

Learner Resources

CWS2010W: In-Home Services Skills



VIRGINIA DEPARTMENT OF
SOCIAL SERVICES

WDS Workforce Development
and Support

Table of Contents

Seven Essential Practices of Meaningful Assessment ...	1
Common Misconceptions About the CANS.....	2
Using the CANS – Effective Communication	4
Protective Capacities and Protective Factors	5
Use of the CANS in Trauma - Informed Treatment.....	6
Service Planning Process.....	16
CANS Reports.....	17

SEVEN ESSENTIAL PRACTICES OF MEANINGFUL ASSESSMENT

1. **PROCESS FIRST:** The necessary steps of engagement, trust-building, thoughtful inquiry, listening, exploring, and partnering occur *before* completing tools or creating plans. When we follow this order, the tools and plans are co-created and more accurate, fair, and effective. The Suite of Tools are meaningful when their completion is preceded by an array of best practices.
2. **ENGAGEMENT AND TRAUMA:** Doing our work with an ever-present trauma lens automatically supports engagement. Through formal and informal engagement practices we build trusting and collaborative relationships that inspire and promote meaningful change. Engagement utilizes foundational practices of Cultural Humility, Collaborative Practice, Trauma-Informed Practice, Strengths-Based Practice, and Solution-Focused Practice.
3. **CONTINUAL ASSESSMENT:** Assessments are not isolated or occasional events that occur only when there is a tool to complete or a report to create. Assessments are an ongoing process that begin at the very first contact and thread throughout every interview, conversation, visit, and meeting involving and/or about the family. We are constantly gathering, sorting, and evaluating information we receive that is simultaneously relevant to different assessment tools.
4. **SOLUTION-FOCUSED PRACTICE:** Solution-Focused strategies are grounded in the assumption that people are resilient, resourceful, and competent. Regularly using Solution-Focused Questions provides genuine opportunities for people to connect to their insight and formulate a narrative that provides true and helpful information. Solution-Focused strategies help uncover past examples of protection, potential support, and position both parties to look forward for real solutions. The strategies are trauma-informed because they support family members' choice, power, and agency.
5. **BEHAVIORAL LANGUAGE:** Language that is simple, objective, and behavioral leaves no room for misinterpretation or confusion. We use clear, action-focused words with families. We avoid using professional jargon and acronyms. We avoid words that are vague, passive, or "buzzwords". We are mindful that softened language maintains its intended meaning and impact. We speak and write in ways that are best understood by children and families.
6. **PROTECTION FRAMEWORKS:** We use both protection frameworks—Protective Capacity and Protective Factors—and understand the difference between the two. These frameworks define the structure and components that are most relevant to immediate and sustained child protection.
7. **TEAMING:** We regularly and frequently utilize informal teaming (collaborative practice, network building, and partnering) and formal teaming (Family Partnership Meetings and Child and Family Team Meetings) to optimize assessments, decision-making, safety, and support for children, youth, and parents.

Common **Misconceptions** About the Child and Adolescent Needs and Strengths Assessment (CANS)

Misconception	Information
<p>“There will be a significant amount of repetitive data entry when we complete the CANS on every caregiver because 99 percent of the caretaker domains will be the exact same for each child.”</p>	<p>The Caregiver section (Caregiver Strengths and Needs) is completed for each individual child because the intent is to rate the ability of the caregiver to care for and relate to that <i>specific</i> child, , i.e., how well the caregiver provides for and relates to <i>that</i> child. Although some items may be rated similarly for all the children in a family, many others, for example, Supervision; Knowledge of a Child's Needs; Involvement with Care; and Safety will likely be different. In addition, sometimes there are "targeted" children in a household that a parent or caregiver treats differently.</p>
<p>“The CANS is not an effective assessment in areas of abuse and/or neglect.”</p>	<p>In 2016, the CANS was modified to include the Child Welfare Module and additional items were added to the Trauma Module. These modules are required on the DSS version, and contain multiple items relevant to abuse and neglect, such as the following:</p> <ul style="list-style-type: none"> • <i>Physical Abuse</i> • <i>Neglect</i> • <i>Sexual Abuse</i> • <i>Emotional Abuse</i> • <i>Domestic Violence</i> • <i>Violence in the Community</i> • <i>Condition of the Home</i> • <i>Parent/Caregiver Frustration Tolerance</i> • <i>Discipline</i> • <i>History of Maltreatment</i> • <i>Relationship to Abuser</i> <p>These are just a sampling of the items in these two Modules.</p>

“It takes two hours to complete the CANS assessment.”	Once a rater has collected information about the child and family and is familiar with the CANS assessment, it should take no longer than 20 minutes to complete.
“The online version of the CANS training is not sufficient.”	Perhaps employing some best practices regarding comprehension and application will assist in completing the online training for the CANS. For instance, it is best to take notes when participating in the training. Be sure to refer back to those notes again and again. The <i>Item and Rating Definitions Manuals</i> should be consulted every time the CANS is being rated.
“The CANS does not assess infants.”	The Birth to Four version of the DSS CANS assesses infants and caregivers. It contains items such as: <ul style="list-style-type: none"> • <i>Maternal Availability</i> • <i>Substance Exposure</i> • <i>Prenatal Care</i> • <i>Adaptability</i> • <i>Persistence</i> • <i>Attachment</i>
“The CANS is just an observation with no input from the family.”	The CANS should only be completed with the family. The assessment can be converted into engagement questions or conversation starters.
“The CANS does not streamline with SDM tools.”	FSNA and the CANS have duplicate items; therefore, CANS should streamline with the SDM tools.
“The CANS only focuses upon delinquent behaviors.”	Incorrect. There are two items on the CANS specific to delinquency.

Using the CANS

Effective Communication with Individuals & Families

Courtesy of Mary Beth Rautkis, PhD via canstraining.com

The CANS is by design, a communication tool. The CANS is not a “checklist” to be completed, but the reflection of a family’s experiences that needs to be heard.

Listening is the most important skill that you bring to the assessment. The better you are at listening, the better the information you will receive

Eye Contact

Individuals have varying standards for good eye contact

- Be sensitive to everyone’s level of comfort with eye contact
 - Eye contact involves moving your eyes from the Ipad to the person’s face in a way that feels comfortable for you and for the person to whom you are speaking
 - If an individual is uncomfortable with eye contact, shift your gaze
 - If an individual is comfortable with eye contact, move your eyes from the Ipad to the person to whom you are speaking

Personal Space

Individuals have varying degrees of comfort with personal space

- Respect people’s boundaries
 - Individuals will let you know verbally or non-verbally if you are invading their personal space

Self-awareness

Individuals feel comfortable if you are comfortable

- When feeling discomfort, take a few seconds to think about why
 - Is it because of the type of information that is being shared?
 - Is it because of the physical environment?
- Figure out how to make the situation/physical environment less uncomfortable

Silence

Individuals need time to get their thoughts together

- Be comfortable with silence
 - If concerned that the silence means something else, ask follow-up questions
 - Does what I asked make sense to you?
 - Do you need me to rephrase that question in another way?



Solution-Focused Questions

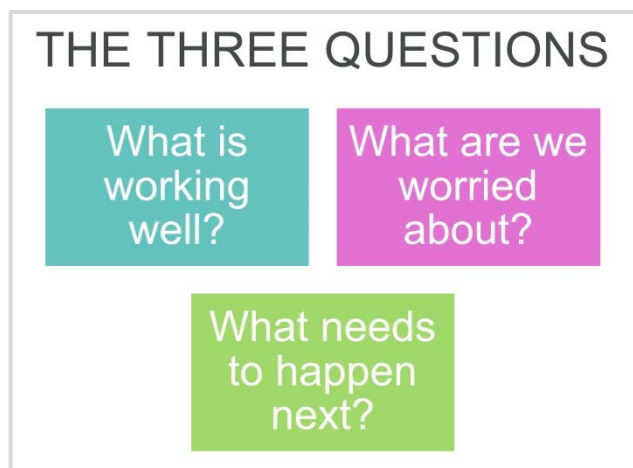
The use of Solution-Focused Questions is a foundational skill and strategy of best practice that helps the worker explore with a family those things that are working well, what we are worried about, and what needs to happen next.

ENGAGEMENT AND SOLUTION-FOCUSED QUESTIONS

- Engagement is the central Practice Profile to help ensure child safety, permanency and well-being. Engagement is the art and skill of interacting with a family in ways that move them toward greater readiness for their own active participation in making change.
- Without engagement, families may complete required steps or services, but the chances are greatly reduced that they will genuinely internalize the need for change and make lasting, meaningful change. Skilled engagement, therefore, is critical to child safety.
- Effective engagement also helps individuals with a history of trauma step out of “fight/flight/freeze” mode so that they can access their best thinking.
- Masterful use of questions is one of the most effective engagement strategies, and an intervention in and of itself.

THE THREE QUESTIONS

- The Three Questions are a deceptively simple framework for exploring strengths, concerns, and necessary next steps with a child, a parent, a family, their network, reporting parties, collaterals and anyone else involved in a case.



- The Three Questions are a component of many other best practice strategies, including:

- Guiding the discussion in Child and Family Team Meetings (CFTM), Family Partnership Meetings (FPM), or Group Supervision.
- Completing the Three Houses with children or youth: House of Good Things = working well, House of Worries = what we’re worried about, House of Hopes & Dreams = what happens next
- Providing a framework for intake/screening questions
- Guiding other conversations or meetings with parents, youth, collaterals or agency staff

SOLUTION-FOCUSED QUESTIONS

- Solution-focused questions are an effective strategy to have conversations with people about what is already working well, or has worked well in the past, in order to successfully engage families, build their hope and belief that change is possible, and focus their energies on positive change.
- The solution-focused approach is based on a simple idea with profound ramifications: that what we pay attention to grows. This highlights the need to ask families and others about safety as rigorously as we ask about danger and risk, because identifying where there is already safety or has been safety in the past holds the solutions, at least in part, to future safety.
- Solution-focused questions also help us conduct a rigorous, balanced assessment by evoking discussion with network members, collaterals, and other agency staff about acts of protection and family strengths, rather than focusing solely on what isn’t working, which leaves us with only half of the picture.
- Solution-focused interviewing is also an excellent strategy to use with youth to help them focus on their strengths, build confidence in their skills, and guide them toward positive choices.
- Solution-focused questions can also be used with resource parents or service providers to guide conversations about a child’s or youth’s behavior, with the goal of stabilizing a placement or identifying additional supports that may be needed.

TYPES OF SOLUTION-FOCUSED QUESTIONS

Past Success Questions ask individuals to recall when things have been better and what made that possible. The person may remember when he/she has been able to cope with a problem or been able to solve it. Remembering one or more past successes is likely to increase the confidence and hopefulness of the individual and usually helps people find ideas to take a step forward.

Example: “It’s not easy being a single parent. How do you do it?”

Example: “After you lost your job, how did you find enough strength to keep moving forward?”

Example: “What would it take for you to bring back the motivation you had last month to get to meetings?”

Exception Questions ask individuals to think about times when the problem could have been happening, but was not, so they can explore what, when, where and how they were able to achieve success. They help people remember that the problem has not always been present, or can help clarify that there was no me when the problem was not happening, which is also important information.

Example: “Was there a time that you (mom) were able to stay clean and sober? How were you able to achieve that? What was it like to parent your kids when you weren’t drinking?”

Example: “Was there a time in your relationship that you (dad) were not using violence or making mom stay away from her family and friends? What did your relationship look like during that time?”

Example: “Are there times that (your foster child) is not acting out? What does his behavior look like at those times? What is happening in the home, at school or in his life when he is at his best?”

Coping Questions ask people to reflect on how they were able to make it through something difficult, painful or challenging without resorting to problem behavior. Coping questions help build people’s sense of self-efficacy and resilience and also show us what strategies they used for success.

Example: “Wow, it’s amazing that your sister died and you were still able to stay sober during that time. How were you able to manage that?”

Example: “It shows so much strength that you got yourself and the kids out of the house after your boyfriend started using again. How were you able to do that?”

Position (or Relationship) Questions ask a person to think about a situation or problem from someone else’s perspective, or by putting themselves in the other’s shoes. This helps them understand the impact of their

actions or behavior on another person and see it from their eyes. Position questions can help build empathy and understanding of how one’s own actions affect another person.

Example: “If your son were here, what do you think he would say about how your drug use affects you as his dad?”

Example: “If your mom were here, what do you think she would say about the kind of relationship she wants for you and your children?”

Example: “If you put yourself in my shoes as the worker, what would you be worried about?”

Preferred Future Questions ask the person to think about what the best possible future would look like if they were able to change their issue or problem. They help build a vision for what things will look like when the problem is no longer happening, and assist in setting goals.

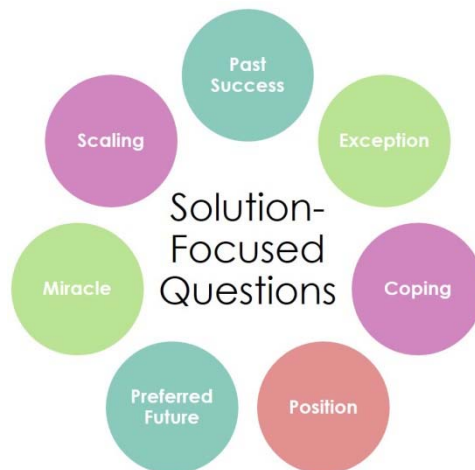
Example: “If the best possible future happened and your child welfare case was closed, what would your life look like? Where would you be living? What would you be doing? How would you be parenting your children?”

The Miracle Question is a special type of preferred future question that can help people get clarity on how the problem impacts their daily life and what life would look like without the problem happening.

Example: “Imagine you woke up tomorrow and a miracle had happened over night, and all the trouble was gone. How would you know it was over? What would be different that would tell you the problem was no longer happening? What is the first thing you would be doing to start the day? What would the rest of your day look like? What would things look like for your children?”

Scaling Questions are a powerful, flexible strategy that can be adapted to many situations to help gauge or clarify a person’s (or all team members’) perspective on an issue. The important thing about scaling questions is not necessarily the number that someone picks, but rather the chance to explore with them the reasons that they picked that number.

Follow-up questions are the key; for example, asking someone what it would take to move them up one number, or why they picked that number and not a lower



or higher one. Follow-up questions help us get to the underlying reasons for someone's perspective and explore next steps.

Scaling questions can be used to scale many different areas, including but not limited to:

- Willingness
- Confidence
- Readiness
- Agreement

For example, how willing is someone to participate in a safety network, how confident are FPM participants that a plan will keep a child safe, how ready is a parent to make a change, how much do team members agree with the decision a team is making.

Example: "On a scale of 1 to 10, where 1 is that you are not at all ready to stop using drugs, and 10 is that you are completely ready, where would you rate yourself today? How did you pick a 9? What would it take to move you from a 9 to a 10?" (Or: "Wow, you're very ready — what made you pick a 9 and not a 8? Have you ever been at a 9 before? What were the steps you took at that me?")

Example: "On a scale of 1 to 10, where 1 is that you have no confidence that this plan will keep the child safe, and 10 is that you are completely confident the plan will keep the child safe, where would you rate? How did you pick a 4? What puts you at a 4 instead of a 3? (Or: "What would you need to see happen to be at a 5 instead of a 4? What would you need to see happen to be at a 6?")

APPRECIATIVE INQUIRY

Appreciative Inquiry is a term that is often used interchangeably with solution-focused approaches.

Appreciative inquiry is based on the belief that what we pay most attention to has the best chance of growing. Fundamentally, appreciative inquiry is the concept that asking questions about *what is working* is more effective in creating change than focusing our attention primarily on the problem.

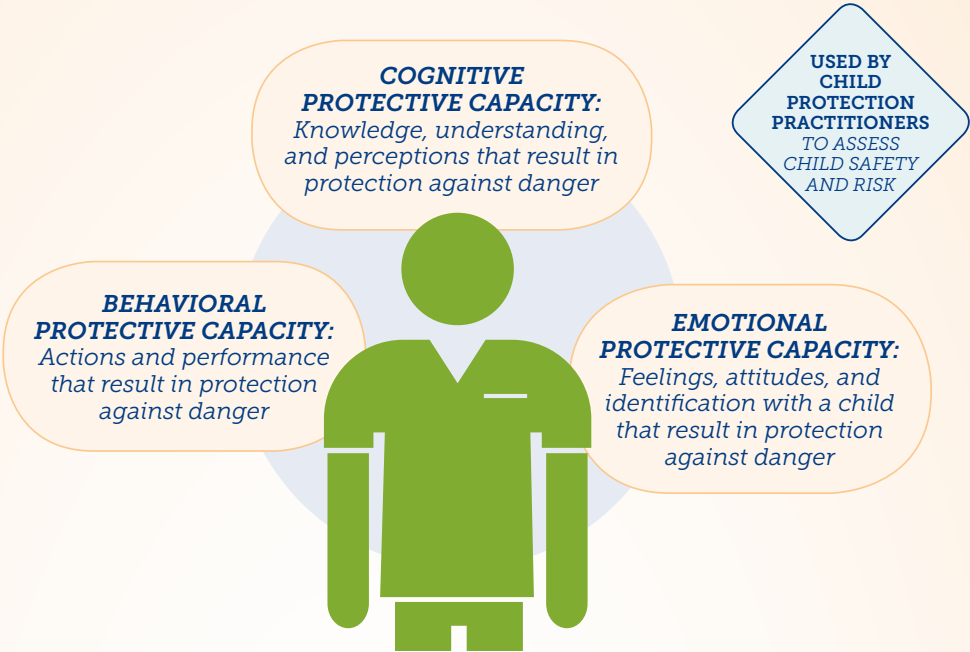
It goes beyond work with families. Appreciative inquiry is also an approach to supervision, coaching, and organizational change that mirrors solution-focused questions to help workers pay attention to what they are doing well and the good things they are already doing that they can use to grow their skills. It is an important parallel process for agencies.

Protective Capacities and Protective Factors: Common Ground for Protecting Children and Strengthening Families

Child welfare practitioners use varied but complementary frameworks for assessing child safety and working with families. A shared understanding of definitions and common ground can help strengthen consistency in services for families.

PROTECTIVE CAPACITIES FRAMEWORK

Protective capacities¹ are caregiver characteristics directly related to child safety. A caregiver with these characteristics ensures the safety of his or her child and responds to threats in ways that keep the child safe from harm. Building protective capacities contributes to a reduction in risk.



PROTECTIVE FACTORS FRAMEWORK

Protective factors² are conditions or attributes of *individuals, families, communities, or the larger society* that reduce risk and promote healthy development and well-being of children and families, today and in the future.



THE COMMON GROUND

Both frameworks are strength-based approaches to assess, intervene, and serve families. By promoting both protective capacities (at the individual level) and protective factors (at the individual, family, and community levels), we can best ensure child safety and promote child and family well-being.



Access more information through the Capacity Building Center for States at <https://capacity.childwelfare.gov/states> and Child Welfare Information Gateway at <https://www.childwelfare.gov>.

¹ ACTION for Child Protection conceptualized and developed the Caregiver Protective Capacities as a component of a comprehensive safety practice model called SAFE (Safety Assessment and Family Evaluation).

² The Children's Bureau uses a protective factors framework adapted from the Strengthening Families framework developed by the Center for the Study of Social Policy, with the addition of a sixth factor: nurturing and attachment.

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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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.

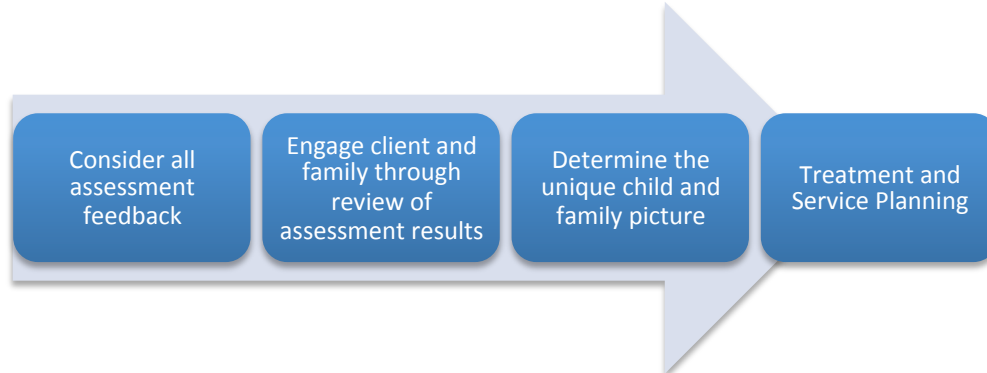
The CANS tool and scores can be used:

- ❖ 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;

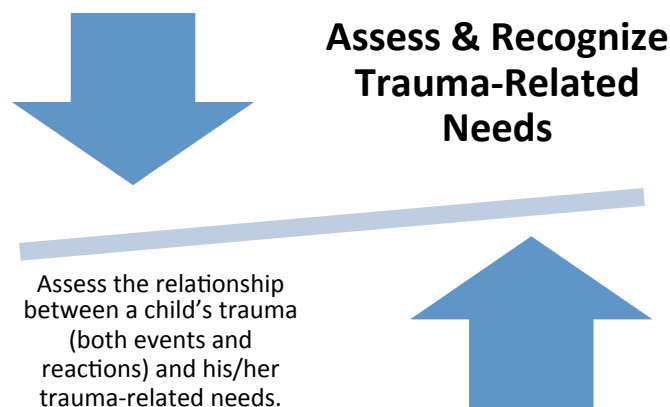
- ❖ To decide the best type of treatment, services, or placement for a child based on child/caregiver's needs;
- ❖ To monitor a child's progress in treatment or services over time.

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

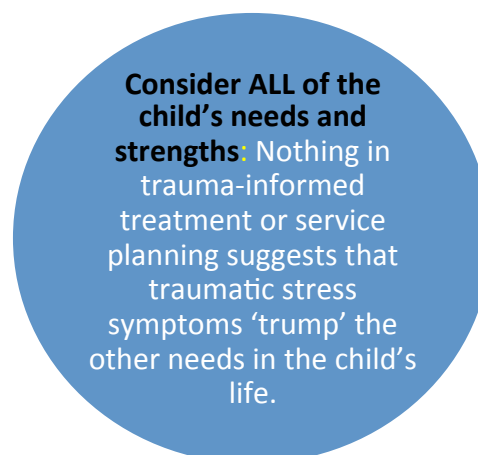
Overview of Trauma-Informed Treatment and Service Planning



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

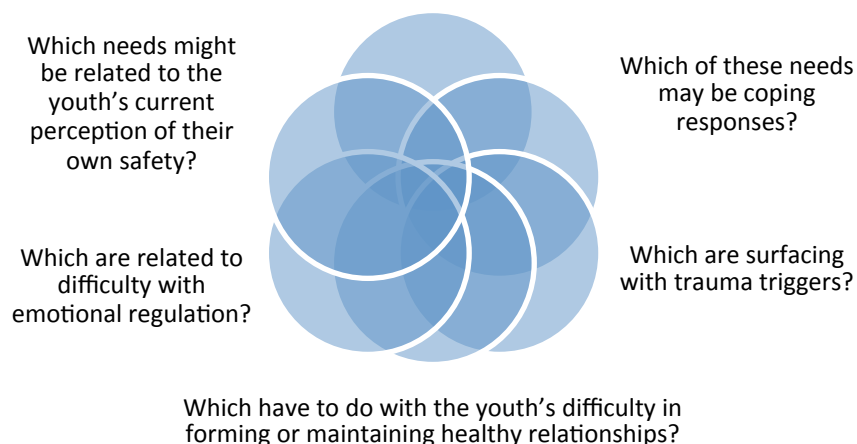


- ❖ STEP 2: Consider all of a child's needs and strengths when creating trauma-informed plans.



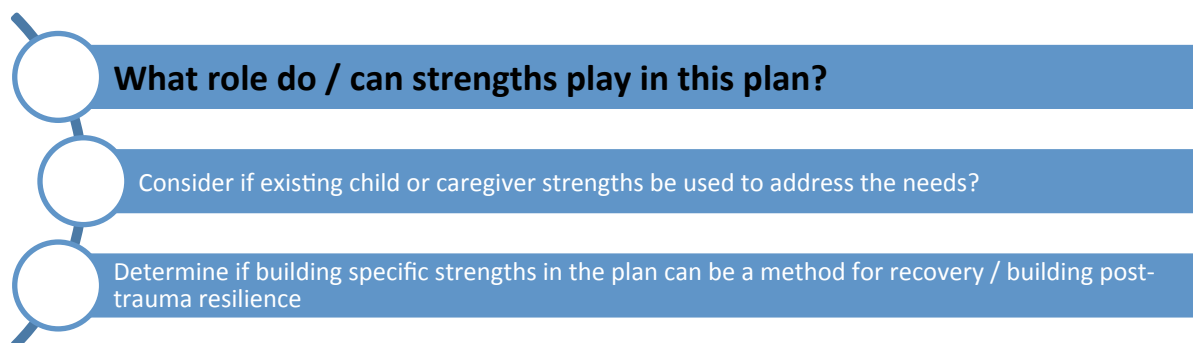
- ❖ STEP 3: Connect the dots between elevated needs and trauma experiences on the CANS using a trauma lens; share these connections with youth/families in a way that makes sense*.

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.

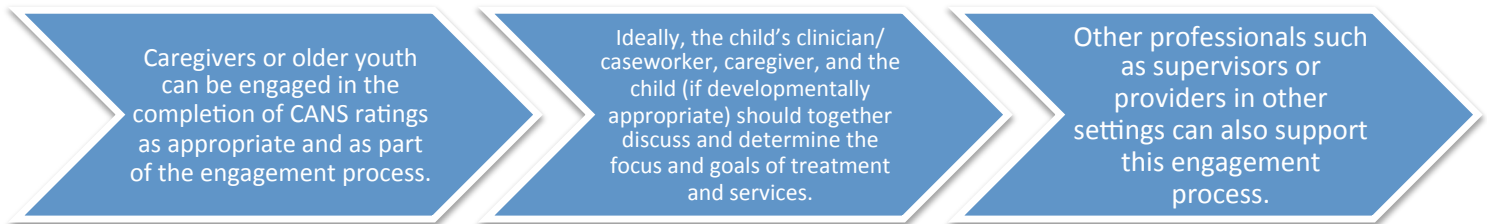


- ❖ STEP 5: Educate and collaborate with families and other providers about the potential role of trauma in relation to the child's identified needs/presenting problems.

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.

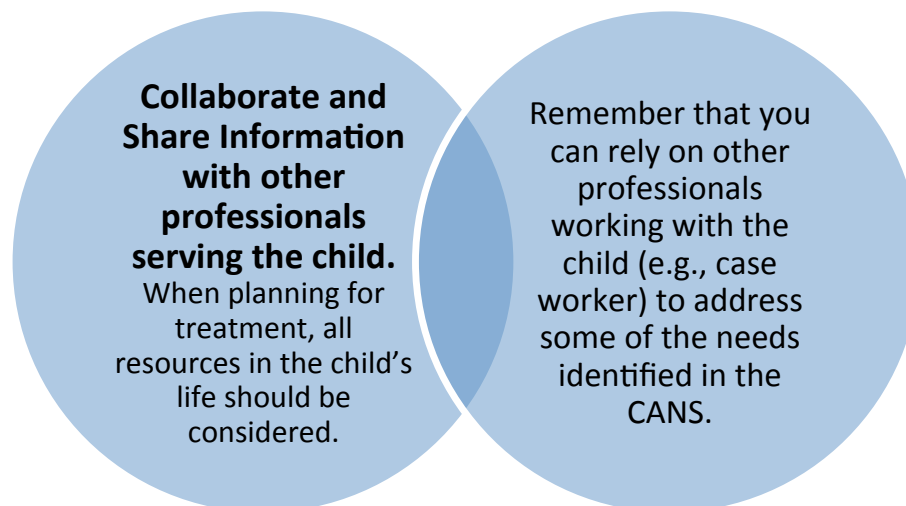
- ❖ STEP 6: Throughout the assessment process, engage youth and family members! Include the child and family in the treatment/service planning process at various stages and in meaningful ways. Once the CANS has been completed, the clinician/caseworker and child's family should work collaboratively to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

Integrate Youth and Family Engagement throughout the Process!

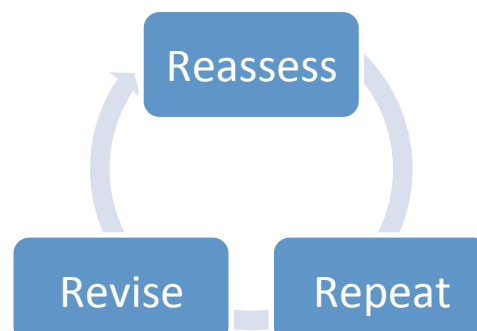


- ❖ STEP 7: Collaborate with other professionals serving the child.

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:

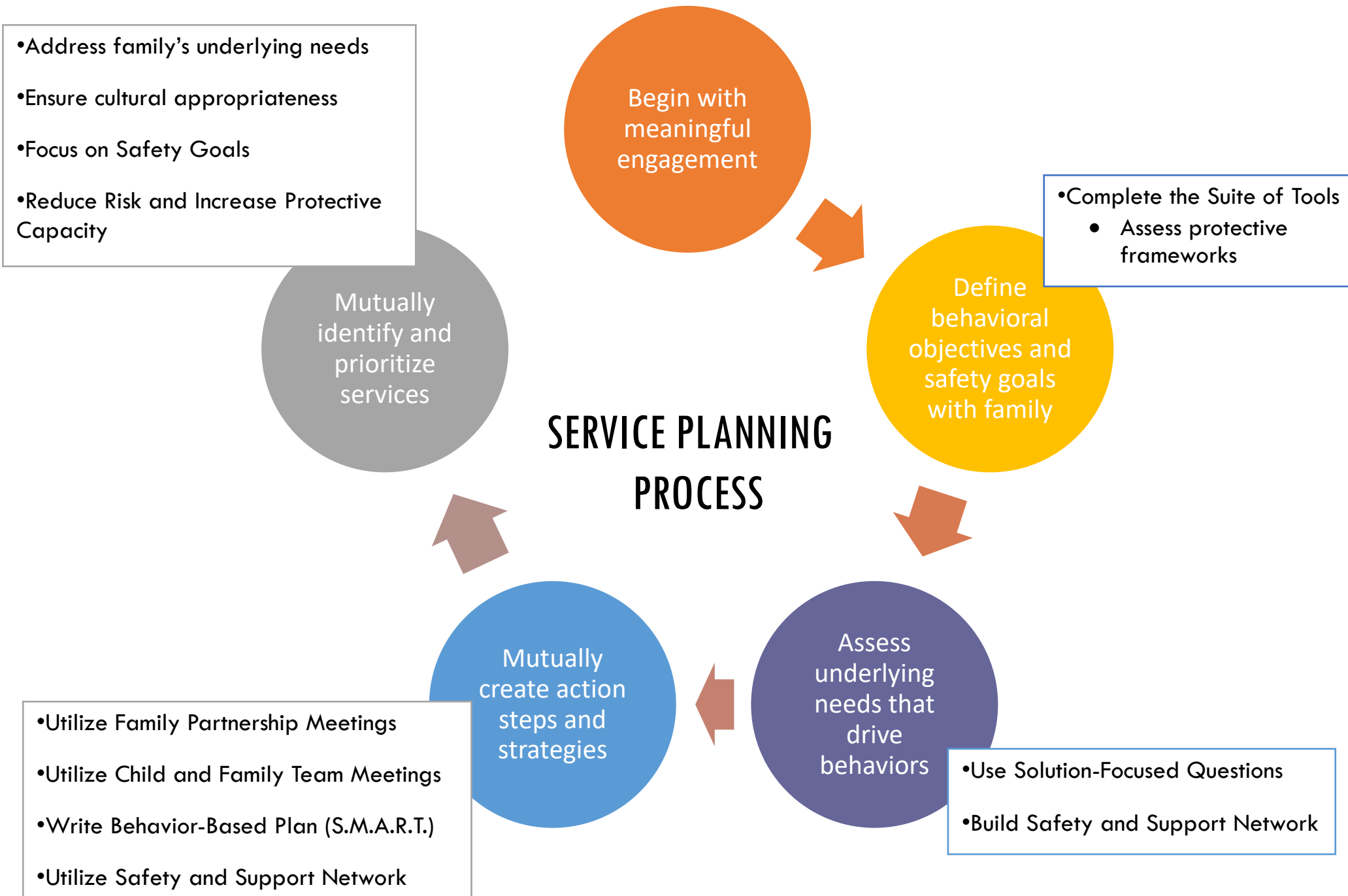
- ❖ Watch the child/caregiver's initial needs and note changes in needs over time, including the development of new needs
- ❖ Watch and better conceptualize/understand worsening of symptoms as they change together
- ❖ Watch to see if some symptoms peak prior to decreasing once in treatment or services (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.





Child and Adolescent Needs and Strengths (CANS) Reports

A Step by Step Technical Guide

Permanency Report

This report enables the Family Services Specialist to examine the Parent/Caregiver assessments across time. The Family Services Specialist may access the report for any child for whom he or she has completed an assessment.

Permanency Report Usage – Referral source must be DSS

- Comparison is conducted across both comprehensive and reassessments
- Comparison is conducted across all assessment reasons – Initial, Reassessment, Discharge
- Report items are generated from the Parent/Caregiver domain and Child Welfare module

Follow the steps below to generate a Permanency Report.

Step 1: On the menu bar at the top of the page, select the **Reports** tab to open the dropdown menu

Step 2: Select **Client Reports** from the dropdown list

Step 3: Select **Permanency**

Step 4: Select options for each of the editable filters (all of the filters are required)

- Dropdown list only populates with active caregivers attached to the selected child
 - Only closed assessments populate the field
 - Assessments are dated/time stamped by the system upon closing the assessment
- Select one caregiver (at a time) to compare across all assessments
 - Can compare as many as three assessments
 - Initial assessment populates as the first assessment
 - At least one calendar day must distinguish between Assessment 2 and Assessment 3
 - If two assessments were closed on the same date, the most recent (by time) should be selected (two assessments closed on the same date will not populate as the two most recent assessments)
 - The report will run if only two or one assessment is available
 - If no data is available to populate the assessment, the system will populate the report field with the message: *No Data Available*

Step 5: Select **View Report** on the top right corner of the screen

Note: The bottom portion of the report details the following:

- Issues resolved in the most recent period
 - Items for which the score changed from a 2 or 3 to a 0 or 1, in the most recent assessment
- Issues requiring continued intervention
 - Most recent assessment rating of 2 or 3
- If no items fall into these conditions, the message “None Noted” will appear

Permanency Report

State: Virginia Locality: Locality A Child Search: marian Child: Marian, Martin The (1221) Caregiver: T, T View Report

Report Date: 12/20/2017 12:22 PM CANVaS 2.0 Permanency Report Page: 1 of 5

Child Name: Martin Marion Caregiver Name: T, T
DSS ID #: testconsumer010 Caregiver Relationship: Sister

Notes:

This report will enable the user to examine the Parent/Caregiver assessment across time. The user will be able to generate this report for any child on their caseload with closed assessments.

Question	CANS Comprehensive - 0 - 4 12/05/2017	CANS Comprehensive - 0 - 4 12/19/2017	CANS Comprehensive - 0 - 4 12/20/2017
SUPERVISION	2	1	1
SAFETY	2	2	2
CONDITION OF THE HOME	1	3	0
MARITAL/PARTNER VIOLENCE IN HOME	1	1	2
HISTORY OF MALTREATMENT	1	2	1
RESPONSIBILITY IN MALTREATMENT	1	1	2

Individual Progress Report

This report enables the Family Services Specialist to review the individual child's assessments across time.

Individual Progress Report Usage – Referral source must be DSS

- Comparison is conducted across both comprehensive and reassessments
- Comparison is conducted across all assessment reasons – Initial, Reassessment, Discharge
- Available for all children in the system
- Generates for CANS 0-4 and CANS 5+ separately

Follow the steps below to generate an Individual Progress Report.

Step 1: On the menu bar at the top of the page, select the **Reports** tab to open the dropdown menu

Step 2: Select **Client Reports** from the dropdown list

Step 3: Select Individual Progress

Step 4: Select options for each of the editable filters (all of the filters are required)

- Dropdown list only populates with children receiving services within the locality
 - Only closed assessments populate the field
 - Assessments are dated/time stamped by system upon closing the assessment
- Select the child
 - Can compare as many as three assessments
 - Initial assessment populates as the first assessment
 - At least one calendar day must distinguish between Assessment 2 and Assessment 3
 - If two assessments were closed on the same date, the most recent (by time) should be selected (two assessments closed on the same date will not populate as the two most recent assessments)
 - The report will run if only two or one assessment is available
 - If no data is available to populate the assessment, the system will populate the report field with the message: *No Data Available*

Step 5: Select **View Report** on the top right corner of the screen

Individual Progress Report

Page: 1 of 2

Report Date: 2022/06/21 10:23 AM

Child Name: Pina Peach

DOB: 05/05/2014

Notes:

This report will enable the user to review the individual child's assessments across time.

Life Domain Functioning	Question	CANS Assessment: 5-6/13/2014	CANS Assessment: 5-6/27/2017	CANS Assessment: 5-6/25/2017
FAMILY		1	3	1
LIVING SITUATION		1	3	1
SLEEP		2	1	1
SOCIAL FUNCTIONING		2	1	1
SEXUAL DEVELOPMENT		0	0	1
RECREATION		1	1	1
DEVELOPMENTAL		0	0	1
COMMUNICATION		0	0	1
JUDGMENT		2	0	1
ACCOMMODATION		0	0	1
LEGAL		0	0	1
MEDICAL		0	0	1
PHYSICAL HEALTH		0	1	1
DAILY FUNCTIONING		0	0	1

For more information go to:

https://www.csa.virginia.gov/Content/pdf/CANVaS_2.0_Report_Manual.pdf

Child and Adolescent Needs and Strengths Assessment (CANS) – CANVaS 2.0 Reports Manual, Version 1.0