Treating Complex Trauma in Child Welfare

Paul Brylske,
The Family Center
at Kennedy Krieger Institute

4th BIENNIAL TRAUMA CONFERENCE
Addressing Trauma across the Lifespan: Integration of Family, Community, and Organizational Approaches
October 3rd & 4th, 2013

Trauma Training Academy
The Family Center
at Kennedy Krieger Institute

Objectives

- Understand the use of treatment foster care in the treatment of complex trauma
- Understand the implementation process of a treatment framework (ARC)
- Understand the implementation of a outcome measurement tool (CANS)
- Understand the use of the CANS as a assessment and treatment planning tool which supports the treatment of complex trauma

Prevalence of Trauma—United States

- Each year in the United States, more than 1,400 children—nearly 2 children per 100,000—die of abuse or neglect.
- In 2005, 899,000 children were victims of child maltreatment. Of these:
  - 62.8% experienced neglect
  - 16.6% were physically abused
  - 9.3% were sexually abused
  - 7.1% endured emotional or psychological abuse
  - 14.3% experienced other forms of maltreatment (e.g., abandonment, threats of harm, congenital drug addiction)

Source: USDHHS. (2007) *Child Maltreatment 2005;* Washington, DC: US Gov't Printing Office.

U.S. Prevalence, cont'd

- One in four children/adolescents experience at least one potentially traumatic event before the age of 16.[1]
- In a 1995 study, 41% of middle school students in urban school systems reported witnessing a stabbing or shooting in the previous year.[2]
- Four out of 10 U.S. children report witnessing violence; 8% report a lifetime prevalence of sexual assault, and 17% report having been physically assaulted.[3]

1. Costello et al. (2002). *J Trauma Stress*;5(2):99-112.
2. Schwab-Stone et al. (1995). *J Am Acad Child Adolescent Psychiatry;34*(10):1343-1352.
3. Kilpatrick et al. (2003). US Dept. Of Justice http://www.ncjrs.gov/pdffiles1/nij/194972.pdf

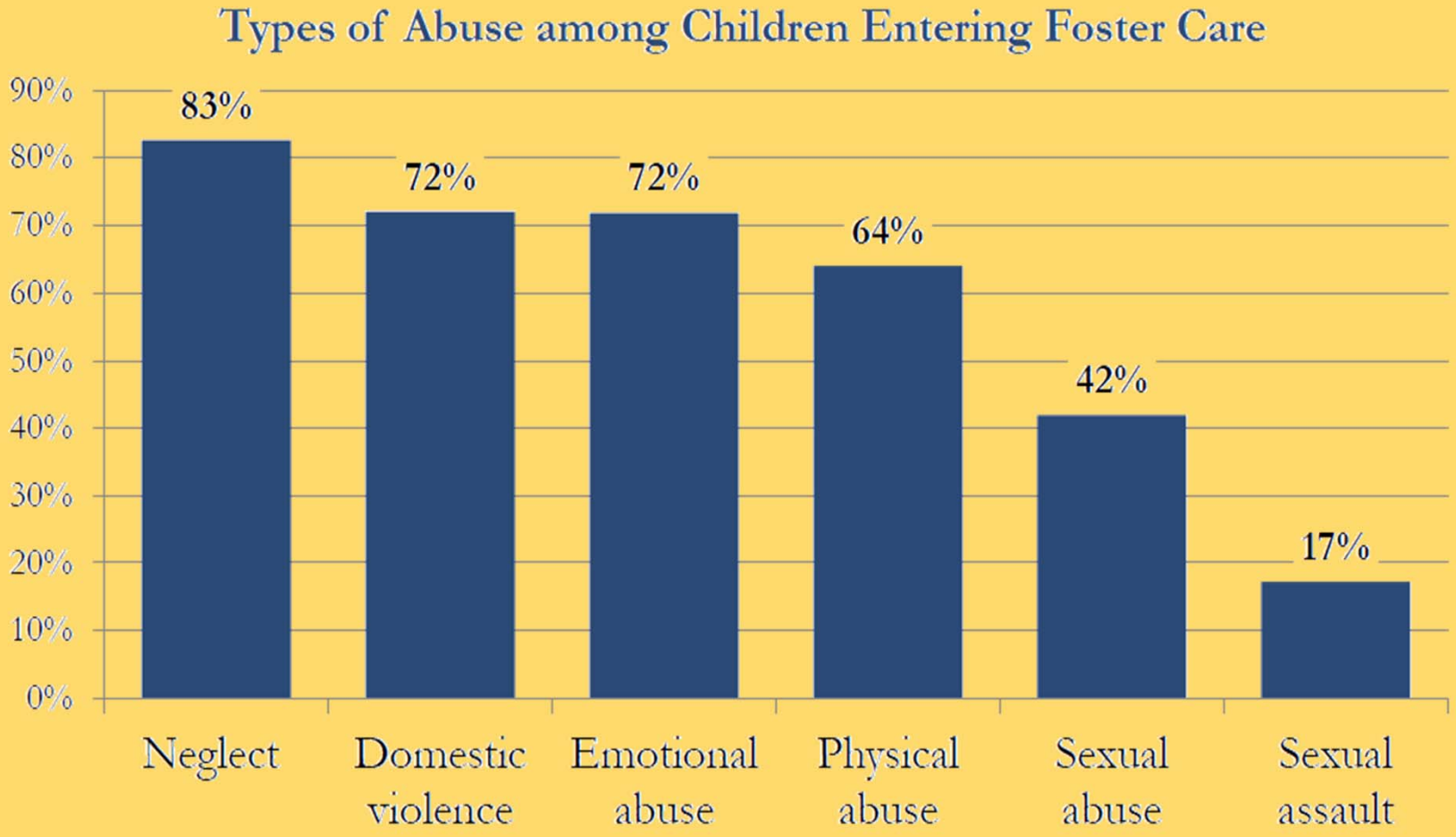
Prevalence of Trauma in the Child Welfare Population

- A national study of adult "foster care alumni" found higher rates of PTSD (21%) compared with the general population (4.5%). This was higher than rates of PTSD in American war veterans.[1]
- Nearly 80% of abused children face at least one mental health challenge by age 21.[2]

1. Pecora, et al. (December 10, 2003). *Early Results from the Casey National Alumni Study*. Available at http://www.casey.org/NR/rdonlyres/CEFBB1B6-7ED1-440D-925A-E5BAF602294D/302/casey_alumni_studies_report.pdf

2. ASTHO. (April 2005). *Child Maltreatment, Abuse, and Neglect*. Available at: http://www.astho.org/pubs/Childmaltreatmentfactsheet4-05.pdf

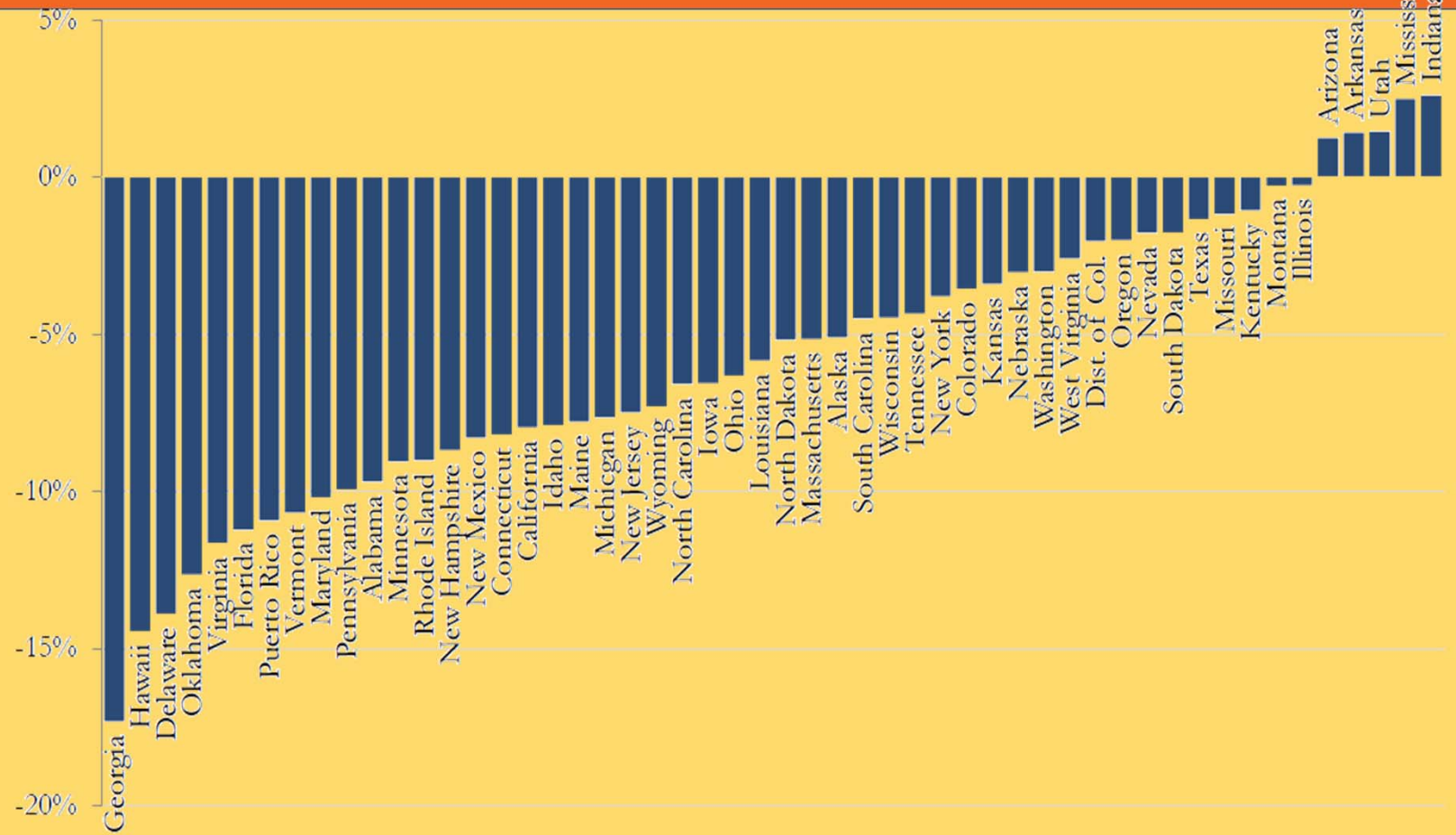
Neglect is the Most Common Trauma Type among Children Entering Foster Care



Greeson, JKP; et al. (2011). Complex trauma and mental health in children and adolescents placed in foster care: findings from the National Child Traumatic Stress Network. *Child Welfare*. 90(6):91.

Foster Care Population Decline by State

Percent Change in Foster Care Population, 2007-2010



Data Source: Adoption and Foster Care Reporting and Analysis System (2002-2010). Children's Bureau, Administration on Children, Youth, and Families (USDHHS, ACF)

ACYF Informational Memorandum ACYF-CB-IM-12-04 (Issued 4/17/2012)

"…there is a growing body of evidence indicating that while ensuring safety and achieving permanency are necessary to well being, they are not sufficient….There is also an emerging body of evidence for interventions that address the behavioral, social and emotional impacts of maltreatment."

ACYF: Trauma Screening, Functional Assessment & Progress Monitoring

- "Functional assessment—assessment of multiple aspects of a child's social-emotional functioning (Bracken, Keith, & Walker, 1998)—involves sets of measures that account for the **major domains of wellbeing**."
- "Child welfare systems often use assessment as a point-in-time diagnostic activity to determine if a child has a particular set of symptoms or requires a specific intervention. **Functional assessment, however, can be used to measure improvement** in skill and competencies that contribute to wellbeing and allows for **on-going monitoring of children's progress towards functional outcomes**."
- "Rather than using a "one size fits all" assessment for children and youth in foster care, systems serving children receiving child welfare services should have an **array of assessment tools** available. This allows systems to appropriately evaluate functioning across the domains of social-emotional wellbeing for children across age groups (O'Brien, 2011) and accounting for the trauma- and mental health-related challenges faced by children and youth who have experienced abuse or neglect."

Valid and **reliable** mental and behavioral health and developmental **screening and assessment tools** should be used to understand the impact of maltreatment on vulnerable children and youth.

TRAUMA SCREENING

- Child and Adolescent Needs and Strengths (CANS) Trauma Version
- Childhood Trauma Questionnaire (CTQ)
- Pediatric Emotional Distress Scale (PEDS)

FUNCTIONAL ASSESSMENT

- Strengths and Difficulties Questionnaire (SDQ)
- Child Behavior Checklist (CBCL), the Social Skills Rating Scale (SSRS)
- Emotional Quotient Inventory Youth Version (EQ-i:YV)

Kennedy Krieger Family Center Treatment Foster Care Mission

Dedicated to providing a quality, culturally sensitive, comprehensive treatment program for children/youth in foster care and their families who have experienced complex trauma, have developmental disabilities and, medically fragile conditions and are at risk of being placed in a more restrictive living environment.

Treatment Foster Care

… is a family-based service delivery approach providing individualized treatment for children youth and their families. Treatment is delivered through an integrated constellation of services with key interventions and supports provided by treatment parents, who are trained, supervised and supported by qualified program staff.

FFTA Standards

TFC is an Evidence-Based Treatment

- The Surgeon General's Report on Children's Mental Health (2002)
- Burns, B.J. and Hoagwood, K.: Evidence-Based Interventions For Severe Emotional and Behavioral Disorders (2002)
- Chamberlain, P. et al. (OSLC, MTFC; 1991, 1994, 1999, 2002)

Real World TFC: "Probably Efficacious"

"Positive effects have been shown in random trials. Findings from researchers beyond the core group have found inconsistent effects... Current efforts in dissemination and additional research may provide evidence required to move TFC in the 'well established' category in the relative near future."

Farmer et al. (2004)

Recommendation for "Real World" TFC

"…. the majority of administrators report their TFC program is primarily aimed at serving youth with serious emotional and behavioral challenges and who have experienced past abuse, neglect, and trauma. For these youth, "hybrid" models of TFC that blend characteristics of the OSLC evidence-based model with components aimed at serving the needs of youth in the "real world" should be considered."

Md. Science to Service (Bruns et al)

TIM Model

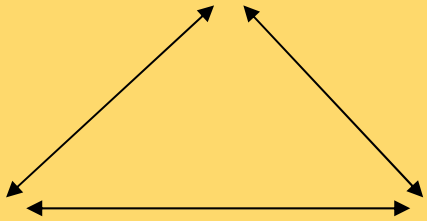
TFC Program Elements	**Evidence-based TFC** (Chamberlain)	**"Real World" TFC** (Farmer) (Bruns)	Trauma Integrative Model (TIM)
Service Coordination/Case Management	Yes	Yes	Yes
Treatment Parents as key providers/change agents	Yes	Yes	Yes
Team approach to treatment	Yes	Yes	Yes
Respite	Yes	Yes	Yes
Work with youth's family	Yes	Yes	Yes
Reduce association with deviant peers	Yes	Yes	Yes
Intensive supervision/support	Yes	No	Yes
Proactive approach to behavior problems	Yes	No	Yes
Addressing previous trauma (ARC)	N/A	N/A	**Yes**
Comprehensive Coordination of Somatic Care	N/A	N/A	**Yes**
Addressing Developmental Disabilities	N/A	No	**Yes**
Preparing for transition to adulthood (TIP)	Not systematic	No	**Yes**
Permanency	N/A	N/A	**Yes**
Family and Youth Voice	N/A	N/A	**Yes**

Trauma Integrative Model

- Systems of Care Principles & Safety – Permanency – Well-being
- Components of evidence based TFC
- Roles of clinical social worker and treatment parent (“Focus of Change”)
- Treatment of
  - Complex trauma/neglect
  - Development disabilities
  - Medically fragile conditions
  - Co-existing disorders (substance abuse & specialties)
- Needs of transition age youth
- Permanency and permanency planning
- Multi-generational complex trauma
- Community Services
  - Out patient psychotherapy, Psychiatry, Medical, Educational, Vocational, Recreational, OT, PT, Nursing, Others as needed
- Youth, family, and stakeholders voice

Focus of Change

Family



Treatment Parent

- Change Agent
- Nurturer/Primary Caregiver
- Observer/Recorder
- Team Member

Child

Clinical Social Worker

- Clinician
- Case Manager
- Team Leader
- Supervisors
- Trainer

PROGRAM DESIGN

Core Principles

- Maximize Family Involvement
- Culturally Competent
- Team-based
- Maximize Natural Support
- Permanency
- Safety
- Community-based
- Individualized
- Strengths-based/Future-focused
- Whatever it Takes
- Outcome-focused

Top Clinical Diagnoses

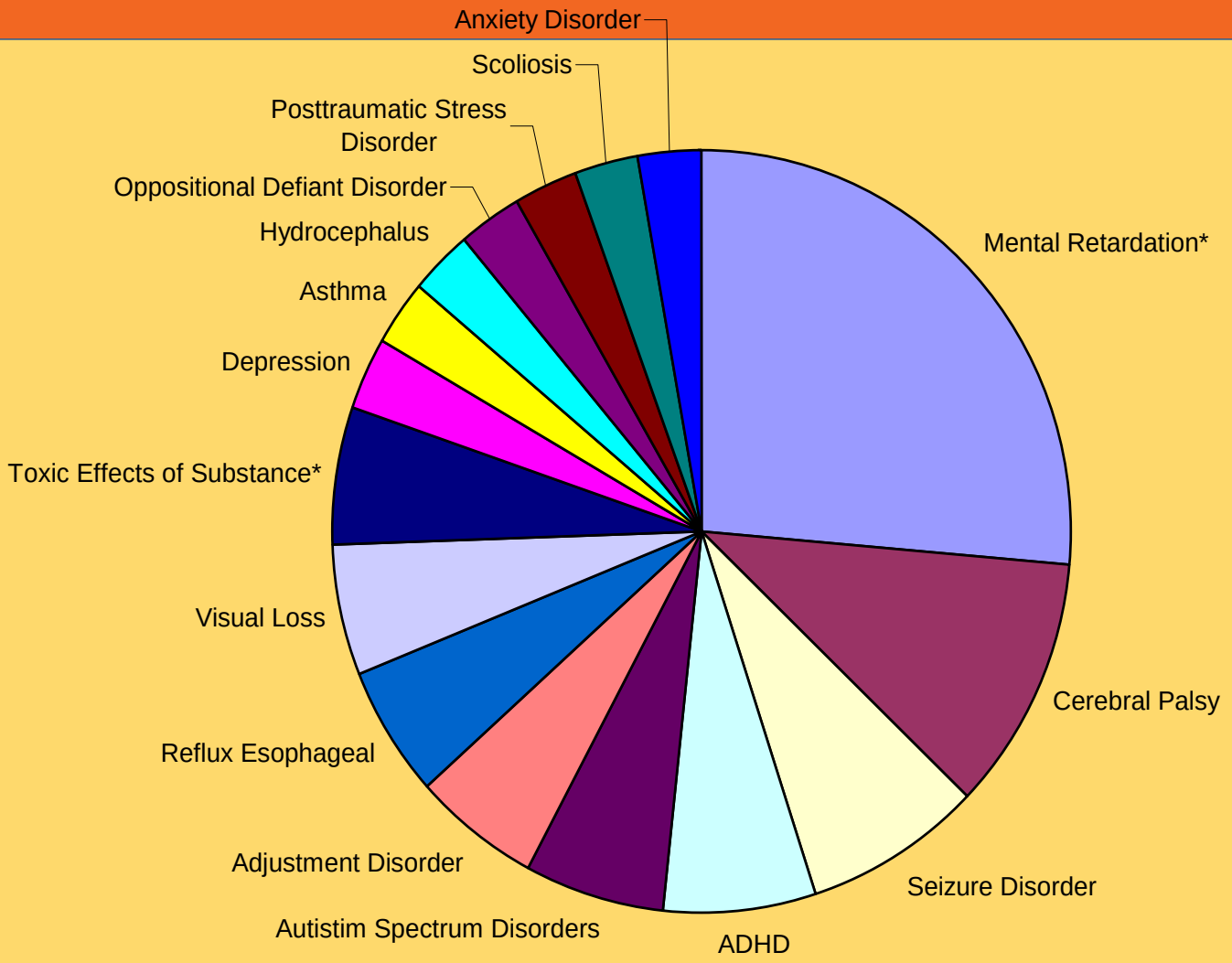
Entry Diagnoses (n=138)	
Axis I	**%**
ADHD	62.22%
Oppositional Defiant Disorder	40.00%
Post Traumatic Stress Disorder	37.78%
Depression/Depressive Disorder	28.89%
Communication Disorders	25.56%

Axis II	**%**
No Diagnosis	62.22%
Diagnosis Deferred	13.33%
Borderline Intellect. Functioning	13.33%
Profound Mental Retardation	2.44%

Axis IV	**%**
Problems with Primary Support	82.89%
Other psycho & Enviro Probs.	40.79%
Education Problems	17.11%

Axis V	
Mean	54.52
StDev	10.95

Medical Team Diagnoses



Adverse Childhood Exposures (ACE) and Medical Issues

Adverse Childhood Exposure	All Clients
Separated from Parent	100.00%
Neglected	76.56%
Physically Abused	65.63%
Sexually Abused	52.34%
Abandoned	39.84%
Emotionally Abused	20.31%
Parental Drug Abuse*	82.03%
Parental Alcohol Abuse*	46.09%
Parental Incarceration*	41.41%
Parental Domestic Violence*	23.44%
Parental Mental Health Problems*	18.75%
Community Violence	27.34%

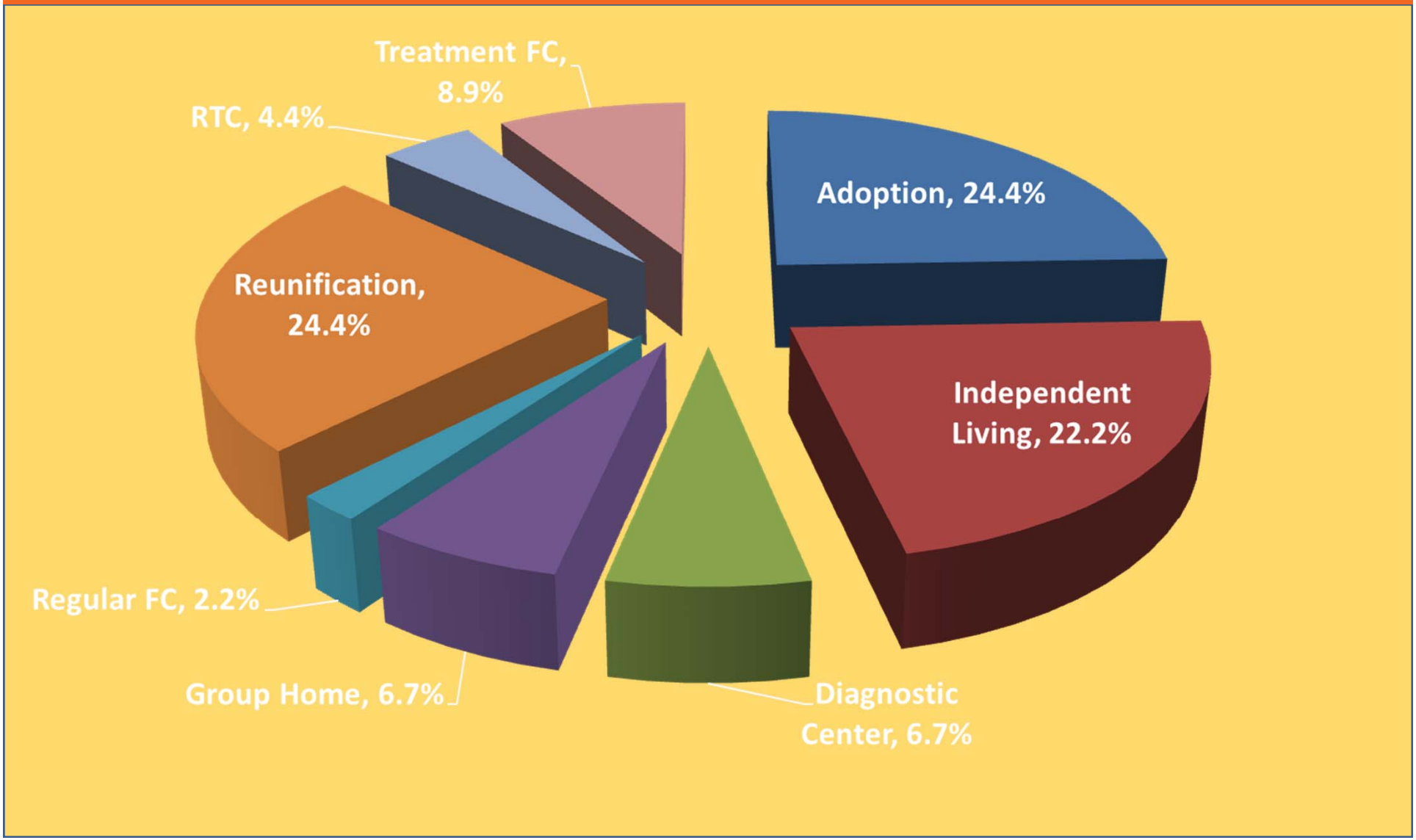
Medical Issue	All Clients
In-Utero Drug Exposure	26.02%
Asthma	17.07%
Visual Problems	17.07%
Lead Exposure	11.38%

(n=138)	All Clients	
	Mean	StDev
Number of ACE per Client	5.2	2.5
Medical Issues per Client	1.99	1.53

Restrictiveness of Placement (n=138)

		Prior Placement	Discharge Placement
Restrictiveness	**Environment**	%	%
More Restrictive	Inpatient Psych Hospital	11.20%	12.98%
	Residential Tx Center	16.00%	3.90%
	Group home/ Shelter	32.00%	18.18%
Total More Restrictive		**59.20%**	**35.06%**
Equally Restrictive	TFC	2.40%	2.60%
Total Equally Res.		**2.40%**	**2.60%**
	Regular Foster Care	32.00%	9.09%
Less Restrictive	Relative	6.40%	23.37%
	Independent Living	0%	14.29%
	Adoption	0%	15.59%
Total Less Restrictive		**38.40%**	**60.14%**
	Armed Services	0%	1.30%
Other	Runaway	0%	1.30%
Total Other		0%	**2.60%**

FY 2012 Discharged Cases Placement Destination Comparison



Placement Stability	Mean (S.D.)
Placement Changes Prior to TFC	3.7 (3.6)
*Placement Changes While in TFC	1.7 (0.8)

* Comparison of placement changes before & during TFC, t-statistics 4.8, $p<0.001$

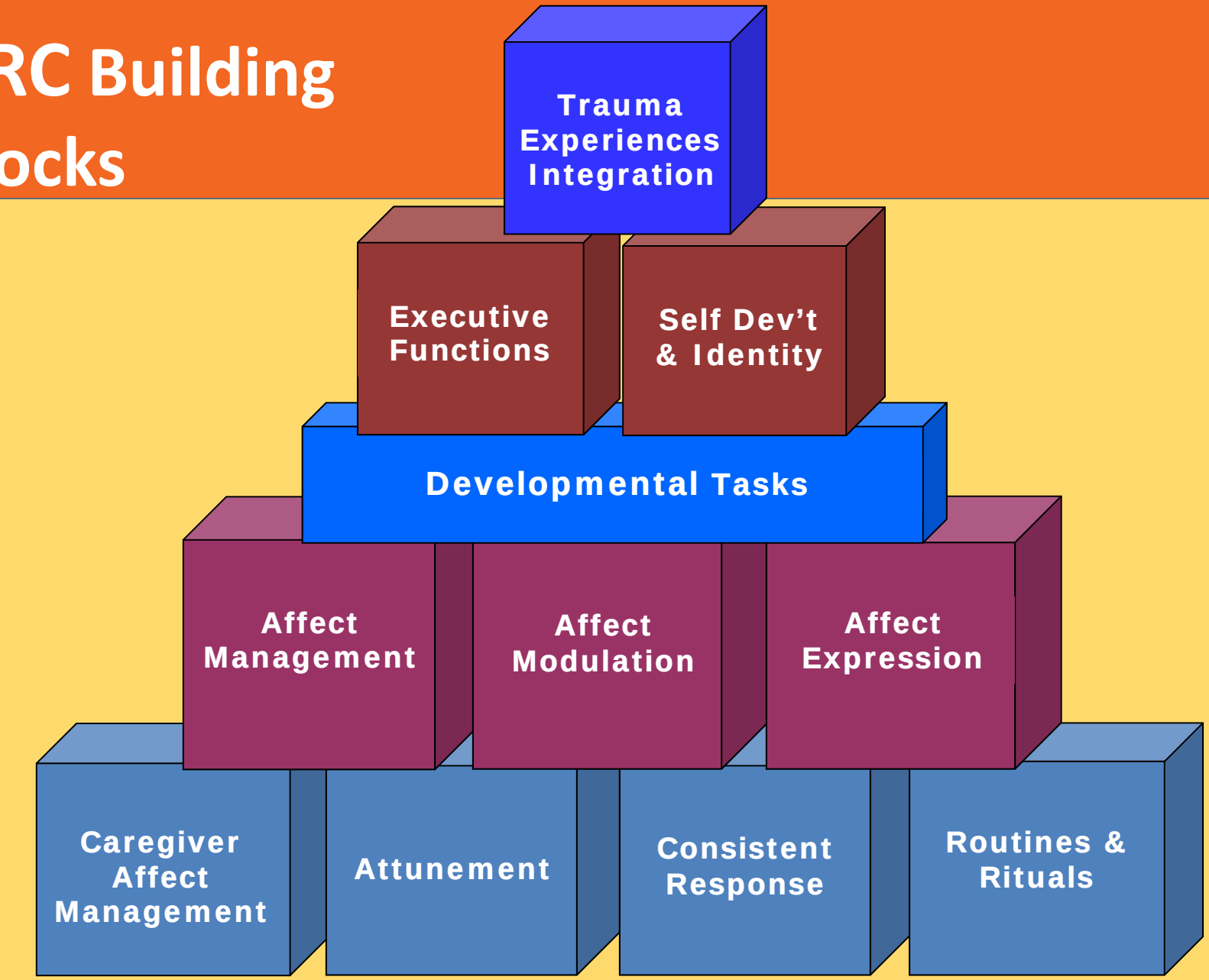
Education	Completed High School
Cook (1991)	54%
Bloome(1997)	77%
Courtney (2005)	67%
Pecora (2003)	86%
Baltimore City	71.4%
Baltimore County	92.3%
Maryland	86.5%
National	86%-90%
TIM/TFC	98%

Attachment, Regulation, Competency (ARC) Treatment Framework

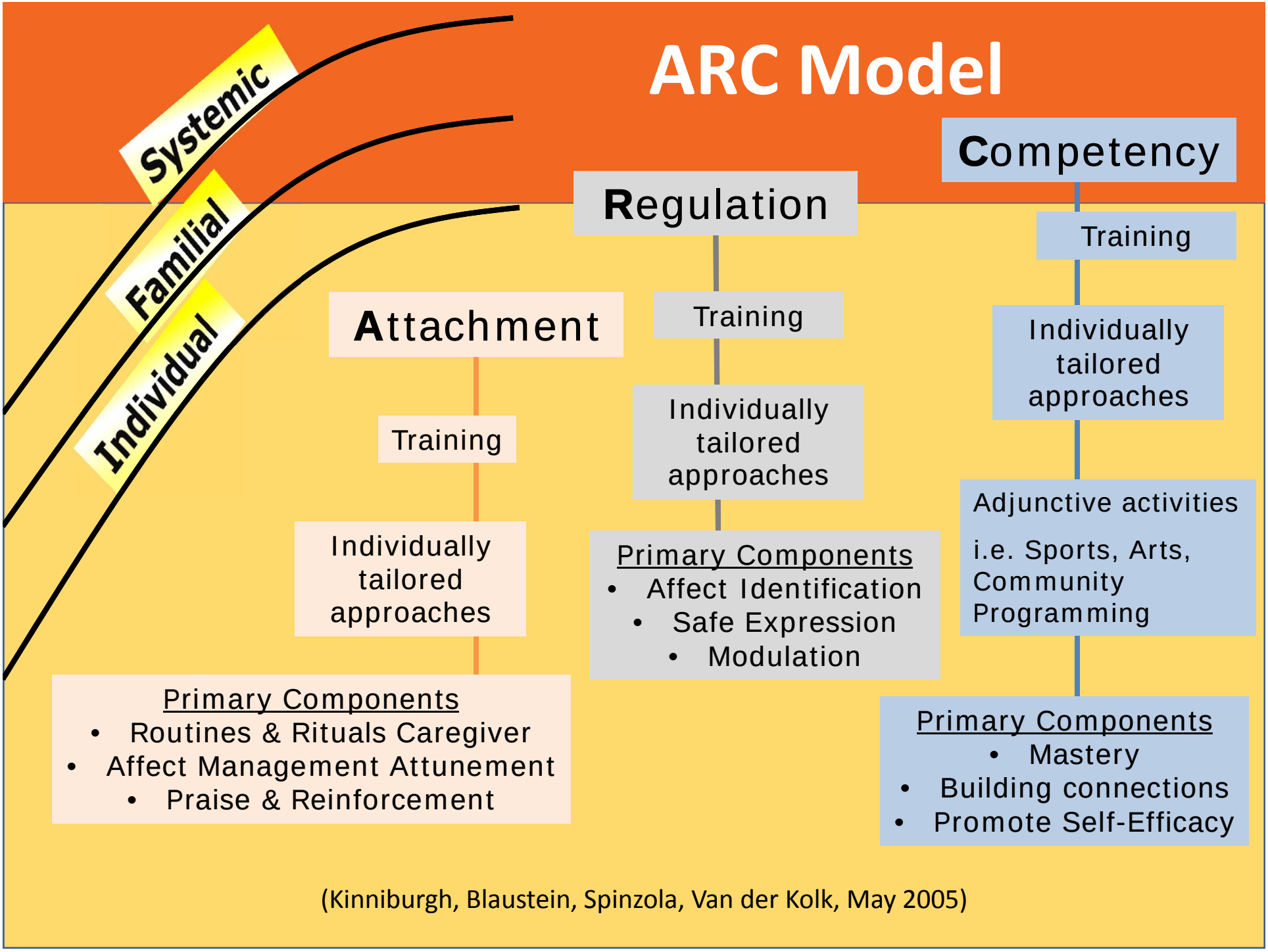
- Component-based vs. manualized protocol
- Grounded in theory & research on complex trauma
- Recognizes core effects of complex trauma:
  - Attachment
  - Self-regulation
  - Competencies
- Understands importance of intervening within the context of the child (family & system)
- Components inform treatment choices
- Recognizes the need for individual tailored trauma interventions
- Recognizes each practitioner's skill level

Kinniburgh & Blaustein 2004

ARC Building Blocks



Kinniburgh & Blaustein 2004



(Kinniburgh, Blaustein, Spinzola, Van der Kolk, May 2005)

Attachment – Key Building Block

- Caregiver Affect Management - Can you "step back?”
  - Identifying values
  - Identifying your triggers
  - Developing trigger protection plan
- Routines and Rituals - "setting up for success"
  - Creating safety plans
  - Creating plans
- Attunement – "getting and staying connected"
  - Identify the child’s triggers
  - Emotional listening
- Consistent Response – Behavioral Management
  - Daily Connection Plans and Praise
  - Limit setting & Discipline
  - ABC Planning

Regulation

- **Affect Identification**
  - Feeling forecast
  - How child communication
  - Tuning into yourself “body alarm system”
- **Affect Modulation**
  - Breathing
  - “six steps supporting modulation”
  - Mind body interventions “bring energy up & down”
- **Affect Expression**
  - Reflective “therapeutic listening”
  - Cognitive triangle (thoughts-feelings-behavior)

Competency

- Developmental Tasks
  - Social skills
  - Motor skills
  - Learning readiness
- Executive functions
  - Problem solving - rationales
  - Psycho-education – triggers- feelings- behaviors
  - Circles of trust
- Self Development and Identity
  - “What influences identity”
  - Identity shield
  - Future focus

Trauma Experience Integration

- Develop good formulation “frame”
- Tune into current observable patterns as they occur
- Validation of current perception experiences (past & present)
- Support modulation strategies
- Build on in-the-moment modulation strategies
- Observe & Reflect on patterns of identity
- Build on in-the-moment thematic/fragmented responses
- Act in present moment
- Rationale for Narration/Processing memories & experiences
- Narration
- Foster - Life narration
- Pacing
- Future focus – alumni support

Trauma Experience Integration

- Actively explore, process, and integrate historical experience into understanding of self in order to enhance capacity to engage in the present.
- Trauma is understood as part of the child's life and does not define who they are.
- Understanding and addressing triggers
- Acceptance of relationships as helpful
- Acceptance of familial relationships

Blaustein & Kinniburgh

ARC Implementation

- Collaboration
  - The Trauma Center at Justice Resource Institute
- Consultation
  - Clinical
  - Programmatic
- Training staff
  - Initial / Ongoing
- Training Treatment Parents
  - Curriculum Development
- Development of Tools
  - Parent toolkit
  - Staff toolkit
  - Programmatic tools
- Measurement of Fidelity & Outcomes
  - Manuals/Clinical Protocols
  - Mapping ARC & CANS
  - Other Measures (Youth Connection Scale, Trauma Symptom Index)

Treatment Parent Training

- **Phase One** – recruitment/orientation/pre-service training/home study process
- **Phase Two** – Following approval, consists of introducing parents to particular child & their needs
- **Phase Three** - Following placement of child in the home consists of formal presentations, small group discussions and in home child specific training
- **Phase Four** – Annual review of Treatment parents job performance and training needs

Treatment Parent Professional Development and Support

- Integrated Professional Development Process
  - Annual Review – Administrative Reviews
- Training in ARC, TIP, Permanency, Behavioral Interventions
- Regular Monthly and Weekend Training
- Child Specific Training
  - On Line Training (foster parent college)
  - Clinical Social Workers as trainers
- Support Groups
- Parent Mentors
- Parent Liaisons/Parent Advisory Board
- Respite
- Bonuses, Recognition, Gifts, Events
- Conferences and Workshops

Clinical Social Worker Professional Development Structure

- Selection
- Orientation
- Supervision – regular/PRN – Emergency Staffings
- Training – Institute, Family Center, TFC, Community (ARC-TIP-EBPs-CANS)
- Psychiatric/Neuro-psychological/Medical Consultations
- Clinical Team Meeting- weekly
- Consultation – ARC
- Permanency Meetings
  - Adoption-Reunification-Transition & Life-long commitment
- Technical Assistance/Training
- Recognition & Support

Assessment/ Treatment Planning/Interventions

- KIDnet Measures & Treatment Plan
  - Child & Adolescent Needs & Strengths (CANS)
- CANS Identified Goals & Interventions
- Psychiatric Consultation & Evaluation
- Neuropsychological Screen
- Medical Consultation
- Referral & integration of treatment
  - Evidence-based trauma treatment
  - Specialty intervention for developmental & medical issues
- Integration of Permanency

KIDnet Data System

- Children Outcome Management System (COMC) www.comc.umaryland.edu
- Devoted to improving quality of behavioral health treatment for children and adolescents through outcomes evaluation
- Through integrating outcomes evaluation into clinical and administrative decision-making enables programs to understand and apply an evidenced based approach to goal attainment and quality improvement

KIDnet Data System cont'd

- Demographic & Diagnostic Information
- Youth, Parent, and Teacher input
- Therapeutic Alliance
  - Family Apgar, Family Adaptation
  - Burden/Contribution
- Risk Scale
- CANS –Over time
- Treatment Plan – Tracking progress over time
- Treatment notes
- Contacts

An Overview of the Child and Adolescent Needs and Strengths (CANS) Assessment

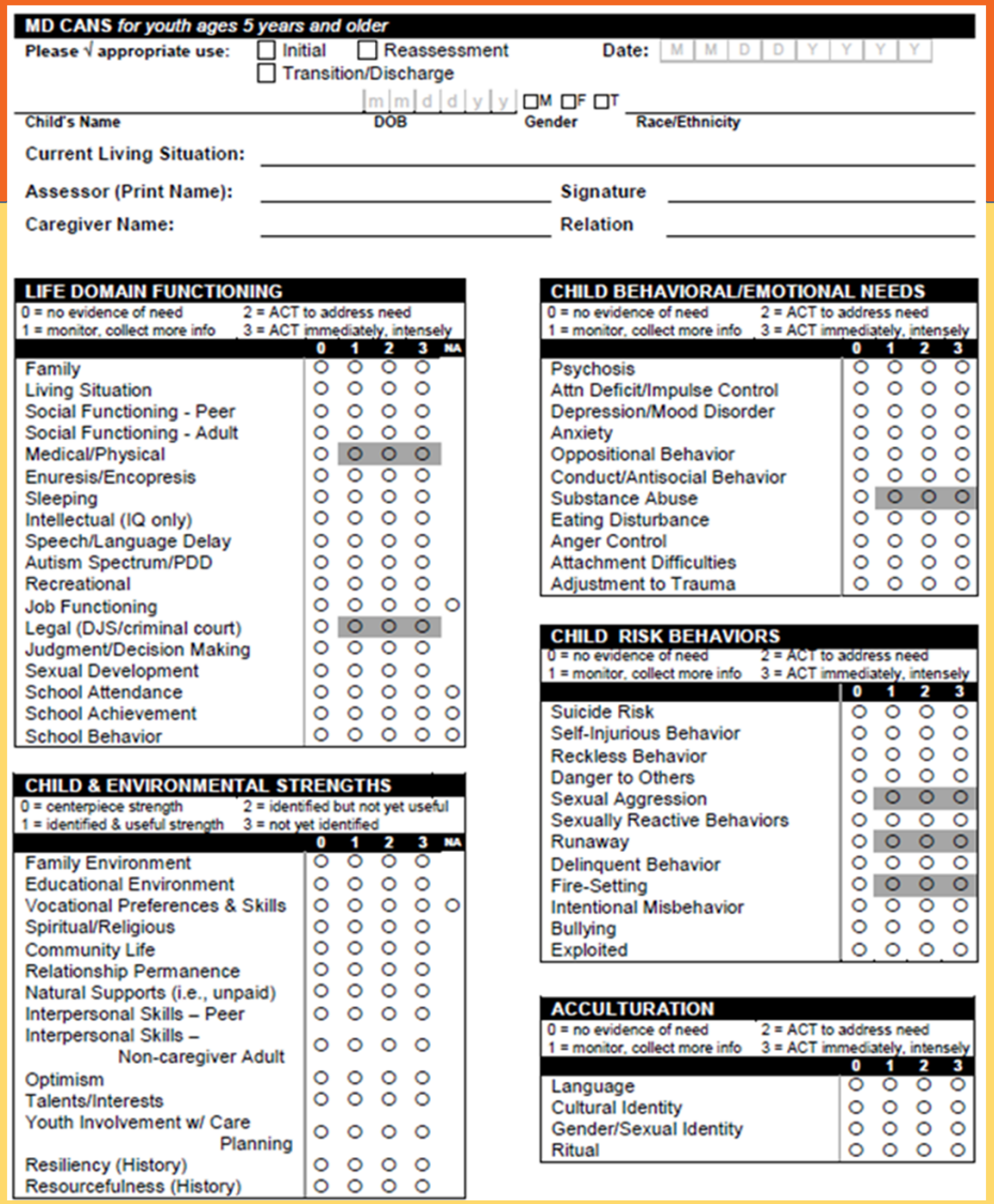
Total Clinical Outcome Management (TCOM)

- ***Total*** means that it is embedded in all activities with children/youth and families as full partners.
- ***Clinical*** means the focus is on child and family health, well-being, and functioning.
- ***Outcomes*** means the measures are relevant to decisions about approach or proposed impact of interventions.
- ***Management*** means that this information is used in all aspects of managing the system from individual family planning to supervision to program and system operations.

TCOM Implementation

	Family & Youth	Program	System
Decision Support	*Service Planning*	Eligibility	Resource Management
Quality Improvement	*Case Management & Supervision*	Accreditation	Transformation
Outcome Monitoring	*Service Planning Transitions & Celebrations*	Evaluation	Performance Contracting

CANS Assessment Form



MD CANS *for youth ages 5 years and older*

Please √ appropriate use: ☐ Initial ☐ Reassessment ☐ Transition/Discharge **Date:** M M D D Y Y Y Y

Child's Name | DOB (m m d d y y) | ☐M ☐F ☐T Gender | Race/Ethnicity

Current Living Situation: _____

Assessor (Print Name): _____ **Signature** _____

Caregiver Name: _____ **Relation** _____

LIFE DOMAIN FUNCTIONING

0 = no evidence of need; 1 = monitor, collect more info; 2 = ACT to address need; 3 = ACT immediately, intensely

	0	1	2	3	NA
Family	○	○	○	○	
Living Situation	○	○	○	○	
Social Functioning - Peer	○	○	○	○	
Social Functioning - Adult	○	○	○	○	
Medical/Physical	○	○	○	○	
Enuresis/Encopresis	○	○	○	○	
Sleeping	○	○	○	○	
Intellectual (IQ only)	○	○	○	○	
Speech/Language Delay	○	○	○	○	
Autism Spectrum/PDD	○	○	○	○	
Recreational	○	○	○	○	
Job Functioning	○	○	○	○	○
Legal (DJS/criminal court)	○	○	○	○	
Judgment/Decision Making	○	○	○	○	
Sexual Development	○	○	○	○	
School Attendance	○	○	○	○	○
School Achievement	○	○	○	○	○
School Behavior	○	○	○	○	○

CHILD & ENVIRONMENTAL STRENGTHS

0 = centerpiece strength; 1 = identified & useful strength; 2 = identified but not yet useful; 3 = not yet identified

	0	1	2	3	NA
Family Environment	○	○	○	○	
Educational Environment	○	○	○	○	
Vocational Preferences & Skills	○	○	○	○	○
Spiritual/Religious	○	○	○	○	
Community Life	○	○	○	○	
Relationship Permanence	○	○	○	○	
Natural Supports (i.e., unpaid)	○	○	○	○	
Interpersonal Skills – Peer	○	○	○	○	
Interpersonal Skills – Non-caregiver Adult	○	○	○	○	
Optimism	○	○	○	○	
Talents/Interests	○	○	○	○	
Youth Involvement w/ Care Planning	○	○	○	○	
Resiliency (History)	○	○	○	○	
Resourcefulness (History)	○	○	○	○	

CHILD BEHAVIORAL/EMOTIONAL NEEDS

0 = no evidence of need; 1 = monitor, collect more info; 2 = ACT to address need; 3 = ACT immediately, intensely

	0	1	2	3
Psychosis	○	○	○	○
Attn Deficit/Impulse Control	○	○	○	○
Depression/Mood Disorder	○	○	○	○
Anxiety	○	○	○	○
Oppositional Behavior	○	○	○	○
Conduct/Antisocial Behavior	○	○	○	○
Substance Abuse	○	○	○	○
Eating Disturbance	○	○	○	○
Anger Control	○	○	○	○
Attachment Difficulties	○	○	○	○
Adjustment to Trauma	○	○	○	○

CHILD RISK BEHAVIORS

0 = no evidence of need; 1 = monitor, collect more info; 2 = ACT to address need; 3 = ACT immediately, intensely

	0	1	2	3
Suicide Risk	○	○	○	○
Self-Injurious Behavior	○	○	○	○
Reckless Behavior	○	○	○	○
Danger to Others	○	○	○	○
Sexual Aggression	○	○	○	○
Sexually Reactive Behaviors	○	○	○	○
Runaway	○	○	○	○
Delinquent Behavior	○	○	○	○
Fire-Setting	○	○	○	○
Intentional Misbehavior	○	○	○	○
Bullying	○	○	○	○
Exploited	○	○	○	○

ACCULTURATION

0 = no evidence of need; 1 = monitor, collect more info; 2 = ACT to address need; 3 = ACT immediately, intensely

	0	1	2	3
Language	○	○	○	○
Cultural Identity	○	○	○	○
Gender/Sexual Identity	○	○	○	○
Ritual	○	○	○	○

CANS: EIGHT SECTIONS

- Life Domain Functioning
- Child Behavioral/Emotional Needs
- Child Risk Behaviors
- Acculturation
- Trauma Stress Symptoms
- Trauma Experiences
- Child & Environmental Strengths

YOUTH

- **CAREGIVER** Needs & Strengths (Permanency Plan and Current)

CANS Scoring Guidelines

NEED ACTION LEVELS

- **0 = Nothing**, due to no evidence of need
- **1 = Monitor** or collect more information, due to suspicion or history
- **2 = ACT to address need**, due to evidence of need
- **3 = ACT immediately/intensely**, due to evidence of imminent danger to safety, health, and/or development

CANS Scoring Guidelines

STRENGTH ACTION LEVELS

- **0 = Use as centerpiece** in strength-based plan, due to identified & highly useful strength
- **1 = Use** in strength-based plan, due to identified & useful strength
- **2 = Consider further development** before using this identified but not yet useful strength
- **3 = Consider identification of potential skill/resource**, to build this not yet identified strength

Child & Adolescent Needs & Strengths Assessment

- Assessment
- Support Treatment and Service Planning
- Outcome Monitoring/Quality Improvement
- Use in Relation to Specific EBPs
- Supports the Treatment of Complex Trauma
- Use to Increase Capacity for Trauma-related service

CANS Implementation

- **Collaborations**
  - Children Outcome Management Center (COMC)
  - University of Maryland SSW – Institute for Innovation & Implementation
  - Northwestern University - Center of Child Trauma Assessment and Service Planning
- **KIDnet Data Base**
  - Assessment /ITP/outcomes
  - CANS – Program management-supervisory-treatment
- **Training**
  - Initial/Annual
- **Implementation CQI**
  - Compliance
  - Reliability
- **Integration**
  - Systemic (algorithm)
  - CSOMS
  - Maryland's Family Center Practice Model -LDSS
  - Programmatic (supervision & outcomes)
  - Treatment (CANS Mapping with ARC treatment interventions)

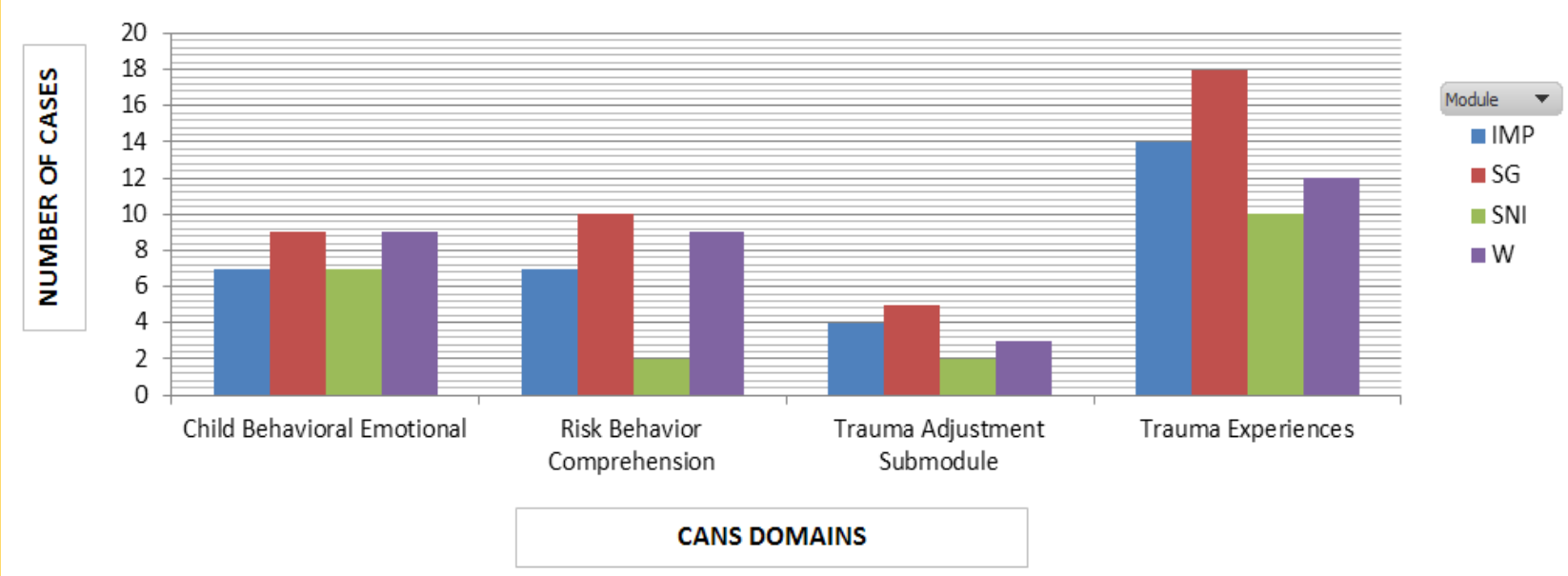
CANS Domain Scores Comparison: Statistical Significance

t1: Admission, t2: Discharge n=104

	Statistical Significance (Improvement)		
CANS Domain	**Mean**	**Confidence Interval (CI)**	**Probability (p)**
Developmental	1.2	95% CI 0.05 to 2.39	$p < 0.05$
Strengths	1.8	95% CI 0.41 to 3.13	$p < 0.05$
Trauma Experiences	0.7	95% CI 0.06 to 1.33	$p < 0.05$
Acculturation	0.63	95% CI 0.15 to 1.11	$p < 0.05$
Sexuality	0.58	95% CI 0.04 to 1.11	$p < 0.05$
Risk Behavior Comprehension	1.19	95% CI 0.58 to 1.80	$p < 0.05$
Traumatic Sexual Abuse	0.92	95% CI 0.17 to 1.68	$p < 0.05$
Trauma Adjustment	1.87	95% CI 1.01 to 2.74	$p < 0.05$

Domain Score Comparison

t1: 7/22/12, t2: 7/22/13



LEGEND
IMP -Score Improved from Time1 to Time2
SG - Score of 0 or 1 Stayed Good from Time1 to Time2
SNI - Score of 2 or 3 Showed No Improvement from Time1 to Time2
W - Score has gotten worse from Time1 to Time2

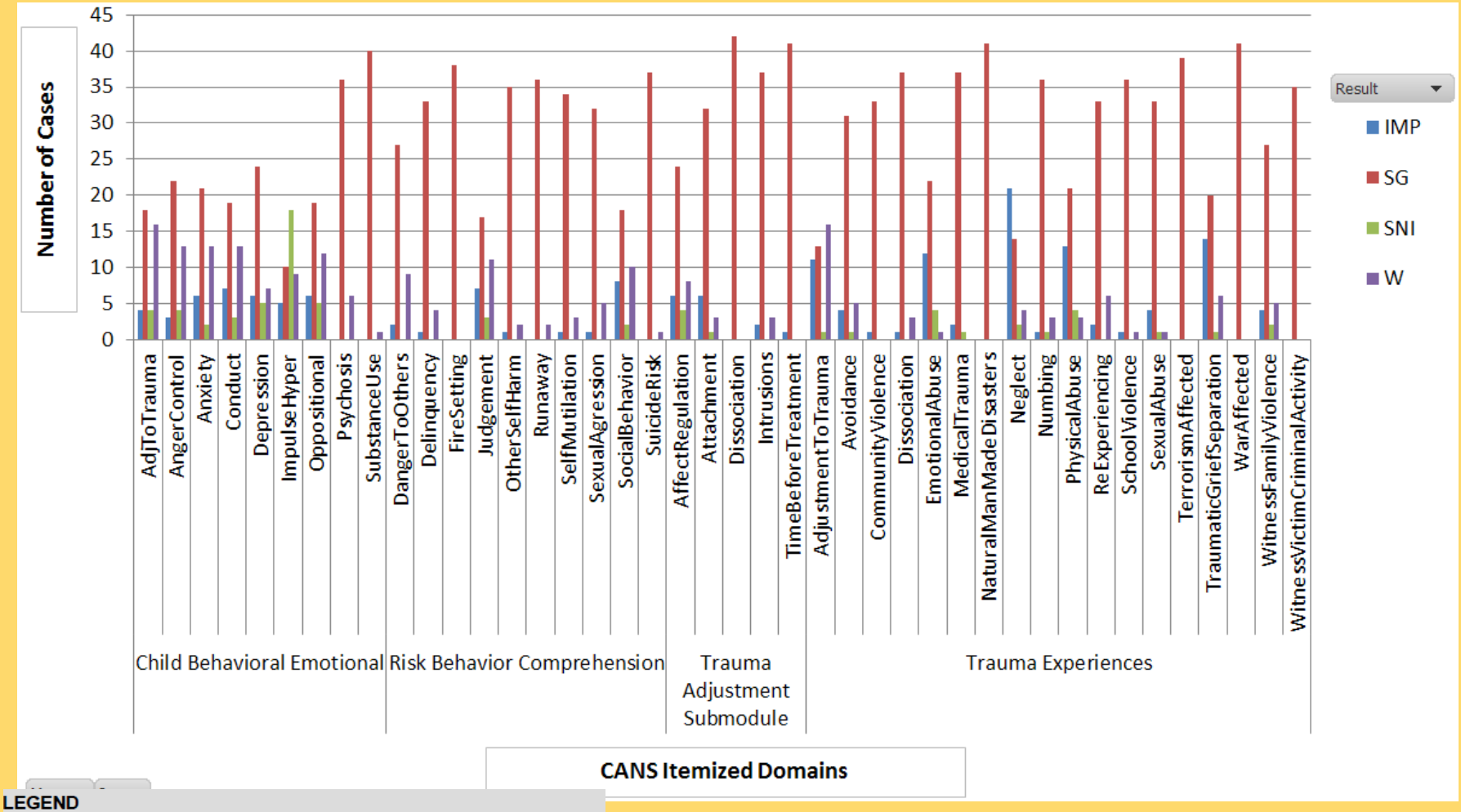
Analysis Help

According to the data shown, in the CANS Module Child Behavioral Emotional, from t1 to t2

- 7 cases (youth) had scores that improved
- 9 cases (youth) had scores that stayed good
- 7 cases (youth) had scores that remained the same, no improvement
- 9 cases (youth) had scores that got worse

Itemized Domain Score Comparison

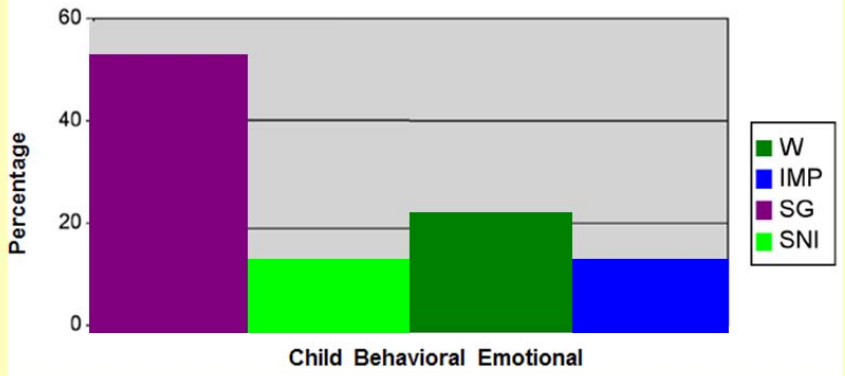
t1: 7/22/12, t2: 7/22/13



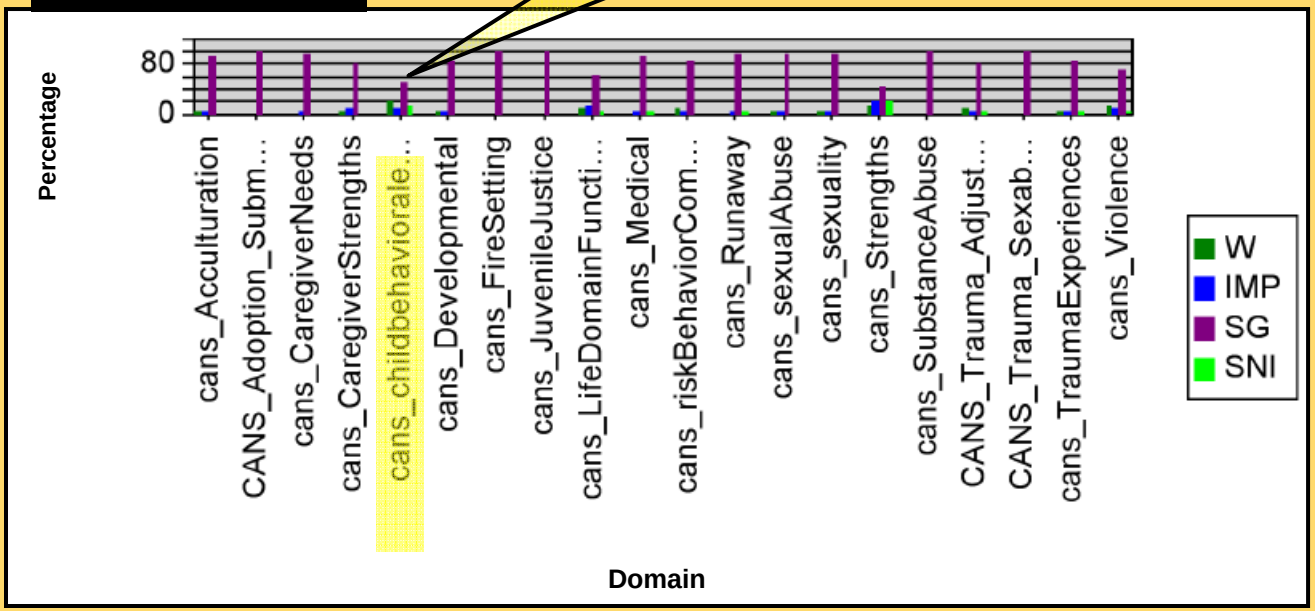
LEGEND
IMP -Score Improved from Time1 to Time2
SG - Score of 0 or 1 Stayed Good from Time1 to Time2
SNI - Score of 2 or 3 Showed No Improvement from Time1 to Time2
W - Score has gotten worse from Time1 to Time2

Total Percentages

Result Code	Description
IMP	Score “Improved” from Time1 to Time2, decreased to a 0 or 1
SG	Score of 0 or 1 “Stayed Good” from Time1 to Time2
SNI	Score of 2 or 3 “Showed No Improvement” from Time1 to Time2
W	Score has gotten “Worse” from Time1 to Time2, increased to a 2 or 3



All Domains



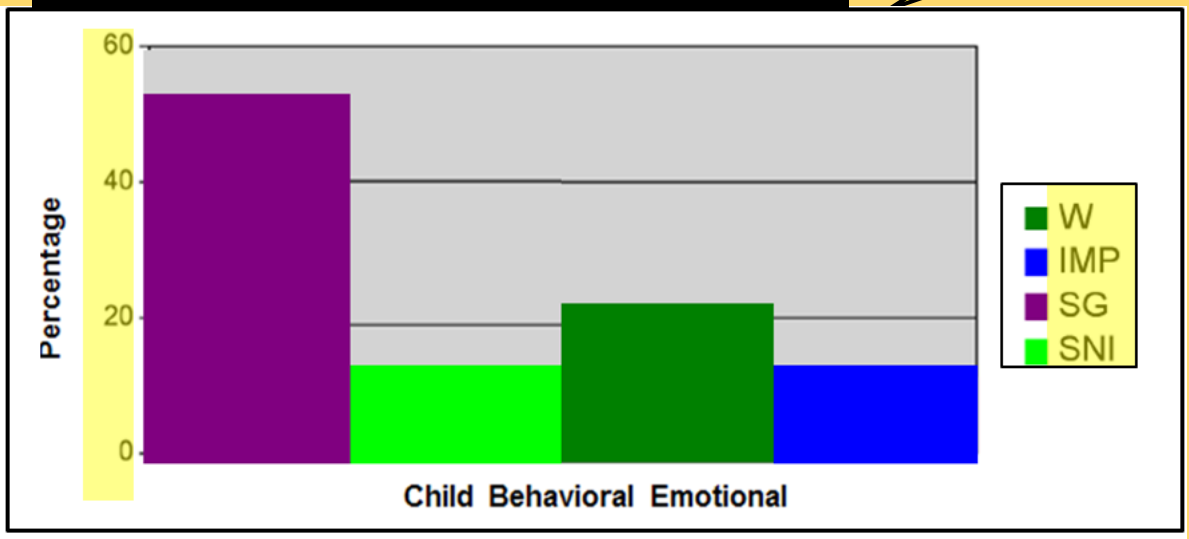
Domain-Specific Percentages

KEY	
Result Code	**Description**
IMP	Score "Improved"
SG	Score "Stayed Good"
SNI	Score "Showed No Improvement"
W	Score has gotten "Worse"

Domain Total Percentages

	Result Code	Percentage
cans_childbehavioralemotional		
	SG	53%
	SNI	12%
	W	21%
	IMP	11%

Domain: Child Behavioral Emotional



Domain-Specific Counts

KEY	
Result Code	**Description**
IMP	Score "Improved"
SG	Score "Stayed Good"
SNI	Score "Showed No Improvement"
W	Score has gotten "Worse"

Domain Total Percentages

	Result Code	Count
cans_childbehavioralemotional		
	SG	170
	SNI	40
	W	69
	IMP	36

Domain: Child Behavioral Emotional

Domain Total Percentages

	Result Code	Percentage
cans_childbehavioralemotional		
	SG	53%
	SNI	12%
	W	21%
	IMP	11%

Item-Specific Counts and Percentages

KEY

Result Code	Description
IMP	Score "Improved"
SG	Score "Stayed Good"
SNI	Score "Showed No Improvement"
W	Score has gotten "Worse"

Domain Items

Domain Count and Domain Item Percentages

cans_childbehavioralemotional

Item	Result Code	Count	Percentage
AdjToTrauma	W	9	25%
AngerControl	W	12	34%
Anxiety	W	13	37%
Conduct	W	5	14%
Depression	W	11	31%
ImpulseHyper	W	2	5%
Oppositional	W	12	34%
Psychosis	W	5	14%

Domain: Child Behavioral Emotional

Domain Total Percentages

	Result Code	Count	Percentage
cans_childbehavioralemotional			
	SG	170	53%
	SNI	40	12%
	W	69	21%
	IMP	36	11%

Case-Specific Score Comparison

Domain Items

Domain Count and Domain Item Percentages

cans_childbehavioralemotional

Item	Result Code	Count	Percentage
AdjToTrauma	W	9	25%
AngerControl	W	12	34%
Anxiety	W	13	37%
Conduct	W	5	14%
Depression	W	11	31%
ImpulseHyper	W	2	5%
Oppositional	W	12	34%
Psychosis	W	5	14%

Time1 / Time2 Score Comparision

ns_childbehavioralemotional

AdjToTrauma

Youth Name	Time1 Scor	Time2 Scor	Result
[redacted]	2	3	W
[redacted]	2	3	W
[redacted]	0	1	W
[redacted]	1	2	W
[redacted]	0	1	W
[redacted]	1	2	W
[redacted]	1	2	W
[redacted]	0	1	W
[redacted]	0	1	W

Time1 / Time2 Score Comparision

ns_childbehavioralemotional

Depression

Youth Name	Time1 Scor	Time2 Scor	Result
[redacted]	1	2	W
[redacted]	0	1	W
[redacted]	0	1	W
[redacted]	1	2	W
[redacted]	1	2	W
[redacted]	0	1	W
[redacted]	0	1	W
[redacted]	0	1	W
[redacted]	0	2	W
[redacted]	0	2	W
[redacted]	0	1	W

Time1 / Time2 Score Comparision

ns_childbehavioralemotional

Anxiety

Youth Name	Time1 Scor	Time2 Scor	Result
[redacted]	1	2	W
[redacted]	0	1	W
[redacted]	0	1	W
[redacted]	1	2	W
[redacted]	1	2	W
[redacted]	0	1	W
[redacted]	0	1	W
[redacted]	1	2	W
[redacted]	1	2	W
[redacted]	0	1	W
[redacted]	0	1	W
[redacted]	0	1	W
[redacted]	1	2	W

ARC/CANS Mapping: Attachment Block

ATTACHMENT BLOCK

A. Caregiver Affect Management	**PRIMARY:** 116. Natural Supports 118. Parent/Caregiver's Understanding of Impact of Own Behavior on Child 120. Ability to Communicate 122. Mental Health 123. Substance Use 125. Parent/Caregiver Posttraumatic Reactions
	Relevant: 31. Family 55. Attachment Difficulties 102. Discipline 119. Empathy with Children 90. Intimate Relationships 99. Marital/Partner Violence in the Home 113. Partner Relationship 114. Relations with Extended Family Members 121. Physical Health *Applicable to Young Child (0-5) Only:* 82. Maternal Availability
B. Attunement	**PRIMARY:** 55. Attachment Difficulties 100. Knowledge of Child's Needs 117. Parent/Caregiver Ability to Listen as a Parent 119. Empathy with Children
	RELEVANT 20. Family 70. Social Behavior 102. Discipline 120. Ability to Communicate *Applicable to Young Child (0-5) Only:* 82. Maternal Availability
C. Consistent Response	**PRIMARY** 95. Safety 96. Supervision 102. Discipline 104. Demonstrates Effective Parenting Approaches 120. Ability to Communicate
	RELEVANT 100. Knowledge of Child's Needs 117. Parent/Caregiver ability to listen as a parent 118. Parent/Caregivers Understanding of Impact of own Behavior on Child 119. Empathy with Children 120. Ability to Communicate
D. Routines/Rituals	**PRIMARY** 22. Educational Setting 46. Rituals 115. Community Involvement 103. Learning Environment 27. Spiritual/Religious 47. Cultural Stress 108. Organization
	Relevant 39. Sleep 41.School Behavior 42. School Achievement 43. School Attendance

ARC/CANS 2.0 Mapping Project, Northwestern University, Kisiel & Blaustein

ARC/CANS Mapping: Self-Regulation Block

SELF-REGULATION BLOCK

A. Affect Identification	**PRIMARY:** 17. Avoidance 18. Numbing 19. Dissociation 59. Somatization **RELEVANT:** *none*
B. Modulation	**PRIMARY:** 24. Coping and Savoring 49. Attention Deficit/Impulse Control 50. Depression 51. Anxiety 54. Substance Abuse 56. Eating Disturbance 57. Affect Dysregulation 58. Behavioral Regression 60. Anger Control
	RELEVANT 16. Re-experiencing 19. Dissociation 39. Sleep 52. Oppositional Behavior 59. Somatization 61. Suicidality 62. Self-Mutilation 63. Other Self Harm 66. Runaway
C. Affect Expression	**PRIMARY** 20. Family 21. Interpersonal 33. Social Functioning 55. Attachment Difficulties
	RELEVANT 31. Family 70. Social Behavior 74. Communication

ARC/CANS 2.0 Mapping Project, Northwestern University, Kisiel & Blaustein

ARC/CANS Mapping: Competency Block

COMPETENCY BLOCK

Developmental Tasks	*YOUNG CHILD (0-5 years)*	*SCHOOL AGED (6-12 years)*	*ADOLESCENT (13-18 years)*
	PRIMARY 72. Motor 73. Sensory 74. Communication 84. Playfulness 28. Community Life 33. Social Functioning 35. Recreational 41. School Behavior 42. School Achievement 94. Job Functioning	**PRIMARY** 28. Community Life 33. Social Functioning 35. Recreational 41. School Behavior 42. School Achievement 94. Job Functioning	**PRIMARY** 87. Independent Living Skills 89. Parenting Roles 90. Intimate Relations 92. Educational Attainment 28. Community Life 33. Social Functioning 35. Recreational 41. School Behavior 42. School Achievement 94. Job Functioning
	RELEVANT 21. Interpersonal 22. Educational Setting 23. Vocational 44. Language *Applicable to Young Child (0-5) Only:* 75. Failure to Thrive 76. Feeding/Elimination 77. Birth Weight 78. Prenatal Care 79. Substance Exposure 80. Labor and Delivery 86. Day Care Preschool		

Executive Functions	**PRIMARY** 49. Attention/Impulse Control 68. Judgment **RELEVANT** 34. Developmental/Intellectual 52. Oppositional Behavior 60. Anger Control *Applicable to Young Child (0-5) Only:* 83. Curiosity
Self and Identity	**PRIMARY** 19. Dissociation 25. Optimism 26. Talent/Interest 27. Spiritual/Religious 30. Resilience 40. Sexual Development 45. Identity 46. Ritual
	RELEVANT 21. Interpersonal 24. Coping and Savoring 47. Cultural Stress 52. Oppositional Behavior 83. Curiosity *Applicable to Transition to Adulthood Only* 93. Victimization

ARC/CANS 2.0 Mapping Project, Northwestern University, Kisiel & Blaustein

Integration of Assessment/Training & Treatment Interventions

- Assessment
  - CANS Item - Anxiety
- ARC Component
  - Affect Modulation
- Training - “Tools”
  - Bio-feed back – ‘heart math”
    - “belly breathing” – “bubble breathing”
  - Stress ball

Lessons Learned

- Administrative buy-in and leadership are essential
- Need for long term vision (with adjustments)
- “Cultural Shift”
- Implementation is everything
  - Create buy in and “value added” at all levels
  - Keep it about kids and families
  - Keep it transparent and real
- Resources are necessary but not everything
  - Dedication + Money = time
- Collaborations are necessary (and can be fun)
- Don’t give up: ignore the skeptics

Next Steps…

- Complete development of manuals
  - Staff & parent training
  - Clinical Protocols
- Complete development, implementation, integration of measures &tools
  - CANS/Trauma Symptom Index/Youth Connection Scale
  - ARC/TIP/Permanency
- Complete development of fidelity measures
- Integration of tools & measures in KIDnet system
- Measure & improve
- Continue to publish, present & collaborate

Trauma Resources

National Traumatic Stress Network (NCTSN) http://www.nctsn.org/

Learning Center for Child and Adolescent Trauma http://learn.nctsn.org/

SAMHA Trauma-Informed Care & Trauma Service http://www.samhsa.gov/nctic/trauma.asp

Chadwick Trauma-Informed Systems Project (CTISP) http://chadwickcenter.org/CTISP/ctisp.htm

Child Welfare Information Gateway http://www.childwelfare.gov/responding/trauma.cfm

The National Center for Trauma-Informed Care http://www.samhsa.gov./nctic/default.asp

The Trauma Center at the Justice Resource Institute http://www.traumacenter.org

Family Informed Trauma Treatment Center (FITT) http://www.fittcenter.umaryland.edu/

The Trauma Training Academy Northwestern http://kennedykrieger.org/patient

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