.

✓ Were this child's symptoms evident prior to his/her trauma exposure?

If the child's symptoms were evident prior to his/her trauma exposure, assess to see if child's symptoms worsened or changed following the trauma. If symptoms changed or worsened following the trauma, then the intervention approach should be trauma-sensitive if not trauma-focused. At the very least, the child and family should be given psychoeducation about how trauma can impact a range of emotions and behaviors and/or exacerbate already present mental health symptoms.

✓ Does this child have a family history of mental health problems?

If yes, consider the possibility that this child's symptoms may be due to a genetic predisposition and/or other life events rather than related to traumatic events alone and may require intervention specific to those symptoms or diagnoses that may be in addition to trauma-focused intervention.

✓ Are there particular needs that surface or worsen when the child is faced with different situations or potential triggers/reminders of the trauma?

Consider whether the child's symptoms are expressed differently or exacerbated in different situations (e.g., home vs. school) or with different people. If so, this child may be expressing symptoms in reaction to specific trauma triggers which can include particular situations (e.g., specific times, places, events, or people) or sensations (smells, tastes, touches or sounds) related to the trauma experience(s). If symptoms appear related to trauma triggers, trauma treatment or services should assist the child in identifying their triggers and coping with them appropriately.

✓ Are there specific needs that are related to the youth's difficulty with emotional regulation?

Difficulties with emotional regulation are common for traumatized children and can manifest in several ways. Consider all the areas that reflect the youth's difficulty with controlling or

modulating their emotional responses (e.g., emotional outbursts, problems with anger control, constricted emotions), or identifying or expressing certain emotions. These reactions may occur in relation to specific trauma triggers or more broadly.

- ✓ Are there specific needs related to the youth's difficulty in forming/maintaining relationships?

Consider the range of needs that may reflect a youth's difficulty relating to others. This may manifest as problems with attachment relationships; interpersonal difficulties or problems forming or maintaining relationships with other caregivers, adults, or peers; difficulty in the context of family relationships; and problems with boundaries, trust, or social isolation.

- ✓ How does the child/family view the symptoms?

Sometimes families fail to recognize trauma-related symptoms due to a lack of education about traumatic stress, a desire to minimize the impact of the trauma, or a heightened concern related to symptoms or risk behaviors that require a good deal of attention from caregivers or service providers. In this case, the child/family would likely benefit from psycho-education on common reactions to trauma in a non-blaming, normalizing fashion as part of trauma-focused treatment or services.

Strategies for Integrating Needs and Strengths into the Trauma-Informed Treatment/Service Plan:

1. Priority in treatment/service planning must be given to "actionable" items on the CANS.

- ❖ The rating of a 3 indicates that the child is in immediate and intense need of intervention in a particular area(s). These items rated as 3 should always be incorporated into the plan and may help to determine the level or intensity of care the child requires. For instance, a child who is rated as a 3 on several risk behaviors or suicidality/self-harm may need to be supervised at all times, requiring a plan to be made to do this successfully in the home or transfer the youth to a higher level of care (i.e., residential) where such supervision can be guaranteed.
- ❖ The items rated as 2 on the CANS also deserve attention in treatment planning, though the need for intervention will not be as immediate as those rated as 3.

2. Risk behaviors scored at a 2 or 3 on the CANS should be given priority in trauma-informed planning as many times these behaviors (e.g., substance use, running away, self-mutilation) are used for coping with traumatic stress or represent other areas that may be dysregulated (e.g., emotions) due to past trauma exposures. Building healthy coping mechanisms and finding more effective ways to regulate emotions is often a key initial part of trauma-informed treatment or services.

3. Traumatic stress symptoms, especially those with ratings of 2 or 3, need to be included and addressed in a developmentally sensitive way in trauma-informed treatment and service plans.

4. Other trauma-related emotional/behavioral needs, especially those with ratings of 2 or 3, should be included in trauma-focused treatment and service plans. These include areas of need that have been linked to difficulties with adjustment following trauma, possibly as a means of coping with trauma experiences, triggers, or ongoing stressors related to the trauma.

5. Other non-trauma-related needs should also be included in planning. For instance, items rated as 2 or 3 sometimes reflect issues that can be addressed in other services. For instance, if a child has a 2 on school attendance because they have no transportation to school, a child's caseworker may work with the family and local community resources to ensure that child has a safe way to get to school. Other items may require attention in therapy such as suicidal ideation, which needs to be addressed by a trained mental health professional.

6. Child strengths, including interests and talents, should be considered in treatment or service planning. This is especially the case as traumatized children sometimes develop distorted and negative views of self, others, and the world around them. Core strengths or protective factors are critical in buffering youth against the harmful effects of trauma and helping them recover from trauma. Building and using a child's strengths can increase a sense of hope and the ability to recognize the positive aspects of life.

- Strengths with any score (a rating of 0, 1, 2, or 3) on the CANS can be incorporated into planning. Centerpiece strengths (score of 0) can be highlighted in treatment or services as areas where the child is presently doing well and may be used as a vehicle in meeting other goals. These centerpiece strengths (if applicable) may also be used as a means of helping a child address his/her trauma when appropriate (e.g., use of a particular talent/creative interest as a format for developing trauma narrative).

- Strengths rated as 1 or 2 may need some attention in therapy in order to help them develop further. Maximizing development of particular strengths can even be written as a treatment goal.

- Strengths rated as 3 may deserve immediate attention in or outside of therapy. They should be included in therapy treatment planning if their absence is debilitating (i.e., optimism) or if development thereof would benefit the particular child or family (i.e., spirituality).

Incorporating Caregiver Needs and Strengths into the Treatment/Service Plan:

Caregivers' strengths, as reflected on the CANS, should also be considered and built upon in treatment/services as appropriate to assist with the process of recovery from a child's trauma.

- Caregivers should be acknowledged for any strengths rated as 0.
- Strengths rated as 1 or 2 may be developed enough and continue to grow if used appropriately to support the child in treatment or services.

- Strengths rated as a 3 may help the clinician determine if the caregiver has or lacks the skills or supports necessary to participate in the child's treatment or services, or if they need individual attention or support to first develop these skills themselves.

Caregivers' needs, as rated on the CANS, should be considered in treatment or service planning. This will help the clinician/caseworker determine how to best fit the caregiver into the child's treatment or services, and whether the caregiver would benefit from their own treatment or additional supports.

Using CANS Scores to Monitor Treatment/Service Plans Over Time:

CANS scores provide the assessor/clinician with more than just a snap-shot of the child's needs at the time they present for treatment or services. The CANS should be used to **monitor and track progress over time,** and can provide data to support the need to **adjust treatment or service plans**.

Specifically, the CANS data helps the clinician/caseworker do the following:

- Watch the child/caregiver's initial needs and note changes in needs over time, including the development of new needs
- Watch and better conceptualize/understand worsening of symptoms as they change together
- Watch to see if some symptoms peak prior to decreasing once in treatment or services (not uncommon in trauma-focused treatment)
- Identify changes in a child's strengths over time
- Identify areas the clinician didn't expect or intend to change
- Understand the child's needs at the termination of treatment/services, to identify needs to be addressed in step-down services or monitored by caregivers over time.

All of the above can be done by looking at changes in individual items or averaging the changes in specific domains or item groupings over time.

Finally, CANS scores can be considered on an agency or systems level (e.g., across multiple children) to determine specific program level needs, if a program is meeting their goals, or if there are any gaps in services (e.g., are trauma-focused treatment or services in place to address the range of trauma-related symptoms? Are there any gaps in services to address the commonly occurring needs?).

This approach outlines a method for grouping CANS items in relation to a complex trauma framework and planning for trauma-informed treatment/services in accordance with this framework. While this represents one approach to utilizing the CANS in a trauma-informed manner, please note that this framework can be expanded or adapted in ways that make sense in your particular setting.

We welcome any feedback or questions you may have in relation to the use of this resource.