

**Colorado Title IV-E Waiver Final Evaluation Report  
Annex: Child Welfare Resiliency Center Program  
Evaluation Report**

7-County Consortium

Child Welfare Resiliency Center  
Program Evaluation Final Report

September 2018



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# Child Welfare Resiliency Center Program Evaluation Report

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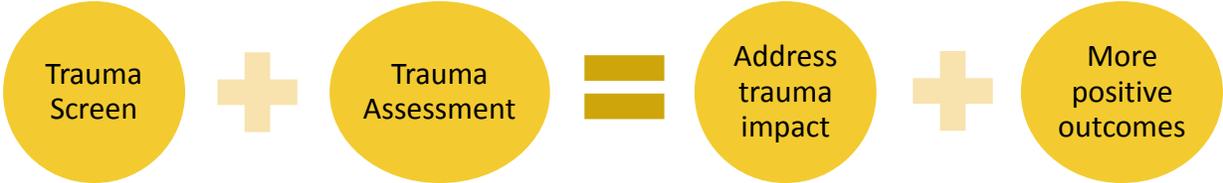
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# 1. Introduction

This report presents evaluation findings of the 7-County Child Welfare Resiliency Center (CWRC) trauma-informed practice intervention. In mid-2015, the Colorado Department of Human Services (CDHS) invited proposals for an expansion of existing Title IV-E Waiver Demonstration Projects. Seven counties (Arapahoe, Boulder, Denver, Douglas Eagle, Jefferson and Larimer) submitted a proposal as a Consortium to expand their trauma-informed child welfare practice. This proposal was funded and led to the 7-County Child Welfare Resiliency Center.

The goal of the CWRC was to expand trauma-informed practice to include in-depth assessment of trauma to enable serving more children and youth safely at home, with kin or in foster care, rather than in congregate care settings. In the first quarter of 2015, prior to initial implementation of the CWRC intervention, 28% of children statewide were placed in congregate care, compared to 27% for Consortium counties (CDHS Community Performance Center, 2018). The CWRC adapted a model for trauma-focused screening and assessment of child and youth, in addition to ongoing data collection and assessment of child well-being, a first for public child welfare practice in Colorado. The figure below depicts an overview of the CWRC intervention and a more detailed logic model may be found in Appendix 1.



Grounded in the philosophy that children are best cared for within the family system and their community, the CWRC sought to demonstrate that children and youth can be successfully maintained in their own homes, or kin/foster homes if the impact of trauma is addressed via meeting a young person’s developmental, emotional, and cognitive needs. Although specific to juvenile justice, some evidence suggests that system-involved youth with trauma histories and greater mental health needs are more likely to be placed in more restrictive placement settings. Espinosa, Sorensen, and Lopez (2013) examined a sample of 34,222 youth referred to juvenile probation departments in Texas to investigate the role of gender and mental health service need on out-of-home placement. Trauma indicators were one of the most significant predictors of the severity out-of-home placement. While researchers found that boys were placed deeper in the juvenile justice system than girls, regardless of gender, trauma history was the most influential factor in making placement decisions (Espinosa et al., 2013).

Accordingly, key components of the CWRC intervention involved comprehensive trauma screening and assessment, which aimed to assess a child or youth’s needs, challenges and strengths. Each county identified their own target population for the intervention, for which further details may be found in Appendix 2. Seeking to utilize expertise from both child welfare and behavioral health, the intervention relied heavily on coordination and collaboration between public child welfare agencies, community mental health centers (CMHCs) and independent providers, depicted in the figure below. Child welfare caseworkers conducted trauma screens and collected data on well-being, and referred youth who met screen-in criteria to a mental health service partner who conducted in-depth trauma assessments. After completing an assessment, assessing clinicians provided a summary report to the child, family and child welfare caseworker that included recommendations addressing a comprehensive range of needs and in-home parenting strategies.



Clinicians at the Child Trauma Resilience and Assessment Center (CTRAC) at Colorado State University led the development and implementation of conducting trauma assessments, and also trained and certified other clinicians in Consortium counties to conduct assessments for the intervention. CTRAC adapted methods developed by Dr. Jim Henry at the Southwest Michigan Children’s Trauma Assessment Center at Western Michigan University to formalize the assessment model used for the CWRC intervention.

Implementation fidelity was reviewed monthly via project meetings of representatives from each county, including child welfare and behavioral health services. Two additional meetings were also held each month to focus on aspects of implementation, including a meeting of trauma care coordinators to focus on coordination between system partners, and a meeting of the evaluation sub-committee that focused on data collection and reporting for evaluation

purposes. A greater description of data sources used for the evaluation may be found in Appendix 3.

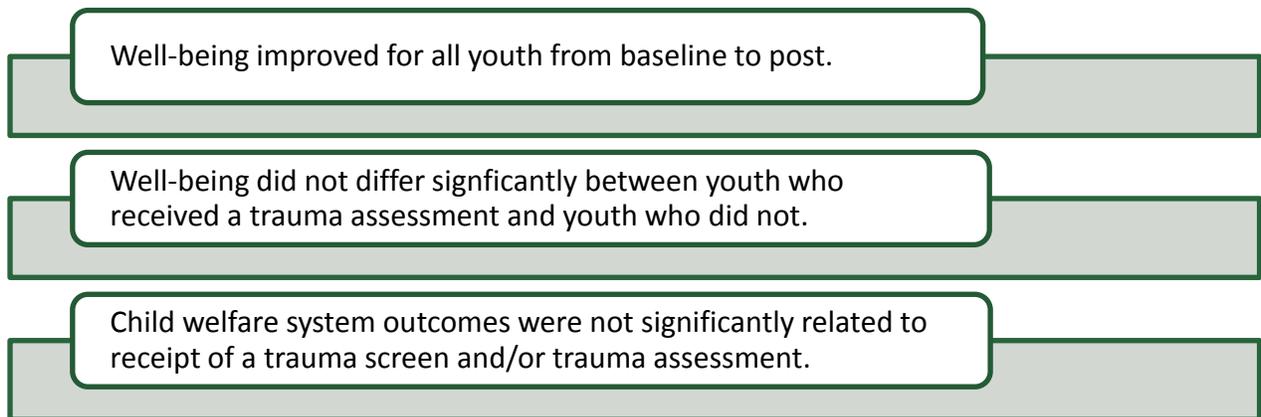
By the end of the two-year timeframe, the CWRC expected fewer youth in out-of-home care, particularly congregate care, and greater utilization of a more comprehensive array of services targeting the effects of complex trauma on children and youth. It was also anticipated that the project would help to enhance partnerships across community and systems partners, including behavioral health, the courts and county human service agencies.

## 2. Summary of Findings – At a Glance

### 2.1. Outcomes Evaluation

Overall, significant improvements were found in average scores from baseline to post across TOP domains, suggesting changes in well-being among youth from baseline to post. However, no meaningful differences in well-being were found between youth who received an assessment and youth who did not.

Receipt of a trauma screen and/or trauma assessment was also not found to be predictive of child welfare system outcomes, specifically: subsequent referral, assessment, involvement with Division of Youth Services (DYS), or commitment (following involvement with DHS).



### 2.2. Process Evaluation

As displayed in Table 1 on the following page, over 1,000 youth were screened for the CWRC intervention during the evaluation period. More than two-thirds of youth ( $N = 677$ ) screened-in and were referred for an in-depth trauma assessment and 450 youth were assessed. An additional 127 assessments were planned and a total of 174 closure surveys were completed at

the time of this report. Trauma-focused parenting, trauma-focused CBT and art therapy were the most common trauma-informed treatments recommended for youth who were assessed. Individual and family therapies were the most common traditional services recommended.

**Table 1: Trauma Screens, Trauma Assessments, Closure Surveys, Treatment and Services**

Trauma SCREENS	Trauma ASSESSMENTS	Closure Surveys	Treatments and Services
<p><b>1,029 youth</b></p> <ul style="list-style-type: none"> <li>• 121 screened in, not referred</li> <li>• 677 screened in, referred</li> <li>• 231 screened out</li> </ul>	<p><b>577 youth</b></p> <ul style="list-style-type: none"> <li>• 127 planned</li> <li>• 450 assessed</li> </ul>	<p><b>174 youth</b></p> <ul style="list-style-type: none"> <li>• Closure surveys available for 174 youth</li> </ul>	<p><b>Trauma-Focused</b></p> <ul style="list-style-type: none"> <li>• Trauma-focused parenting</li> <li>• Trauma-focused CBT</li> <li>• Art therapy</li> </ul> <p><b>Traditional</b></p> <ul style="list-style-type: none"> <li>• Individual therapy</li> <li>• Family therapy</li> </ul>

### 3. Outcome Evaluation

The following section presents findings from the outcomes evaluation of the CWRC intervention. Two types of outcomes were examined for this evaluation: child and youth well-being and child welfare system outcomes.

#### 3.1. Measuring Well-being

For purposes of the CWRC intervention, data on child and youth well-being were collected using two separate measures: the Treatment Outcome Package (TOP) and the Child and Adolescent Needs and Strengths Tool (CANS). Both of these measures are currently, and previously have been, used elsewhere by community-based providers and child welfare agencies to assess child well-being, identify trauma exposure and mental health needs, and aid in service planning (Rosenbalm et al., 2016). Both also provide a unique advantage by gathering information from multiple sources in order to gain a comprehensive view of a young person’s functioning.

A total of 840 youth were represented in the TOP data and 43 youth in the CANS data. Overall, youth had an average of three “TOP events” during the evaluation period. Caseworkers were the most common type of rater who completed TOPs for the intervention, followed by youth, parents and clinicians.

### 3.2. Summary of Findings

Overall, significant improvements were found from baseline to post across TOP domains, suggesting changes in well-being among youth from baseline to post. However, no meaningful differences in well-being were found between youth who received an assessment and youth in the control group. Positive changes in well-being found among youth in both groups indicate that while youth in the treatment group did not differ significantly from youth in the control group, the well-being of youth across both groups improved over time.

### 3.3. Administration of the Treatment Outcome Package (TOP)

The TOP measure was used to assess child and youth well-being by six of the seven counties involved in the CWRC intervention, including: Arapahoe, Denver, Douglas, Eagle, Jefferson and Larimer. TOP data were collected on a total of 840 youth for the current evaluation. While each county differed slightly in timeframes for administering the TOP, each county generally completed a TOP at case opening and every 90 days thereafter. More detailed information regarding each county’s criteria for administering the TOP may be found in Appendix 4.

Each TOP administration involved TOP surveys completed by multiple persons (or “raters”), referred to in this report as a “TOP event.” Typically leading TOP events, caseworkers completed close to one-third of all TOP surveys completed (N=10,886), followed by youth, parents and clinicians, depicted further below.



The figure below presents the average number of TOP events for each youth, overall and by county. Youth in Denver and Eagle had data collected for the fewest TOP events, on average, while youth in Jefferson and Larimer counties had data collected for the most. Overall, youth had data collected for an average of three TOP events.

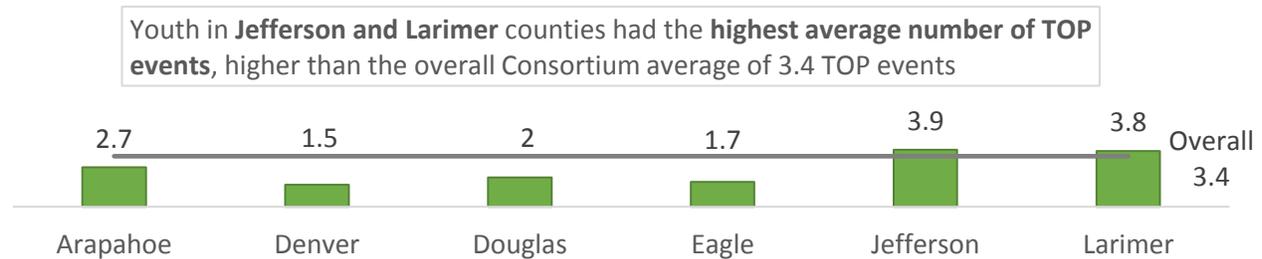


Table 2 presents data on the total number of TOP surveys (as opposed to TOP events) and most common categories of raters who completed surveys in a given county. Not surprisingly, with the exception of Eagle, caseworkers were the most common category of rater represented in the TOP data, likely due to their role in leading the TOP administration process. Other common raters included: youth, parents, non-relative placement providers, clinicians and Guardian ad Litem (GALs).

**Table 2: Total Youth with TOPs and Top 3 Common Categories of TOP Raters by County**

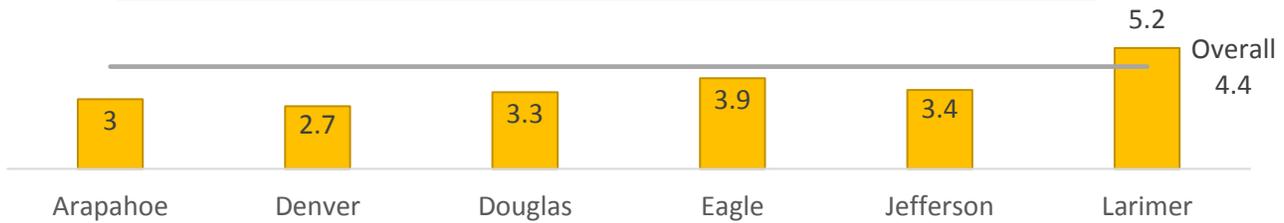
	<b>Arapahoe</b>	<i>n</i> =118	<b>Denver</b>	<i>n</i> =87	<b>Douglas</b>	<i>n</i> =172
1st	Caseworker	100%	Caseworker	100%	Caseworker	100%
2nd	Placement	26.2%	Clinician	41.4%	Clinician	43.0%
3rd	Youth	20.3%	GAL	28.7%	Parent	34.9%

	<b>Eagle</b>	<i>n</i> =23	<b>Jefferson</b>	<i>n</i> =659	<b>Larimer</b>	<i>n</i> =2135
1st	Parent	100%	Caseworker	100%	Caseworker	100%
2nd	Caseworker	82.6%	Youth	29.9%	Youth	60.0%
3rd	Youth	65.2%	Clinician	26.9%	Parent	44.4%

Larimer County completed the greatest number of TOP surveys with youth (*N* = 2,135), and also averaged the highest number of raters per TOP event, depicted in the figure below. Overall, CWRC counties averaged slightly more than four raters per TOP event.

Larimer had the **highest average number of raters** involved in a given TOP event, higher than the overall Consortium average of 4.4 raters



### 3.4. Administration of Child and Adolescent Needs/Strengths (CANS)

Boulder was the sole county to use the CANS measure. An initial CANS was completed with each youth eligible for services with the CWRC intervention at case opening, and every six months thereafter throughout the duration of the case. Additional information regarding Boulder’s criteria for administering the CANS may be found in Appendix 5. Due to differences in administration, similar data describing raters and events are not available for the CANS.

### 3.5. Examining Child and Youth Well-being

To examine youth wellbeing, TOP data were analyzed to determine whether changes in well-being occurred between baseline and post for youth who received a trauma assessment (defined as the treatment group) and youth who did not (defined as the control group). The Lime Survey platform was utilized to collect data on referrals and completion of assessments, which were used to identify whether a youth received an assessment. Average changes in well-being among youth were also compared between treatment and control groups. Following is the methodology that was used to identify the number of TOP events for each youth.

- 1) Treatment group
  - a. Youth who received a trauma assessment and had TOP ratings available
  - b. Identification of average baseline and post-assessment TOP ratings for youth
    - i. Baseline – Averaged TOP scores across all domains and given by raters associated with closest caseworker TOP to a youth’s date of referral for trauma assessment
    - ii. Post – Averaged TOP scores across all domains and given by raters associated with latest caseworker TOP available for a youth
- 2) Control group
  - a. Youth who did not receive a trauma assessment and had TOP ratings available
  - b. Identification of average baseline and post TOP ratings for each youth
    - i. Baseline – Averaged all TOP ratings associated with first caseworker TOP

ii. Post – Averaged all TOP ratings associated with last caseworker TOP

A timeframe for a “TOP event” was defined to include 15 days prior/30 days after a caseworker TOP survey. After removing records to only include youth with at least two TOP events to allow for a pre- and post- comparison, the current analysis consisted of 266 youth who received a trauma assessment and 339 youth who were not assessed, for a total of 605 youth.

**Table 3: TOP Data Summary Statistics by County**

County	# of Youth, by Group		Age			Gender
	Control	Treatment	Min	Average	Max	% Female
Arapahoe	1	23	3	15	21	44
Denver	0	13	7	14	19	46
Douglas	42	3	6	17	20	39
Eagle	0	3	12	14	16	67
Jefferson	60	48	9	17	21	36
Larimer	236	176	1	14	21	42
<b>Overall (N=605)</b>	<b>339</b>	<b>266</b>	<b>1</b>	<b>15</b>	<b>21</b>	<b>42</b>

Data in Table 4 indicate improved functioning at post compared to baseline across all domains. Lower scores represent better functioning and higher scores represent worse functioning.

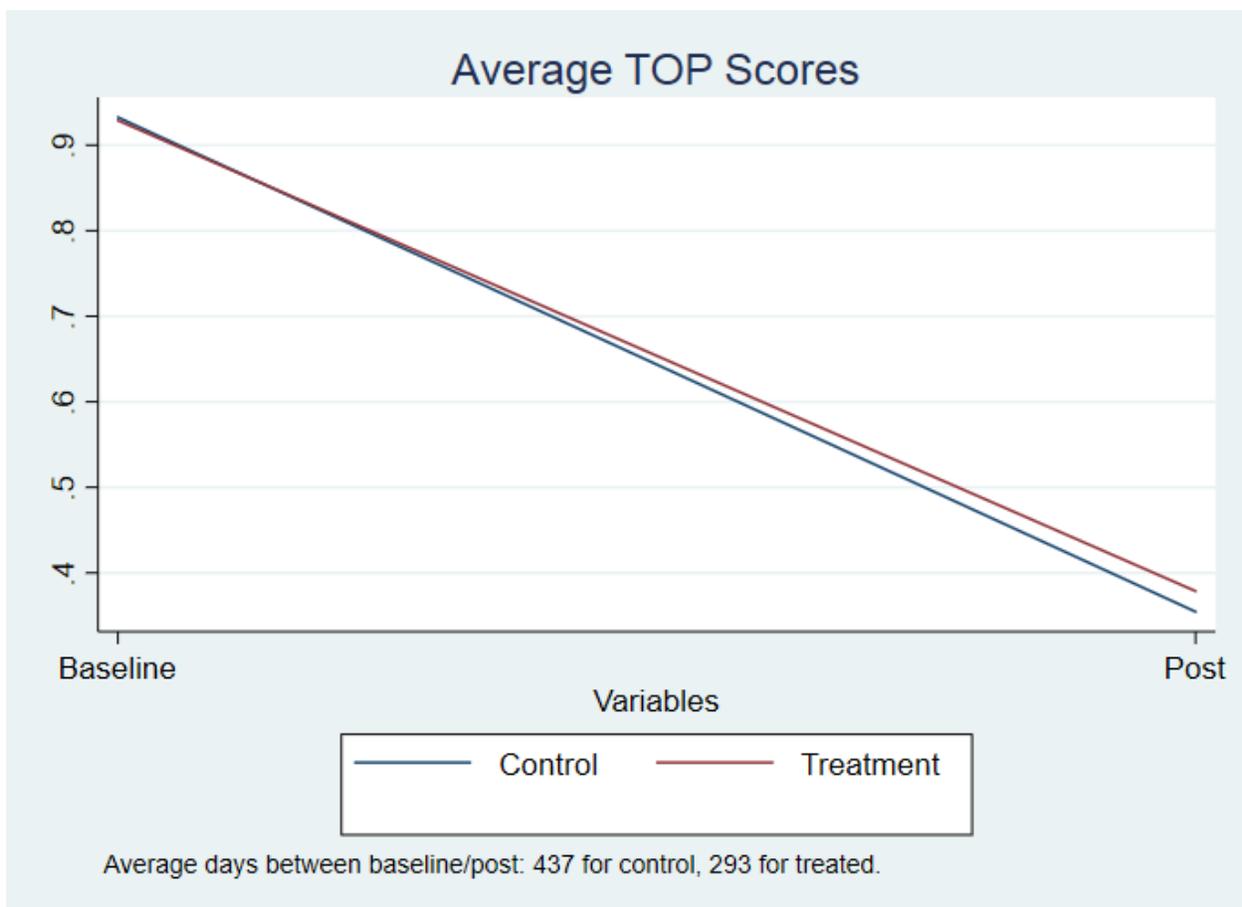
**Table 4: Average TOP Scores (Overall)**

Domain	Baseline			Post			
	Sample (Control / Treatment)	Average	St. Dev.	Domain	Sample	Average	St. Dev.
ADHD	312 / 248	1.05	1.23	ADHD	327 / 257	.52	.89
ASRTV	113 / 97	-.07	.98	ASRTV	105 / 100	-.43	.78
BOWEL	102 / 98	.49	1.91	BOWEL	106 / 100	.23	1.70
CNDCT	317 / 256	1.79	3.47	CNDCT	333 / 263	.94	2.81
DEPRS	306 / 251	1.00	1.29	DEPRS	325 / 255	.25	1.08
MANIC	196 / 148	-.24	.78	MANIC	219 / 154	-.62	.63
PSYCS	302 / 247	.61	1.58	PSYCS	325 / 257	.05	1.04
SEPAX	96 / 95	.52	1.24	SEPAX	103 / 98	.00	1.03
SLEEP	302 / 245	.53	1.28	SLEEP	325 / 253	-.11	.96
STRNG	113 / 97	1.49	1.42	STRNG	106 / 103	.95	1.28
SUICD	303 / 248	1.10	2.18	SUICD	322 / 255	.36	1.33
SA	205 / 155	1.90	3.61	SA	222 / 157	1.17	2.82
UNEAT	109 / 97	.02	.86	UNEAT	105 / 97	-.27	.75
VIOLN	311 / 250	.85	2.07	VIOLN	328 / 262	.11	1.28
WORKF	207 / 157	.85	1.25	WORKF	224 / 160	.17	1.12
SEXWR	311 / 252	.55	1.00	SEXWR	325 / 258	.39	.74
SCONF	206 / 158	1.73	1.10	SCONF	224 / 159	.96	1.10

### 3.5.1. TOP Analysis Results

Analysis of variance (ANOVA) was conducted to analyze the TOP data, examining changes in youth well-being from baseline to post and then comparing average change in well-being between youth receiving the trauma assessment and youth in the control group. A full description of the domains measured by the TOP may be found in Appendix 4. A summary of these results is displayed in Figure 1 below. Overall, significant improvements were found in average scores from baseline to post across every TOP domain; however, no meaningful differences were found between youth receiving the assessment and youth in the control group. Some outcomes trended towards showing stronger declines for assessed youth, but these results were likely by chance due to the high number of outcomes tested. Therefore, Figure 1 displays TOP scores averaged across domains to illustrate the overall similarities between treatment and control groups, including improvements in TOP scores over time.

**Figure 1: Average Top Scores**



### 3.5.2. CANS Data

Boulder was the only CWRC county to use CANS to measure child well-being. Due to differences in data collection and how each measure is structured, youth in Boulder were not included in the analysis of well-being above. To analyze the CANS data, data were first filtered to only keep records for youth with more than one observation. A youth’s “Initial” record was used as a baseline score, and the last record available (by date) as a post score. Overall, 43 youth had both a baseline and post score for 5 of 14 domains measured by CANS: *Life Domain Functioning, Strengths, Cultural Factors, Behavioral/Emotional Needs* and *Risk Behaviors*. Refer to Appendix 5 for a list of domains and items measured by CANS. More than half of youth represented in the CANS data were male, and the average age was 14 years.

**Table 5: CANS Data Summary Statistics**

County	Sample Size	Age			% Female
		Min	Average	Max	
Boulder	43 youth	5	14	17	42

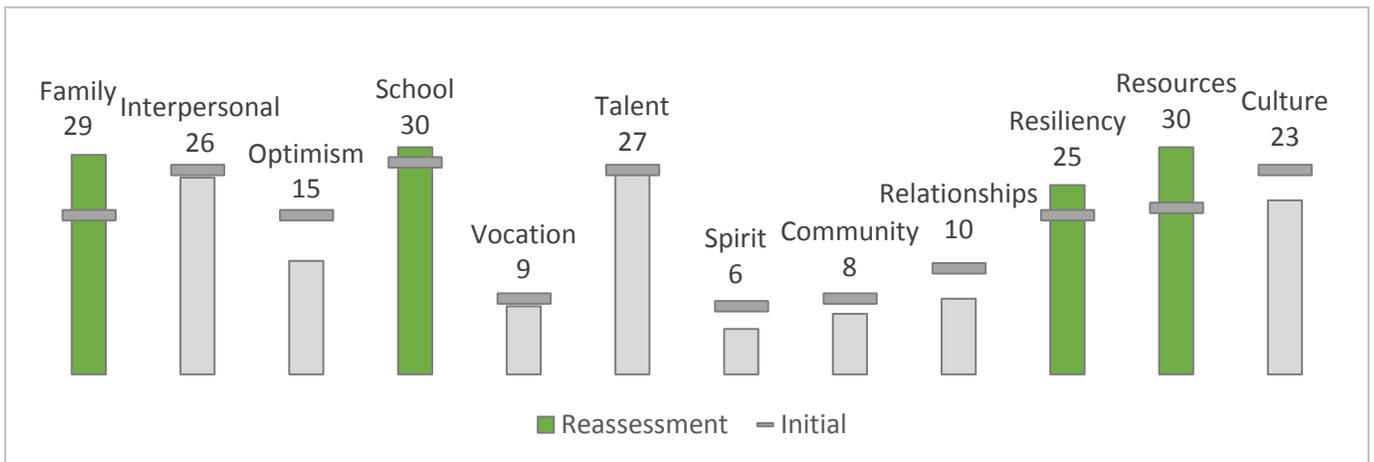
Due to the small number of observations precluding the option for a more rigorous analysis, four domains that had pre- and post-data for all 43 youth were examined to compare the number of youth exhibiting positive functioning at their initial CANS to the number of youth functioning positively at re-assessment. The *Cultural Factors* domain also had data for all 43 youth but was not examined further due to no change in average score between Initial and Reassessment CANS, as shown in Table 6 below. Overall, results were mixed, and provide limited insight into the wellbeing or functioning of youth represented in the CANS data.

**Table 6: CANS Data Average Overall Domain Scores at Initial and Reassessment**

	Initial					Reassessment				
	N	Mean	St. Dev.	Min	Max	N	Mean	St. Dev.	Min	Max
Life Domain	43	17.7	5.7	3	30	43	18.0	5.8	3	28
Strengths	43	20.6	4.6	9	30	43	21.5	4.2	13	33
Cultural Factors	43	0.6	1.0	0	3	43	0.6	1.1	0	5
Behavioral/Emotional	43	12.2	3.8	3	18	43	13.2	3.9	5	21
Risk	43	5.6	3.2	0	14	43	6.1	3.1	0	13
Trauma	20	6.4	1.4	4	9	41	6.2	1.6	3	9
Traumatic Stress	20	5.5	4.2	0	13	41	5.8	4.1	0	14
Substance Use	14	10.4	1.8	7	14	26	8.3	4.1	0	14
Violence	12	13.8	6.3	0	23	23	13.7	6.7	0	23
Runaway	11	9.8	5.8	0	19	31	7.8	5.4	0	19
Juvenile Justice	17	7.7	3.2	2	13	34	7.1	3.9	0	13

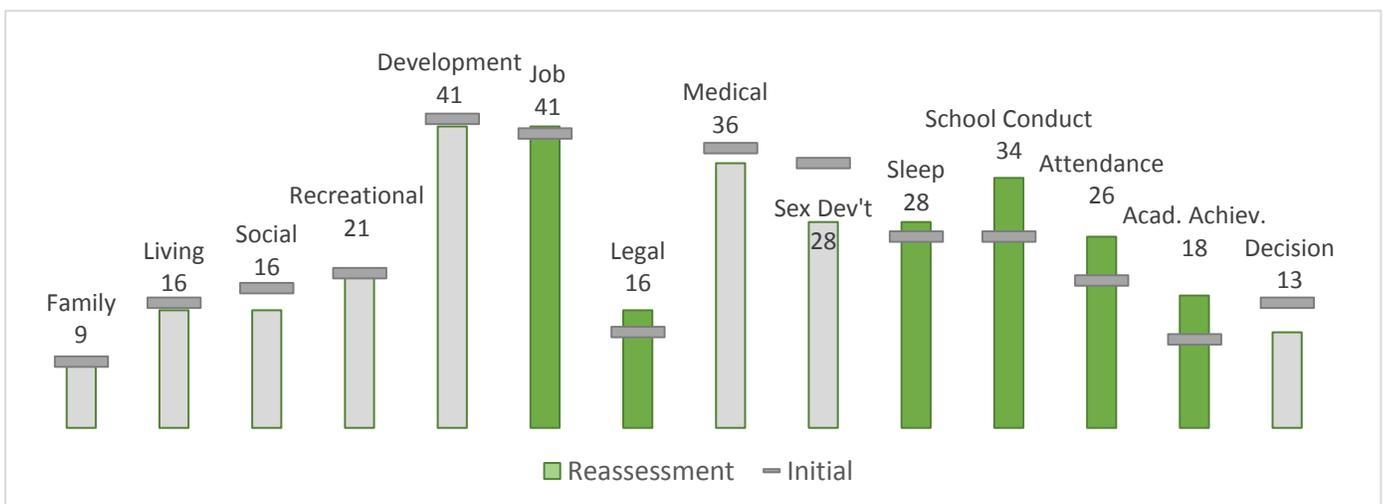
Beginning with the Strengths domain, of the 12 areas measured, four areas saw greater numbers of youth functioning positively at Reassessment compared to Initial, including: *Family*, *Educational Setting*, *Resiliency* and *Resourcefulness*. In regards to the Life Functioning domain, more than half (8) of the domain items experienced decline or no change in the number of youth functioning positively, while six items increased in number: *Job Functioning*, *Legal*, *Sleep* and *School Behavior*, *Attendance* and *Achievement*. Specific change between Initial and Reassessment for each domain are presented in the figures below.

**Figure 2: Youth Strengths**



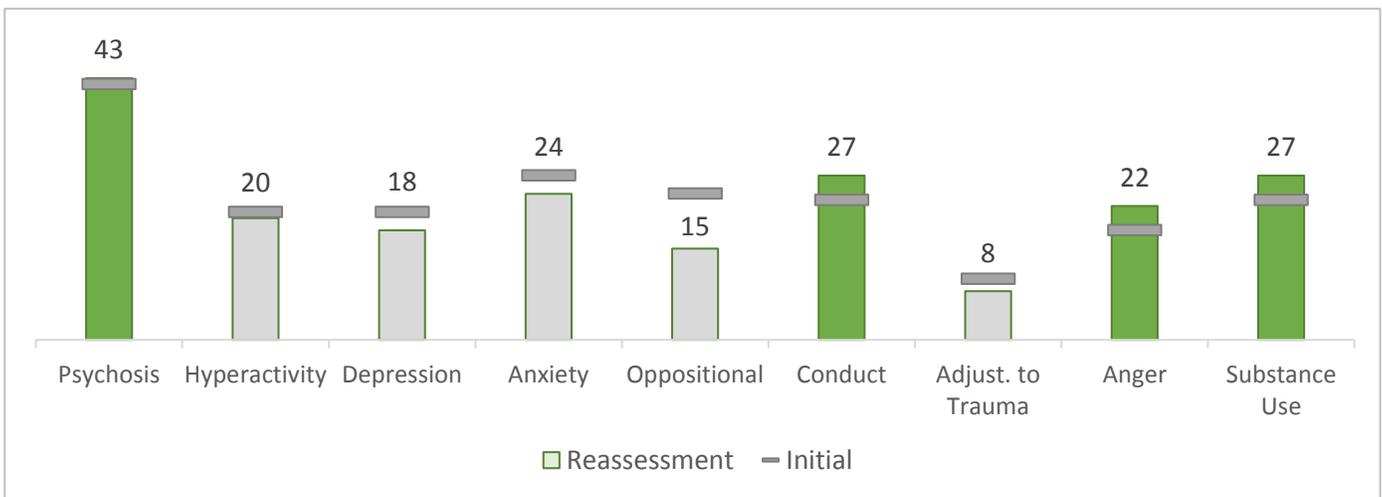
Dashes = youth with positive functioning at Initial CANS.  
 Columns = youth with positive functioning at Reassessment (numbers represent Reassessment).  
**Green** columns = # youth functioning well at Reassessment > # youth functioning well at Initial.

**Figure 3: Life Domain Functioning**



The next domain, related to Behavioral and Emotional needs, increased in the number of youth functioning positively in four of the nine areas measured, including: *Psychosis, Conduct, Anger Control* and *Substance Use*. Almost all youth represented indicated no service need in the area of Psychosis at baseline, and no youth had indicated need in this area at Reassessment. Finally, more than half (5) of the nine items measured in the Risk Behaviors domain saw an increase in the number of youth doing well at Reassessment, including: *Suicide Risk, Non-Suicidal Non-Self Injurious Behavior, Danger to Others, Sexual Aggression* and *Delinquent Behavior*.

**Figure 4: Youth Behavioral/Emotional Needs**



Dashes = youth with positive functioning at Initial CANS.  
 Columns = youth with positive functioning at Reassessment (numbers represent Reassessment).  
**Green** columns = # youth functioning well at Reassessment > # youth functioning well at Initial.

**Figure 5: Youth Risk Behaviors**



### 3.6. Child Welfare Outcomes

In addition to youth well-being, the outcomes evaluation also examined child welfare outcomes. Specifically, data were analyzed to evaluate the trauma screen and assessment as an intervention for preventing subsequent involvement with child welfare and youth services among youth already engaged in the system. A somewhat natural experiment occurred during implementation, where some youth did not receive a trauma assessment due to lack of capacity, and allowed for group comparisons. Child welfare outcomes that were examined include: subsequent referral, assessment, involvement with DYS, and commitment to DYS.

Since receipt of a trauma screen and assessment were based on certain criteria and not randomly administered to youth, the likelihood of systematic selection into the treatment group (youth who received a trauma screen and assessment) was potentially dependent on preexisting characteristics, such as prior involvement with child welfare services. To account for the possibility of selection bias, STATA software's *eteffects* package was used to analyze the data, a method that accounts for selection bias by first estimating the probability of receiving treatment as a function of covariates, and then estimating the likelihood of an outcome based on covariates and the treatment variable. Covariates included: prior involvement with child welfare (e.g., number of prior referrals before receiving treatment as a predictor of subsequent referral), ethnicity (Hispanic, African American, other), age, and gender. Prior number of cases was also included when modeling each outcome.

Two sets of analyses were conducted, in which the treatment group was defined to include youth who received both the trauma screen and assessment of the CWRC intervention. The first analysis compared outcomes of youth in the treatment group to youth in a control group consisting of youth eligible for treatment but never received a trauma screen or assessment. The second analysis compared youth in the treatment group to a second control group that included youth who screened in, but never received the CWRC intervention assessment. Across both analyses, we found no evidence for the trauma screen and assessment as a predictor of subsequent child welfare involvement outcomes. We were interested in analyzing the potential effect of treatment on other child welfare involvement outcomes, including remaining home during child welfare involvement, removal from home, and open case, but were unable due to inadequate sample size.

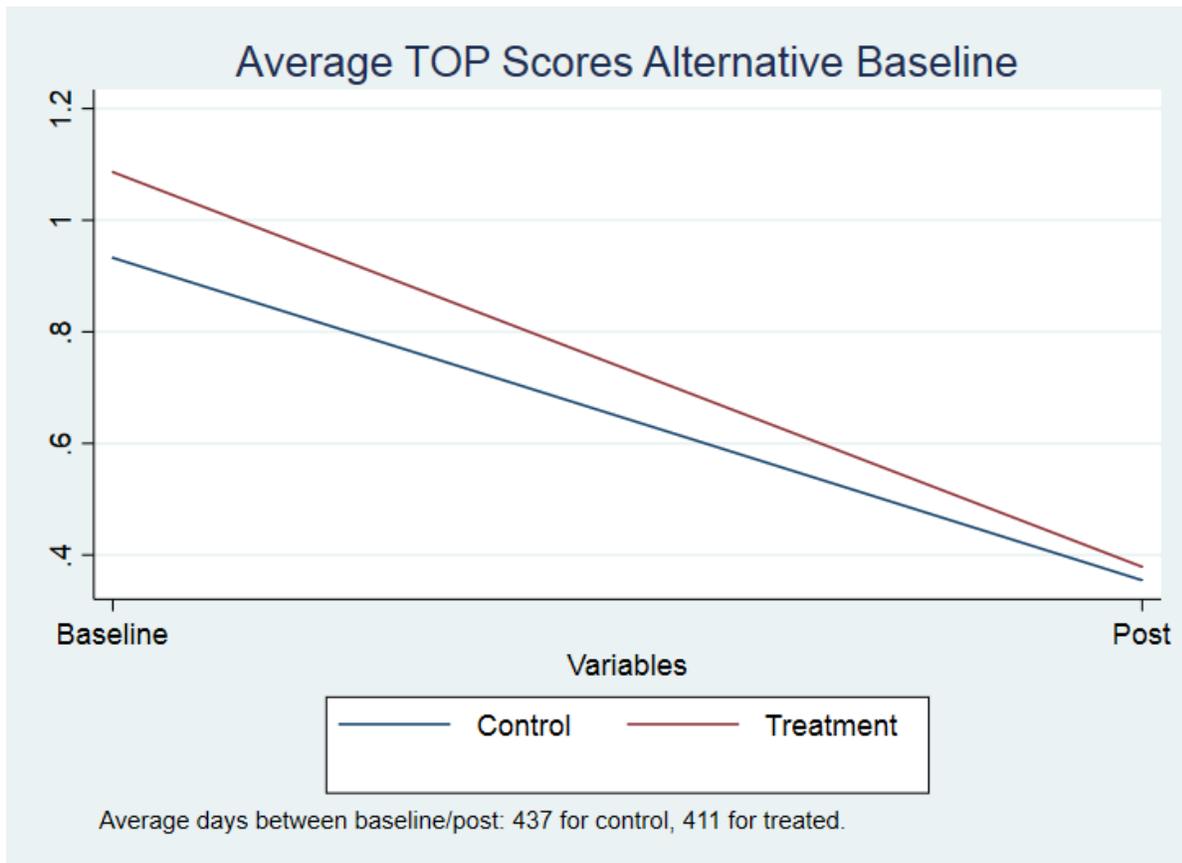
### 3.7. Discussion

Overall, evaluation results provide limited insight into child welfare outcomes or the well-being of youth involved in the CWRC intervention and should be interpreted with caution. In regards to the CANS, small sample size precluded the ability to analyze the data more rigorously. Regarding the TOP measure, while there clearly was a meaningful decline in TOP scores (where lower TOP scores reflect more positive functioning and higher TOP scores reflect worse functioning), the analysis was limited by the non-experimental design of the evaluation. In an effort to address this concern, youth involved in the CWRC intervention who did not receive an assessment were used to create a control group, primarily represented by Douglas, Jefferson and Larimer counties. However, the number of days between baseline and post TOP scores for the control group was much higher than for youth receiving a trauma assessment, suggesting the potential for marked differences between groups. Due to this discrepancy, a second set of ANOVAs was conducted using the first TOP event for each youth (see Figure 6 on the following page), as opposed to the TOP event closest to the trauma assessment date (as in the first ANOVA analysis). Using the first TOP event, the average number of days between baseline/post scores for the treatment group was 411, comparable to the control group's average of 437.

Regardless of the baseline selection method for treated youth, the analysis found little evidence that youth receiving a trauma assessment fared better than youth not receiving one, *overall*. However, the second set of ANOVA analyses revealed a few marginally significant differences that may be worth exploring further. Specifically, physical violence (p-value: .04), school functioning (.05), sexual acting out (.05), suicidal ideation (.08), assertiveness (.10), depression (.11), separation anxiety (.12) all approached significance. If it is indeed the case that youth exhibiting *greater symptoms of trauma are more likely to receive an assessment*, then the comparable outcomes at follow-up suggest greater declines in symptomology from baseline to follow-up for youth in the treatment group (Figure 6). Such instances may be masked in the outcomes analyses due to low power.

The practical implications of the TOP analysis is that the trauma symptomology of youth served in the seven counties were successfully reduced during implementation of the trauma-informed intervention. The fact that youth who do not receive the trauma assessment are also improving is likely indicative of the overall approach and philosophy being employed by the seven counties and providers in regard to treating trauma throughout the continuum of care. Furthermore, if the trauma assessment does not add value in regard to improving youth well-being, then counties can reallocate the resources needed to complete the assessment toward developing and implementing trauma-informed services, potentially increasing the impact of these interventions.

Figure 6: Average TOP Scores from Baseline to Post



Results of the child welfare outcome analysis also provide limited insight into impact of the trauma-informed intervention on child welfare system outcomes. While the current analysis found no relationship between treatment and subsequent child welfare involvement, the observational design of the evaluation and limited sample sizes challenge the ability to make definitive conclusions. Relatedly, it may be that the impact of trauma-informed practice is with child welfare outcomes not examined in the current analysis.

Future recommendations include taking steps to improve the ability to employ a more rigorous evaluation design that would allow for empirical testing of whether trauma-informed practice can impact youth well-being. First and foremost, a reconsideration of the logic model may be useful to help explain how and why the CWRC intervention, defined as the trauma screen and assessment process, would have an impact on well-being for youth with histories of complex trauma and exhibiting trauma symptoms. For example, it is plausible that a trauma assessment may be particularly helpful for providing services to youth experiencing more serious forms of trauma, such as suicidal ideation or sexual behavior. Trained clinicians may be more likely to

identify these serious forms of trauma, and be able to use this information to provide the best available services to youth standing to benefit the most. Therefore, a more rigorous evaluation, such as one with an experimental design, could be tremendously beneficial for improving services to youth if assessments are in fact leading to better outcomes among these youth.

A more rigorous evaluation design would also allow for further empirical testing of the CWRC intervention's impact on service system outcomes. In addition, future analyses that also include post-assessment services would help to determine whether the intervention is leading to more targeted service provision that subsequently leads to positive service outcomes for families.

## **4. Process Evaluation**

This section presents data describing implementation of the trauma screening, referral and assessment processes. Data describing trauma screens and referrals are presented first, followed by data describing the trauma assessment process and subsequent referral of trauma-informed treatment and services.

### **4.1. Trauma Screen Overview**

Trauma screens were conducted using the Trauma Screening Checklists (TSC) developed by Dr. Jim Henry at the Southwest Michigan Children's Trauma Assessment Center. Two TSCs are available, one for children up to age five, and one for children age six or older. Copies of the TSCs may be found in Appendix 6.

Overall, 1,029 youth were screened for trauma during the evaluation period, of which 677 youth (66%) were referred for a trauma assessment after their Initial Screen, 121 youth screened-in but were not referred, and 231 youth screened out. Initial trauma screens completed with youth most often resulted in a Screened-In Referral (with the exception of Douglas County, which screened out 48% of youth at Initial Screen), suggesting that criteria for the eligible population identified for trauma screening were well-targeted. Similarly, among the two counties for which data were available (Jefferson and Larimer counties), Closure Screens frequently led to Screened-Out results. A number of youth received multiple of the same type of trauma screen, including Initial, Re-Screens and Closure Screens – suggesting a need for further examination around implementation fidelity and/or data entry processes.

## 4.2. Trauma Assessment Overview

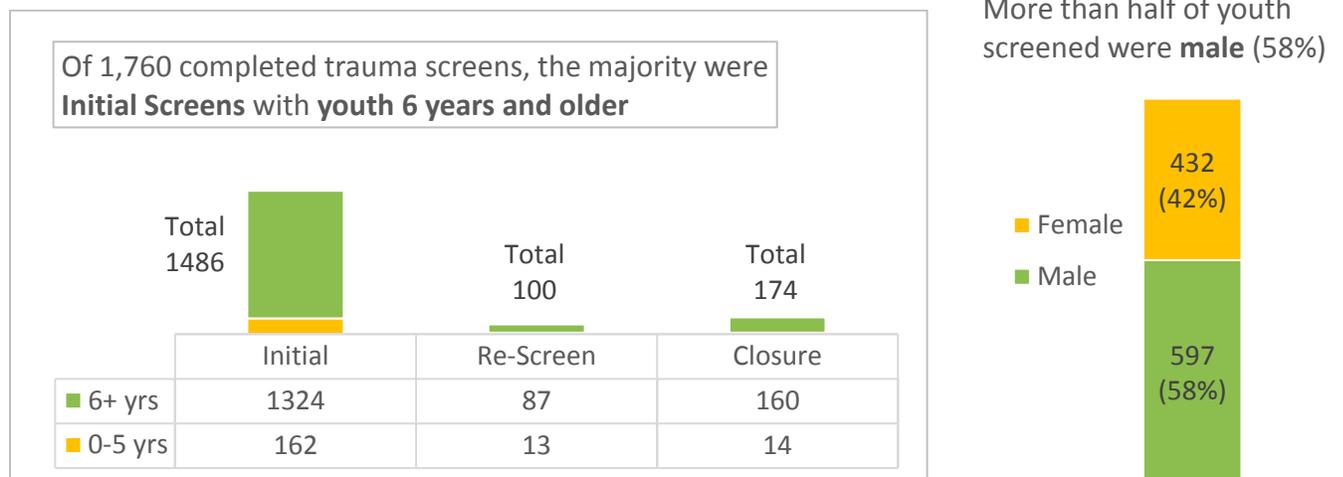
Assessments for the CWRC intervention typically required a full day of time, due to the array of measures and strategies employed to conduct an in-depth assessment of trauma. A list of tools and measures used for the CWRC intervention assessment may be found in Appendix 7.

A total of 450 youth received an assessment during the evaluation period, with assessments planned for an additional 127 youth at the time of this report. The average duration between referral and completion of an assessment was 53 days, and the average time between assessment and debrief report was 47 days. Data from trauma care coordinators indicate that 73% of cases reviewed included assessments completed within the targeted time frame of six weeks from referral.

Closure data were only available for 174 youth, of which 66% ( $n=114$ ) were from Larimer. The most commonly recommended trauma-informed services included trauma-focused parenting, trauma-focused CBT and art therapy. Common traditional services included individual and family therapy.

## 4.3. Trauma Screen Results

The CWRC intervention completed a total of **1,760** trauma screens with **1,029 youth** between July 2014 and April 2018.



Of the total 1,760 screens administered during the evaluation period, 1,283 were unique (depicted below), indicating some youth received more than one Initial, Re-Screen, or Closure screen. Screens categorized as “Other” represent youth who had trauma screens completed in

non-Consortium counties. Specific numbers of Initial, Re-Screen, and Closure Screens administered by each county are presented in the following pages.

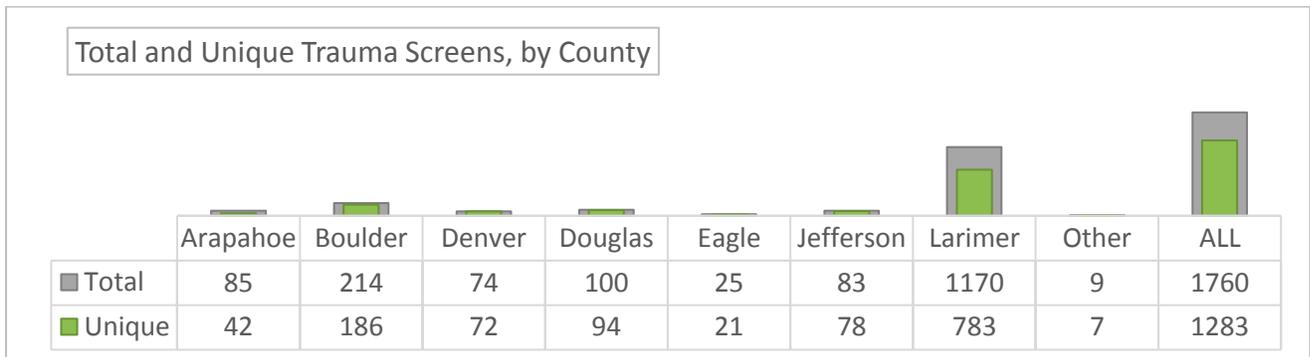


Table 7 presents data for the 1,283 unique Initial, Re-Screens and Closure screens completed during the evaluation period. About two-thirds (66%) of Initial screens were referred, while a large majority (82%) of Closure screens screened out.

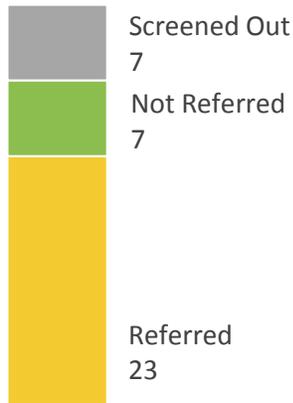
**Table 7: Unique Screens and Screening Outcomes**

	Referred	Not Referred	Screened Out	Total
Initial	<b>677</b>	121	231	1029
Re-Screen	75	6	9	90
Closure	3	26	<b>135</b>	164
Total	755	153	375	1283

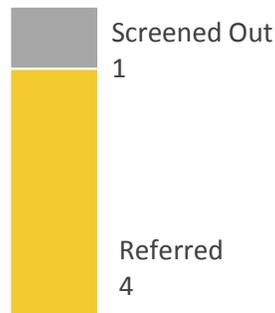
#### 4.3.1. Trauma Screens by County

**Arapahoe** completed **85 total screens** between September 2014 and July 2017. Unique screens included **37 Initial Screens** and **5 Re-Screens**. As displayed in Table 8 on the following page, **6 female** and **21 male** youth were screened (darker shading reflects greater values).

Almost two-thirds (62%) of Initial screens were Referred



Most Re-Screens also resulted in a Referral

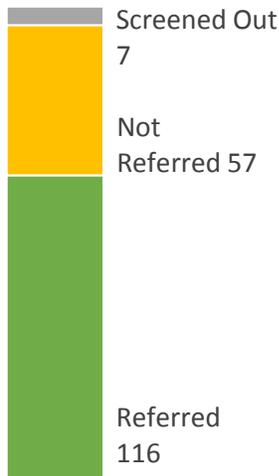


**Table 8: Screened Youth**

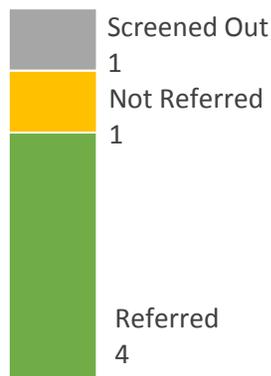
Age	Female	Male
0-5 yrs.	--	1
6 yrs.	--	--
7 yrs.	--	1
8 yrs.	--	1
9 yrs.	3	2
10 yrs.	2	1
11 yrs.	--	4
12 yrs.	--	1
13 yrs.	2	1
14 yrs.	2	3
15 yrs.	6	2
16 yrs.	1	2
17 yrs.	--	2

**Boulder** completed **214 total screens** with **79 female** and **101 male youth** between November 2015 and November 2017. Unique screens included **180 Initial Screens** and **6 Re-Screens**.

Almost two-thirds (64%) of Initial Screens were Referred



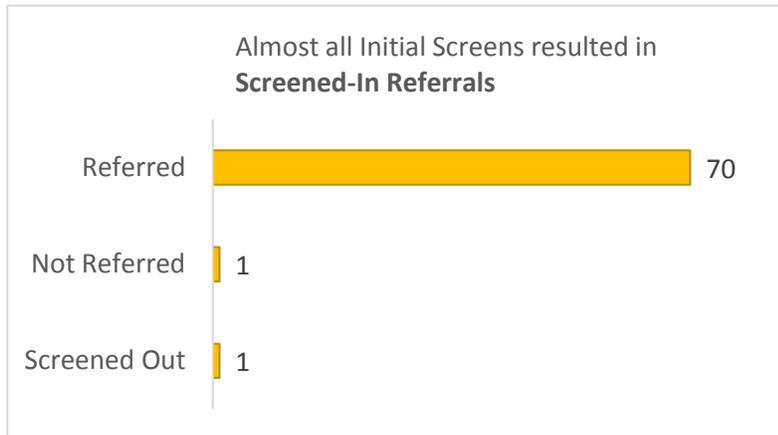
Most Re-Screens also resulted in a Referral



**Table 9: Screened Youth**

Age	Female	Male
0-5 yrs.	16	16
6 yrs.	4	6
7 yrs.	5	4
8 yrs.	3	8
9 yrs.	5	4
10 yrs.	4	3
11 yrs.	4	8
12 yrs.	4	8
13 yrs.	5	7
14 yrs.	9	12
15 yrs.	10	7
16 yrs.	7	13
17 yrs.	3	5

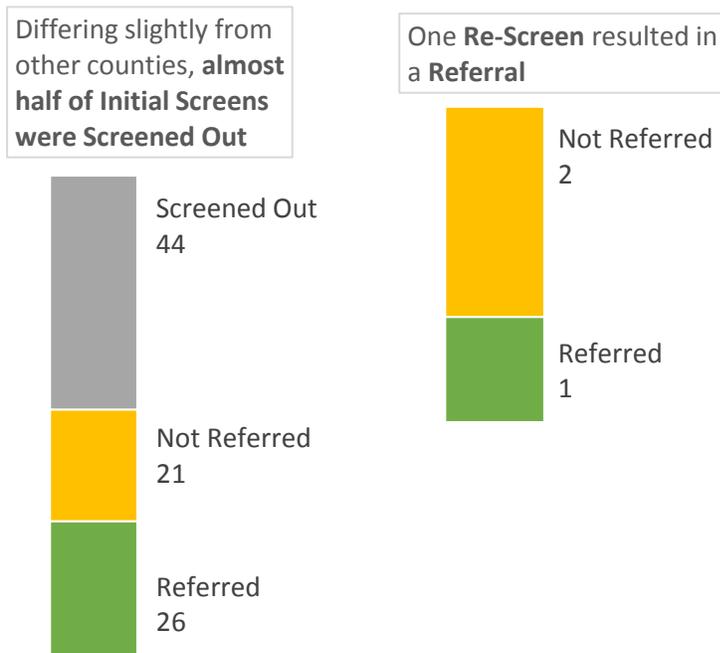
**Denver** completed **74 total Initial Screens** (72 unique Initial Screens) between February 2016 and December 2017. As displayed in Table 10, **79 female** and **101 male** youth were screened.



**Table 10: Screened Youth**

Age	Female	Male
0-5 yrs.	1	2
6 yrs.	--	--
7 yrs.	1	2
8 yrs.	1	1
9 yrs.	--	1
10 yrs.	1	2
11 yrs.	2	3
12 yrs.	2	5
13 yrs.	5	4
14 yrs.	3	4
15 yrs.	4	4
16 yrs.	5	7
17 yrs.	9	3

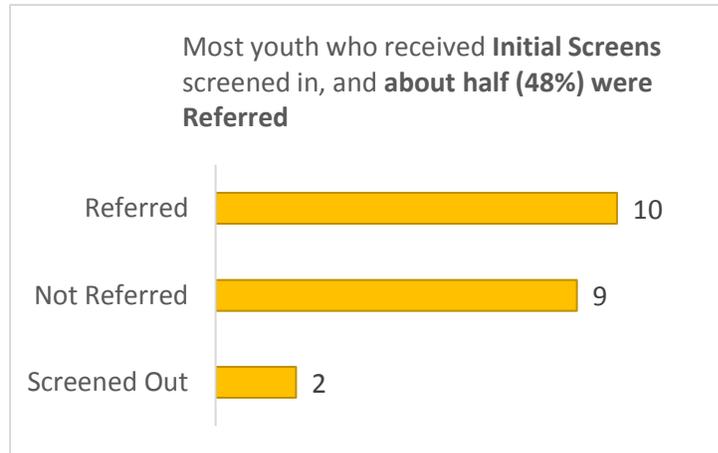
**Douglas** completed **100 total screens** between September 2015 and April 2018. Unique screens included **91 Initial Screens** and **3 Re-Screens**. As displayed in Table 12, 30 female and 61 male youth were screened.



**Table 11: Screened Youth**

Age	Female	Male
0-5 yrs.	--	--
6 yrs.	--	1
7 yrs.	--	--
8 yrs.	--	1
9 yrs.	--	1
10 yrs.	2	--
11 yrs.	1	--
12 yrs.	3	1
13 yrs.	1	3
14 yrs.	4	4
15 yrs.	4	15
16 yrs.	7	16
17-18 yrs.	8	19

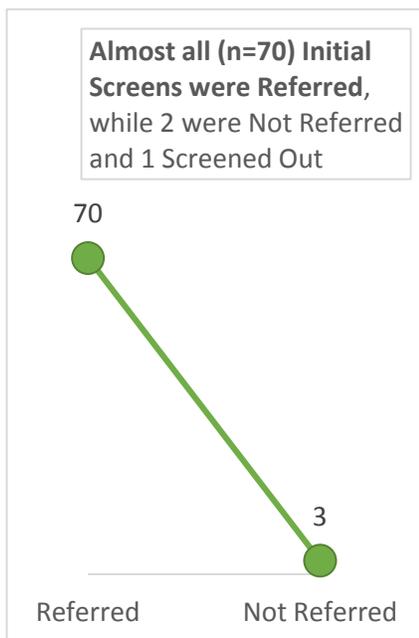
**Eagle** completed **25 total Initial Screens** (21 unique Initial Screens) and between October 2014 and November 2017. As displayed in Table 12, **10 female** and **11 male** youth were screened.



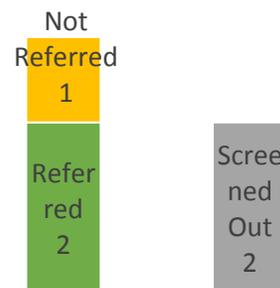
**Table 12: Screened Youth**

Age	Female	Male
0-5 yrs.	3	1
6 yrs.	--	--
7 yrs.	--	1
8 yrs.	1	--
9 yrs.	--	--
10 yrs.	--	1
11 yrs.	1	--
12 yrs.	2	1
13 yrs.	--	2
14 yrs.	2	--
15 yrs.	--	2
16 yrs.	1	2
17 yrs.	--	1

**Jefferson** completed **83 total screens** between January 2016 and April 2018. Unique screens included **73 Initial Screens**, **3 Re-Screens** and **2 Closure Screens**. As displayed in Table 13, 27 female and 46 male youth were screened.



2 Re-Screens were Referred and both Closure Screens Screened Out



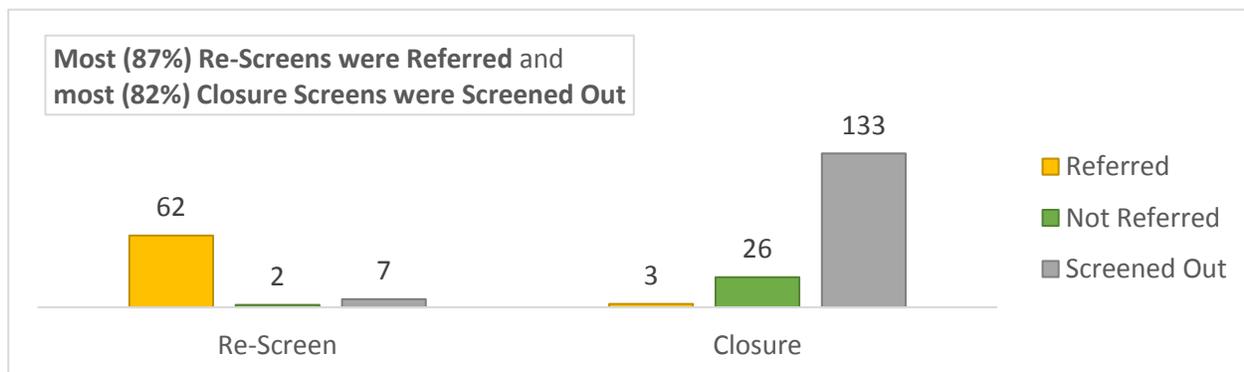
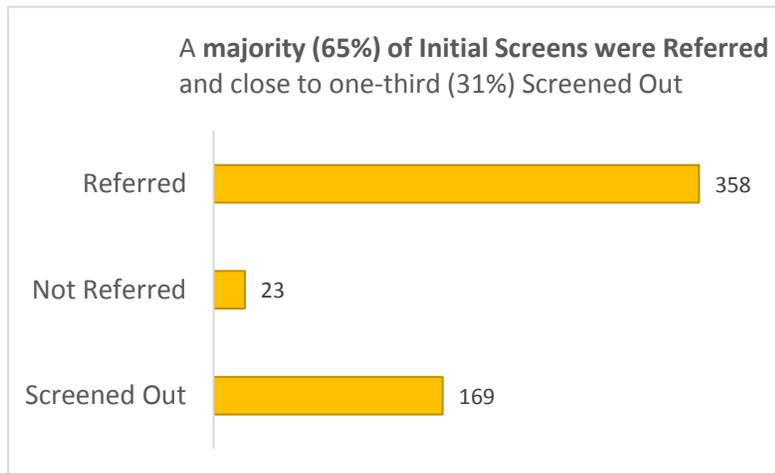
**Table 13: Screened Youth**

Age	Female	Male
0-5 yrs.	--	--
6 yrs.	--	--
7 yrs.	--	--
8 yrs.	--	--
9 yrs.	--	--
10 yrs.	--	3
11 yrs.	1	1
12 yrs.	2	1
13 yrs.	2	5
14 yrs.	8	4
15 yrs.	6	9
16 yrs.	4	9
17-18 yrs.	4	14

**Larimer** completed **1170 total screens** between October 2014 and November 2017. Larimer also completed the greatest number of Closure Screens among the seven counties. Unique screens included **550 Initial Screens, 71 Re-Screens** and **162 Closure Screens**. As displayed in Table 14, 235 female and 315 male youth were screened.

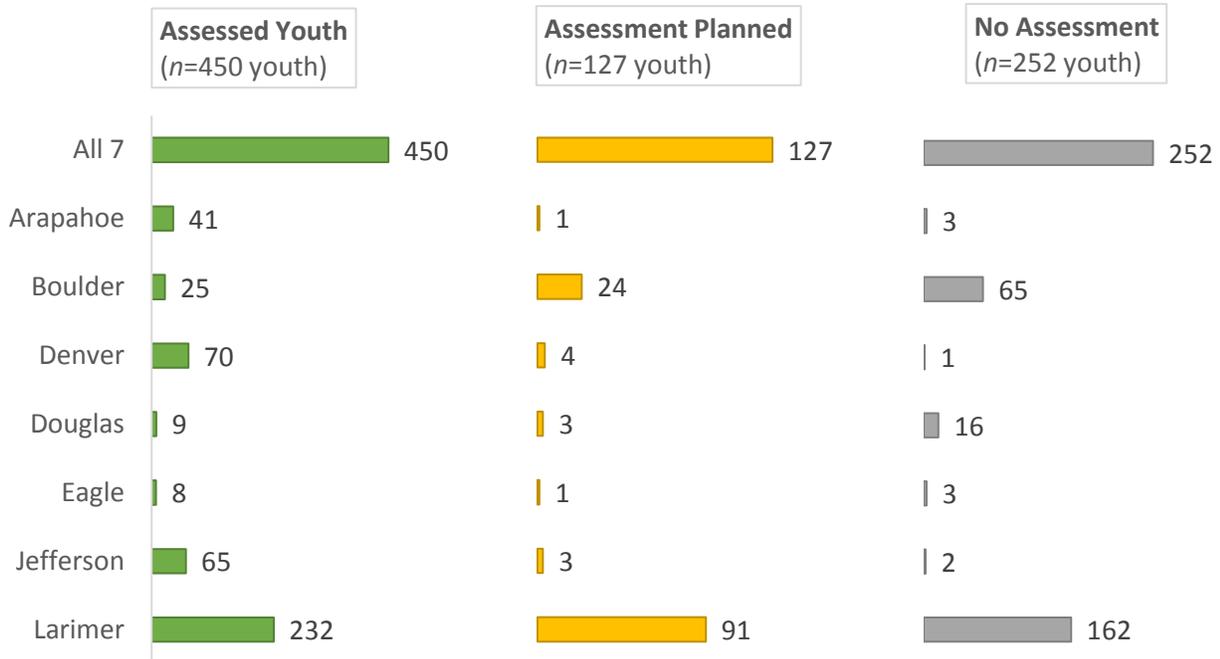
**Table 14: Screened Youth**

Age	Female	Male
0-5 yrs.	28	47
6 yrs.	13	20
7 yrs.	14	17
8 yrs.	20	19
9 yrs.	16	18
10 yrs.	13	26
11 yrs.	11	19
12 yrs.	16	22
13 yrs.	21	23
14 yrs.	22	36
15 yrs.	30	25
16 yrs.	18	31
17 yrs.	13	12



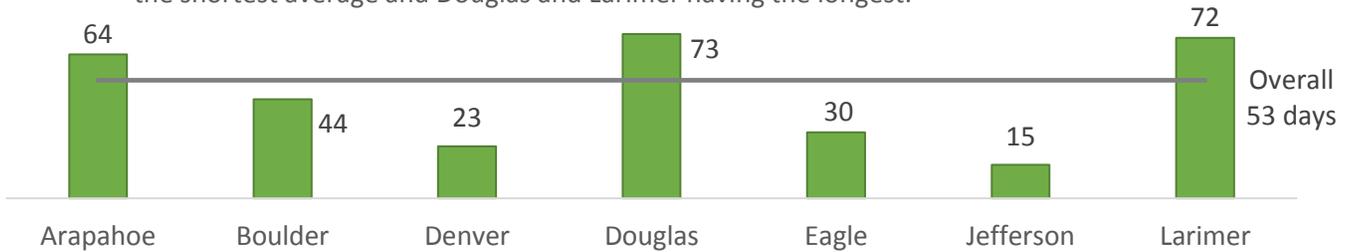
#### 4.4. Trauma Assessments

A total of **829 youth** were referred for and/or assessed for trauma during the evaluation period, with data spanning from May 2015 to April 2018. More than half of the sample, **450 youth**, received a trauma assessment during the evaluation period. Assessments were planned for an additional **127 youth**, and no assessments were planned or completed for the remaining **252 youth** in the sample.

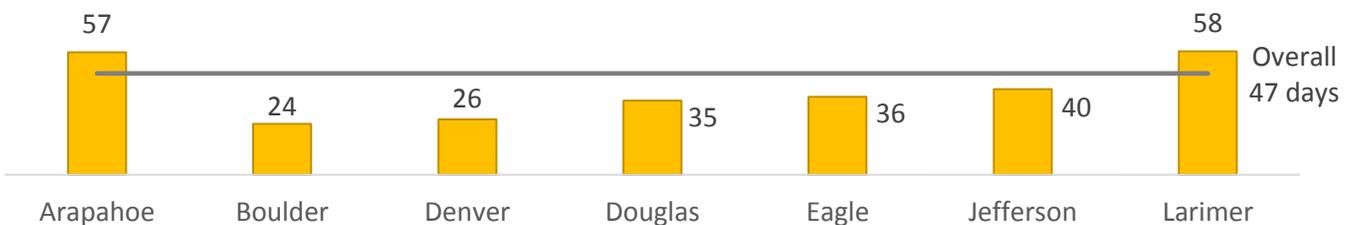


The figures below present average times between referral to assessment, and between assessment to debriefing assessment results with the family. Data indicate considerable variability between these time points across counties, perhaps driven by individual county's business processes and initial implementation while resources were still in development.

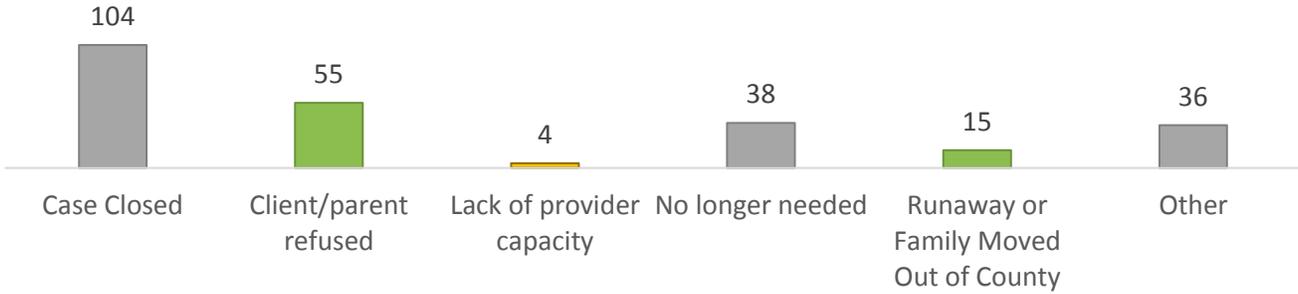
The **overall average time from referral to assessment was 53 days**, with Jefferson having the shortest average and Douglas and Larimer having the longest.



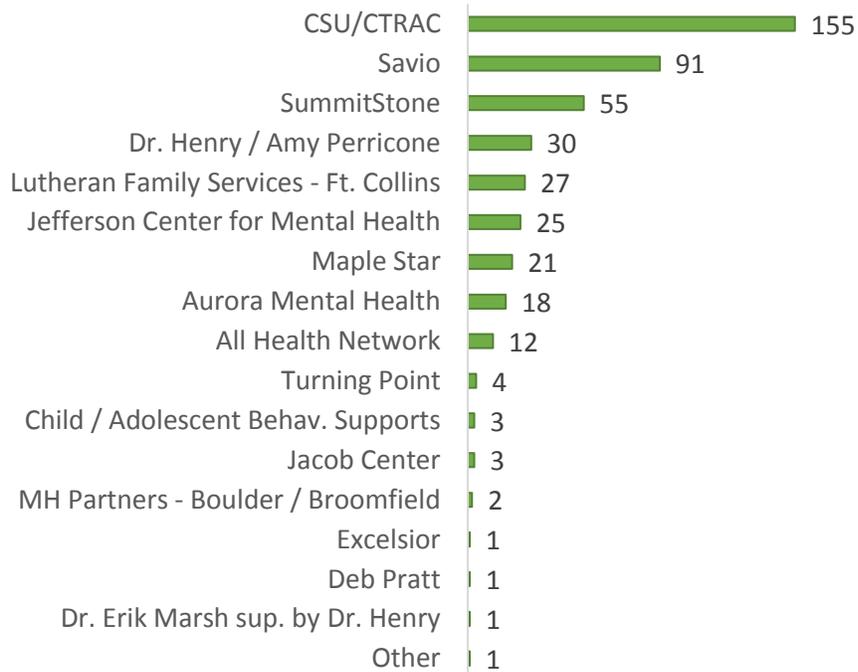
The **overall average time from assessment to debrief report was 47 days**, with Larimer and Arapahoe having the longest times and remaining average times ranging 24-40 days.



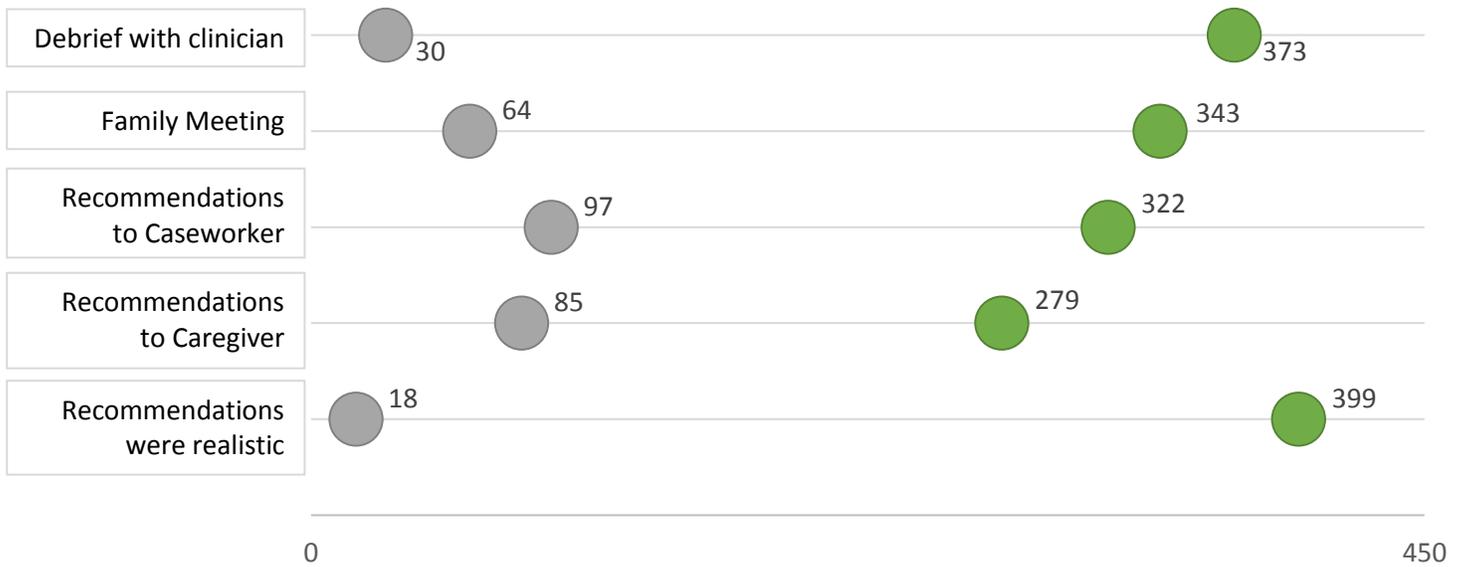
Of the 252 youth who were NOT assessed, **more than half (56%)** were due to **practice related reasons**, including case closure, and **28%** were due to **family refusal or absence**.



**CTRAC** provided the greatest number (34%) of trauma assessments, followed by **Savio** and **SummitStone**



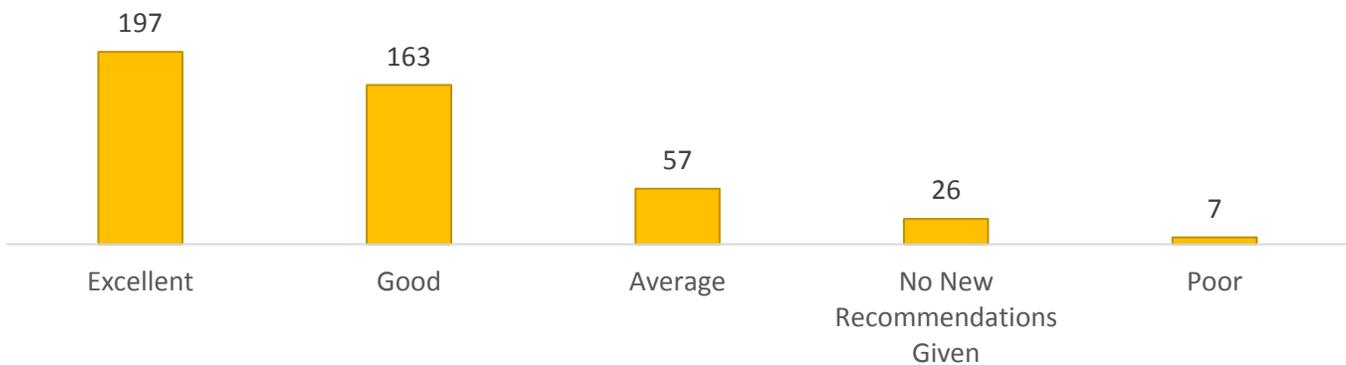
Did the following assessment follow-up activities occur? **Yes (green)** or **No (grey)**?



As depicted in the figure above, follow-up activities after an assessment were implemented more often than not. Debrief and family meetings took place 83% and 76% of the time, respectively. Passing on recommendations immediately to the caseworker and caregiver occurred less often but still consistently, with 72% of caseworkers and 62% of caregivers receiving immediate recommendations. Numbers for each category above do not all total 450 due to data indicating it was sometimes unknown whether an activity took place.

Caseworkers were also asked to rate the recommendations received from an assessment. A large majority (89%) of recommendations were rated as realistic (shown above). A majority of recommendations were also rated as excellent or good in quality, presented below.

A **majority (80%)** of recommendations were rated as **Excellent** or **Good** in quality



This section discusses recommended services and strategies for **174 youth** who received a trauma assessment, with data spanning from December 2016 to April 2018.

A handful of youth (in Denver, Douglas and Larimer counties) had more than one survey completed at case closure, with 181 closure surveys completed for **174 total youth**.

	Arapahoe	Boulder	Denver	Douglas	Eagle	Jefferson	Larimer
■ Total	5	5	19	5	8	22	117
■ Unique	5	5	16	4	8	22	114

In addition to recommending treatments and services, trauma assessment results also provided recommendations for additional assessments as appropriate. Table 15 presents the degree to which five possible assessments were recommended after a trauma assessment, and whether the assessment services were referred, began and/or completed. Medical exams and speech and language assessments were least likely to be recommended, while medication evaluations and educational assessments were the two most commonly begun and completed.

**Table 15: Additional Assessments or Exams**

	Not Recommended	Referred / Receiving	Complete	Not Referred
Educational Assessment	124	<b>17</b>	<b>22</b>	11
Medication Evaluation	118	<b>25</b>	<b>21</b>	10
Medical Exam	<b>152</b>	4	15	3
Occupational Therapy	133	16	11	14
Speech and Language	<b>150</b>	10	10	4

In regards to trauma-focused treatment and services recommended by a trauma assessment, dialectical behavior therapy and play therapy were the least frequently recommended. Conversely, trauma-focused parenting education was the most commonly recommended and completed service, followed by trauma-focused cognitive behavioral therapy (CBT). Animal-assisted therapy and art therapy were the most common trauma-focused services to be recommended but not referred. Further details regarding recommended trauma-focused services are presented in Table 16 on the following page.

**Table 16: Trauma-Focused Therapeutic Services**

	Not Recommended	Referred / Receiving	Completed	Not Referred
Animal-assisted	124	12	9	29
Art	109	25	16	24
Parent Child Interaction	141	10	12	11
Phase-Based Trauma	141	17	11	5
Trauma-focused CBT	124	22	20	8
Sensory / Body-Based	134	15	16	9
Dialectical Behavior	160	3	5	6
Sensory Integration	145	9	11	9
Play	160	6	5	3
EMDR	139	10	9	16
Child-Parent Psychotherapy	143	14	7	10
Trauma-focused Parenting	96	28	32	18
Other	142	15	9	8

As displayed in Table 17, among traditional therapeutic treatments and services, individual and family therapy were the most likely to be recommended, began and completed.

**Table 17: Traditional Therapeutic Services**

	Not Recommended	Referred / Receiving	Completed	Not Referred
Sexual Abuse	150	10	10	4
Substance Abuse	135	22	10	7
Individual Therapy	26	97	38	13
Group Therapy	142	16	12	4
Family Therapy	43	76	36	19
Other	162	2	6	4

Life skills training and services were also included among trauma assessment recommendations, presented in Table 18 on the following page. Mentoring programs and engagement in activities to help promote mastery and development were the two most commonly recommended and completed life skills training or services.

**Table 18: Life Skills/Services**

	Not Recommended	Referred / Receiving	Completed	Not Referred
Life Skill Development	108	32	17	17
Mentoring	47	61	40	26
Sensory-Based Skill Development	142	10	11	11
OT Support for School	147	11	8	8
Social Skill Coaching	141	11	14	8
Social Skills Group	133	16	12	13
Wraparound Services	137	15	12	10
Trauma-informed Yoga	155	4	4	11
Trauma Treatment Coordinator	125	7	33	9
Mastery Development	79	38	32	25
Visitation	145	11	14	4
Developmental Services	161	6	4	3



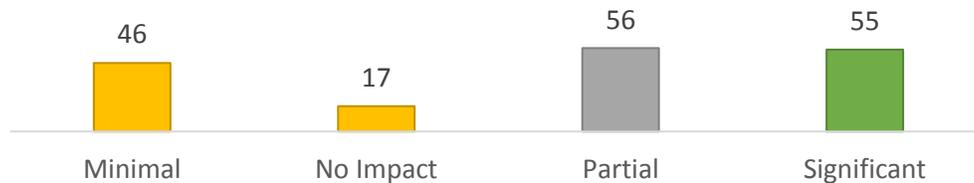
A majority of closure surveys ( $n=145$ , 83%) indicated that **informal strategies and supports** were included among assessment recommendations. Of these, recommended strategies were implemented close to two-thirds (63%) of the time.

Of the 82 cases that did not have strategies implemented, the most common reasons were **family-driven**, including **refusal**, **lack of engagement** or **youth runaway**.



Caseworkers were asked to rate the impact of the trauma assessment and resulting services on resiliency for youth, choosing from a range of “no impact” to “significant impact.” Presented in the figure below, results indicated a somewhat even spread of ratings. About one-third (32%) rated the impact as Significant, another one-third (32%) as Partial, while the remaining third (36%) indicated ratings of Minimal to No Impact.

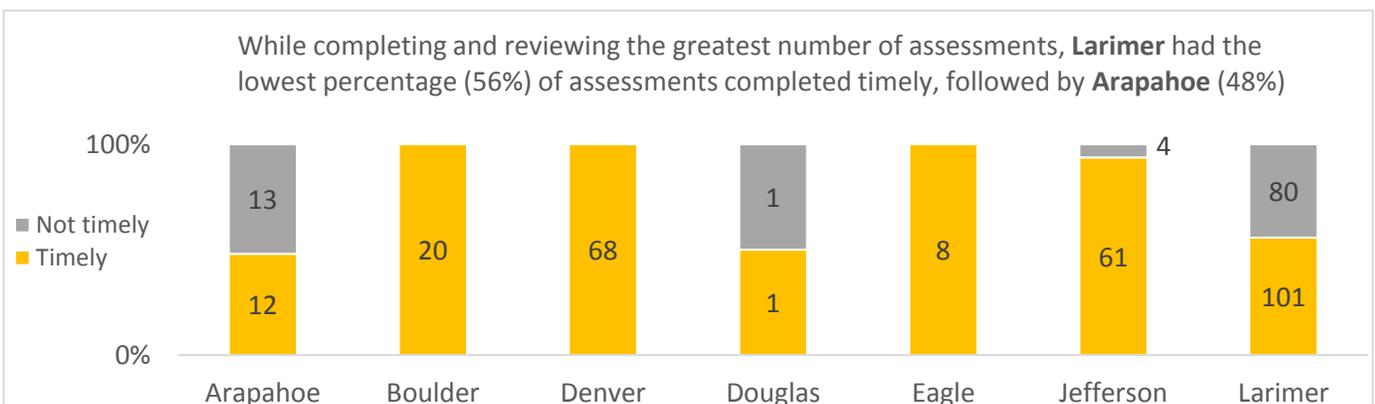
Rate the impact of the trauma assessment and services on resiliency for youth:



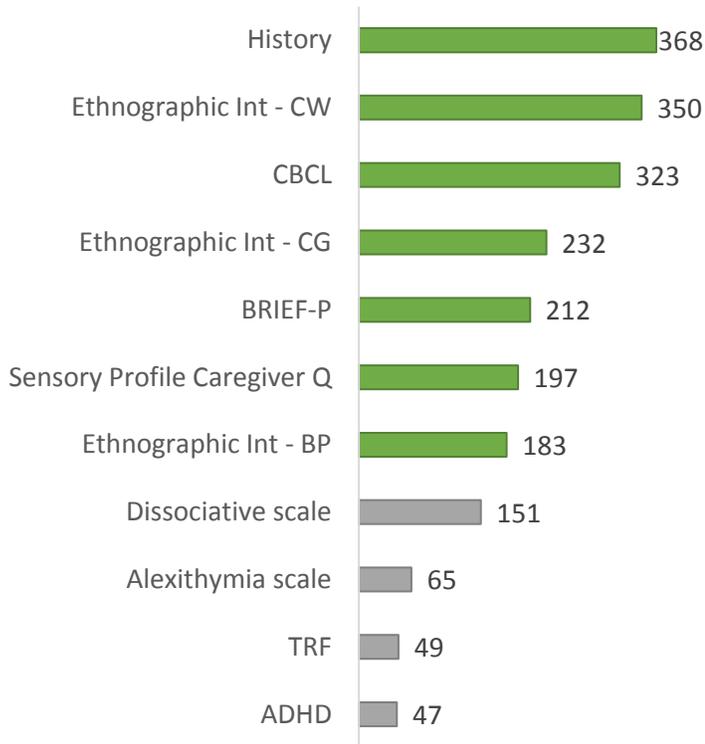
#### 4.5. Trauma Assessment Case Reviews

Of the 450 youth who had assessments completed during the evaluation period, **371** had their cases reviewed by trauma care coordinators to examine whether assessments included all required components. Review results indicated that assessments were completed timely for a majority of cases reviewed ( $n=271$ ; 73%), defined as no later than six weeks after a referral is made. The figure below presents the timeliness status of reviewed cases, by county.

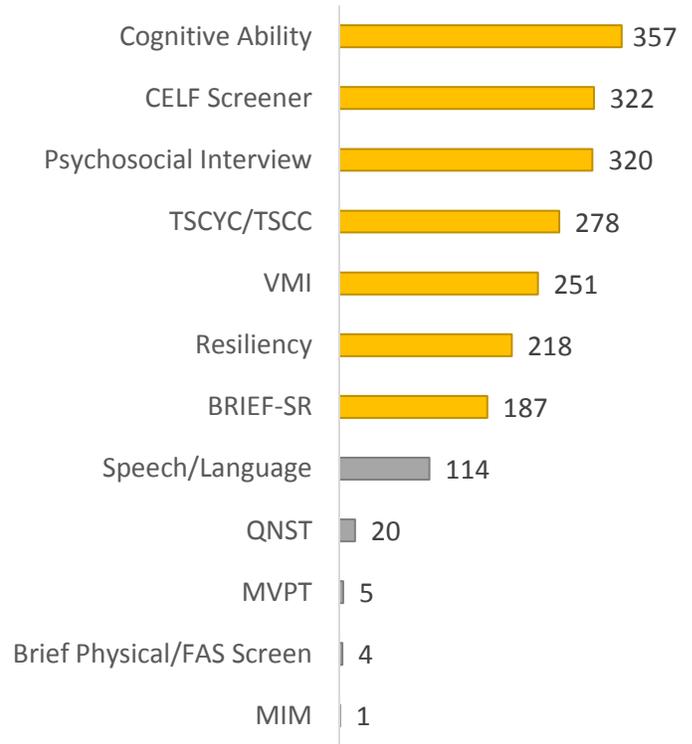
While completing and reviewing the greatest number of assessments, **Larimer** had the lowest percentage (56%) of assessments completed timely, followed by **Arapahoe** (48%)



7 of 11 designated **pre-assessment elements** were included in over 50% of reviewed cases

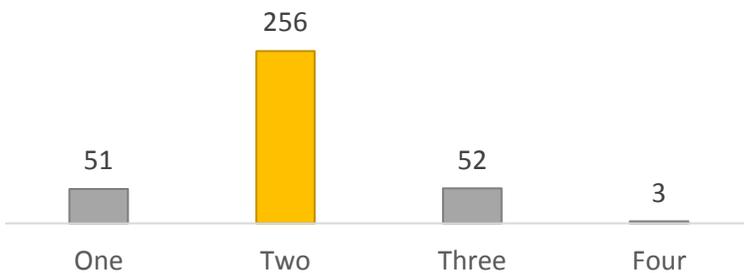


7 of 12 designated **assessment elements** were included in over 50% of reviewed cases



Trauma care coordinators also examined cases to determine the number of clinicians involved in completing the assessment. More than two-thirds (69%) of reviewed cases had two clinicians involved in assessments, and a large majority (86%) had Master’s level training.

More than two-thirds (69%) of cases reviewed had assessments done with **2-clinician teams**

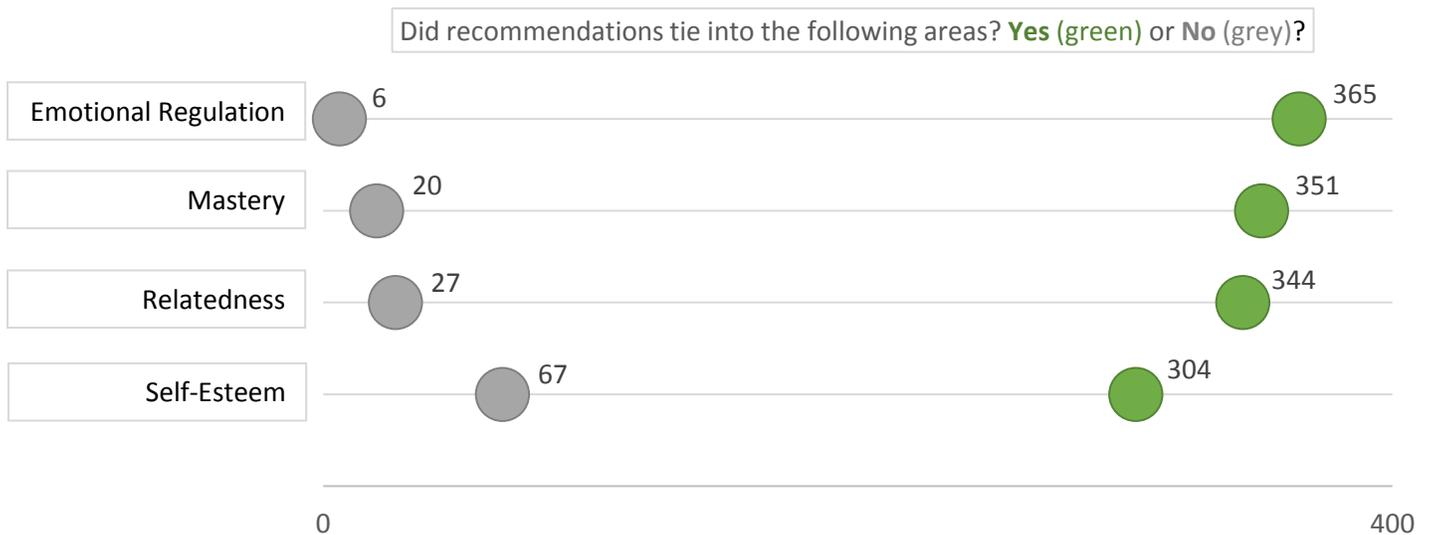
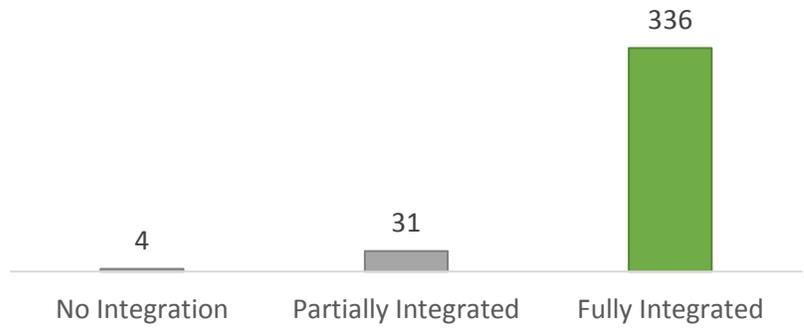


**Table 20: Clinical Assessor Backgrounds**

	Assessments
Masters	318
PhD	111
Licensed Psychologist	61
Occupational Therapist	13
MD/NP	2
Speech/Language	2
Psychiatrist	2

**100%** of cases reviewed included a report with summary and recommendations. About one-third ( $n=119$ , 32%) of reviewed cases also included **recommendations on permanency**.

A large majority (91%) of reports also integrated assessment components into the summary and recommendations, as shown in the figure to the right.



## 5. Conclusion and Implications

In summary, evaluation findings indicate that well-being improved overall for youth involved with the CWRC intervention, with all youth surveyed with a TOP showing a positive change in well-being from baseline to post. No meaningful difference, however, was found in well-being levels or change between youth who were assessed and youth who were not. Similarly, findings indicated no significant relationship between the CWRC intervention and child welfare outcomes. Regarding implementation, the CWRC intervention successfully screened over 1,000 youth during the evaluation period, assessed 66% of youth referred for an assessment, and had assessment plans in place for over 50% of referred youth waiting for an assessment.

Several factors may help to explain why significant differences were not found between the well-being levels of youth in treatment versus control groups. First and foremost, limitations to the evaluation design preclude the ability to draw definitive conclusions regarding a relationship between the CWRC intervention (defined as the trauma screen and assessment

process) and youth well-being. Specifically, the outcomes analysis employed an observational design due to the inability to actively assign participants randomly to either group. Thus, it is not clear how and when youth were designated into each group, and the degree to which youth and families in each group were kept separate in receiving aspects of the “treatment.” Broad training of staff, service provider communities and system partners around complex trauma and its impact on development and interpersonal relationships was also conducted prior to and throughout the evaluation period, and not specific to only staff involved in the CWRC intervention. Training and increased awareness of complex trauma may have led to all or most youth and families receiving some level of trauma-focused practice and services regardless of their encounter with the CWRC intervention.

Moving forward, the 7-County Consortium is in process of implementing and further developing the CWRC trauma-informed intervention, and current findings may help to inform and refine program and evaluation design. Evidence elsewhere suggests interventions aimed at helping youth reframe their thought patterns and understanding of their experiences of trauma have been linked to promoting recovery and well-being (Kelley, Pransky, & Sedgeman, 2014). For example, an intervention known as the *Three Principles* helps youth develop insight into their traumatic histories and its impact in order to develop resilience and achieve resolution related to their trauma. Studies have found the intervention may be helpful in decreasing psychological symptoms and delinquent behavior particularly in residential and justice settings (Kelley et al., 2014). Another study linked Trauma-Focused Cognitive Behavioral Therapy (TF-CBT) to significant decreases in PTSD symptoms among a sample of 132 adolescents receiving treatment from a non-profit residential psychiatric treatment facility in Mississippi. Youth in the sample had histories of trauma exposure, and experienced more acute symptoms than adolescents receiving treatment in other non-residential settings. (Joiner & Buttell, 2018).

Other research has also linked trauma-informed practices to improvement in well-being and achieving permanency. Researchers studied the impact of the Attachment, Self-Regulation and Competency (ARC) intervention on 93 adolescents with complex trauma and child protection involvement receiving services from an outpatient clinic in Alaska. Researchers found that youth who completed the ARC treatment showed a greater level of improvement and high rates of placement permanency. The ARC intervention was also implemented with a highly diverse sample, with varying trauma exposure and histories, involved with child protection (Arvidson et al., 2011). Separately, a longitudinal evaluation was conducted of the Strengthening Family Coping Resources (SFCR) intervention, with a sample of 13 families with children age six or older receiving community-based treatment (Kiser, Backer, Winkles, & Medoff, 2015). The SFCR targets both children and their families, and SFCR was found to

significantly impact both child symptoms and overall family functioning, which did not differ by gender or child age (Kiser et al., 2015).

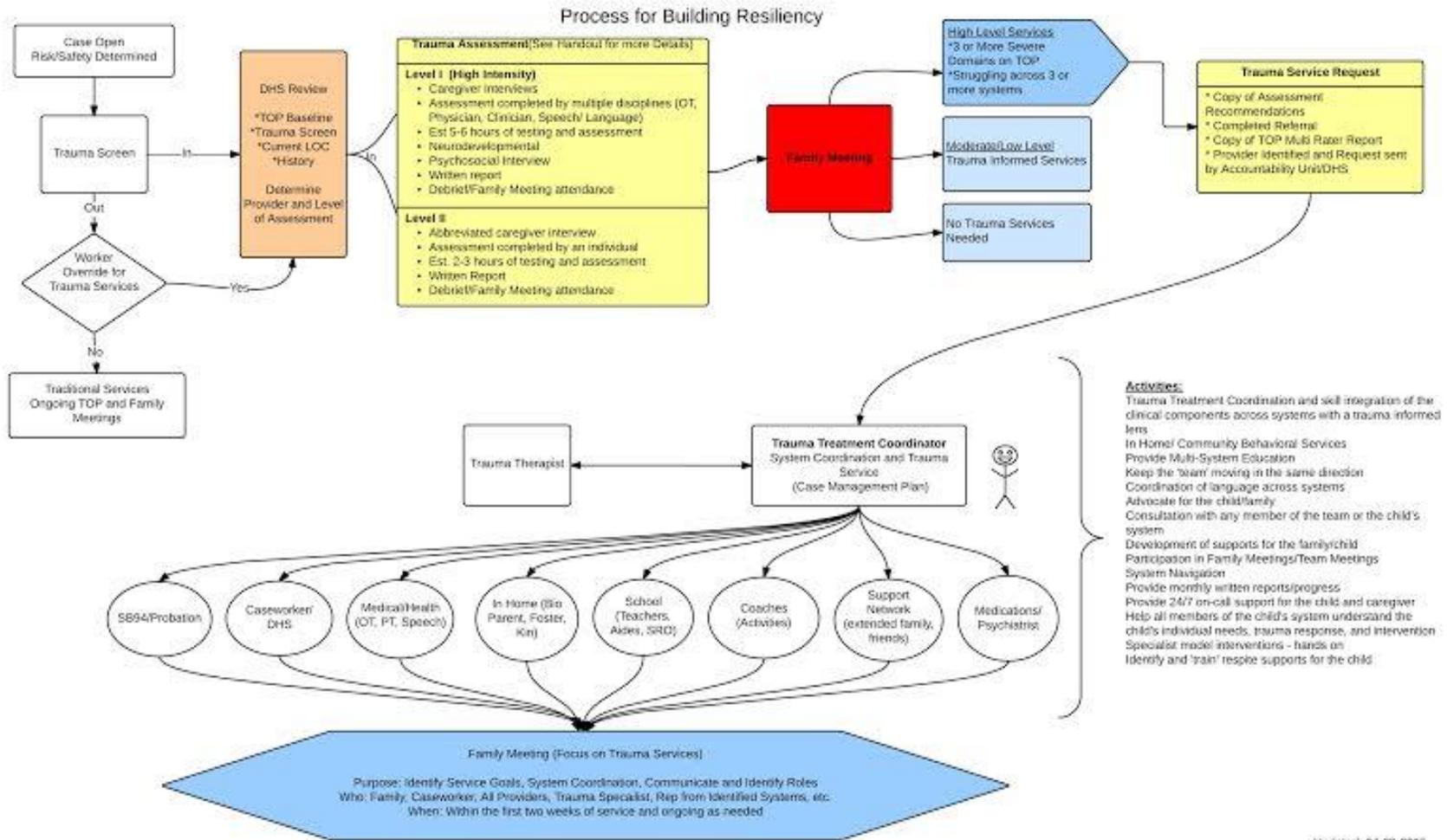
Another intervention, Trauma Systems Therapy (TST) was evaluated with a sample of 1,499 children ages six and older in Kansas who were removed from their caregivers. TST was found to be effective in increasing permanency and children showed improvements in functioning and emotional and behavioral regulation. The evaluation also found that positive effects can be cultivated by any staff member working on the child's service team, and researchers suggest that the influence of TST provided by an entire team, rather than by one staff member, can foster improved outcomes for children. (Murphy, Moore, Redd, & Malm, 2017). In a final example, Weiner, Schneider, and Lyons (2009) examined trauma treatments among a sample of culturally diverse foster care youth. With a sample of 2,434, 3-18 year old youth receiving treatment at various sites in Illinois, the trauma interventions of CPP, TF-CBT, and Structured Psychotherapy for Adolescents Responding to Chronic Stress (SPARCS) demonstrated equally significant effectiveness across racial groups represented in the sample. All three trauma interventions were administered at the community level, and demonstrated significant improvement in youth functioning and symptom reduction. Researchers noted the important of culturally appropriate tools and cultural competence for practitioners implementing trauma interventions with culturally diverse youth (Weiner et al., 2009).

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## Appendix 1 – Child Welfare Resiliency Center Logic Model



## Appendix 2 – CWRC Eligible Populations

### Eligible Population for Screening & Assessment

<b>Arapahoe</b>	<p>All youth with either an open or FAR case (with services) in Arapahoe County are screened for trauma.</p> <p>The county will specifically target 30 youth identified by area administrators (15 youth who have waited longest for permanency, 15 preventative cases), eventually moving to the next longest waiting youth in out of home placement.</p>
<b>Boulder*</b>	FAR-SP; Ongoing Case; Congregate Care; In Care > 2 yrs.; Disrupting Adoptions
<b>Denver</b>	<p>70 of the highest need ‘legacy youth’ cases in congregate care or out of home placement</p> <p>‘Legacy youth’ are youth with extensive system involvement and whose cases have been open the longest.</p>
<b>Douglas</b>	Congregate care; In OOH placement > 2 yrs.; Developmentally disabled youth; Disrupting Adoptions; PA4 youth with an open case and in congregate care
<b>Eagle*</b>	All children/youth with an open child welfare case (approx. 40 children)
<b>Jefferson</b>	<p>All children/youth in residential care as of Oct. 1, 2015; plan to eventually include any child/youth placed in a group home or higher level of care.</p> <p>Administrators and supervisors currently identifying youth for assessment and will eventually complete assessments for all youth who screen in once have capacity to do so</p>
<b>Larimer*</b>	All open cases in PA4 or PA5, and selected PA6 cases (e.g., Disrupting Adoptions); FAR; Ongoing Case

\* Denotes counties with different target populations for screening and assessment; see below for separate criteria for assessment

### Eligible Population for Assessment (if different than target population for trauma screening)

<b>Boulder</b>	Youth with a moderate or high level trauma screen
<b>Eagle</b>	All children/youth with moderate or high level trauma screen
<b>Larimer</b>	All children/youth ages 6 and older, with open case

## Utilizing TOPS Assessment

	Criteria for TOP/CANS	Completion Frequency	Raters/Assessors
<b>Arapahoe</b>	Screen-in: 6 or above	<ul style="list-style-type: none"> <li>• Every 90 days</li> </ul>	Required – CWer, caregiver, youth age 10 and > (also by CWer discretion), therapist, GAL, probation/parole officer Optional – CASA, teacher, birth parent (if not directly involved in case), significant adults; siblings; direct care line staff, if applicable
<b>Denver</b>	Screen-in: 6 or above	<ul style="list-style-type: none"> <li>• Every 90 days</li> <li>• Placement change</li> <li>• Case closure</li> </ul>	CWer, youth age 10 and >, caregivers (including foster parents and kin), therapist, probation/parole officer, GAL
<b>Douglas</b>	Screen-in: 6 or above	<ul style="list-style-type: none"> <li>• Every 90 days</li> </ul>	Youth, caregiver, CWer, probation/parole officer, GAL, other providers
<b>Eagle</b>	Screen-in: 6 or above	<ul style="list-style-type: none"> <li>• Every 90 days</li> </ul>	GAL, therapist, caregiver(s), CWer, teacher
<b>Jefferson</b>	Screen-in: 6 or above	<ul style="list-style-type: none"> <li>• Residential – Every 30 days</li> <li>• Other care levels – Every 90 days</li> </ul>	Required – CWer, youth, caregiver Also invited – GAL, parent/guardian, teacher, probation/parole officer, therapist, CASA, mentor
<b>Larimer</b>	Screen-in: 6 or above	<ul style="list-style-type: none"> <li>• Case opening</li> <li>• Every 90 days</li> <li>• Case closure</li> </ul>	CWer, caregiver, birth parent (if different), youth, therapist

## Utilizing CANS Assessment\*\*

<b>Boulder</b>	Screen-in: 6 or above	<ul style="list-style-type: none"> <li>• Case opening</li> <li>• Every 6 months</li> <li>• Case closure</li> </ul>	CWer, youth, caregiver, clinician, school staff, court officials (GAL, probation, etc.), mentor (if applicable)
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\*\*Unlike the TOP, the CANS measure is completed only by a trained Assessor who gathers ratings or opinions regarding a young person’s functioning from a range of adults and professionals, such as a teacher or therapist. The assessor then synthesizes the information and completes a CANS measure. Assessors are persons who manage the CANS process, and are separate from any parties involved in a given case. Boulder has identified 2 former caseworkers who will be trained as assessors and manage/coordinate the CANS process.

### **Appendix 3 – CWRC Data Sources**

<b>Description of Data</b>	<b>Data Source</b>
Trauma Screens	Trails
Trauma Assessment Referral and Coordination	Lime Survey
Trauma Assessment Recommendations/Services	Lime Survey
Trauma Care Coordinator – Case Review	Lime Survey
Treatment Outcome Package (TOP)	Kids Insight TOP database
Child and Adolescent Needs and Strengths (CANS)	Boulder County data system

## Appendix 4 – Treatment Outcome Package Domains and Scoring

What does TOP measure? TOP Factor Scores

### Child TOP

**Lack of Assertiveness (ASRTV)** This factor taps into potential problems with assertiveness (e.g. had trouble standing up for himself/herself, seemed scared around people, been too shy.)  
**Strength: Assertiveness**

### Incontinence (BOWEL)

This factor taps a construct related to a child’s bowel and bladder functioning. **Strength: Continence**

### Lack of Resiliency (RESIL)

This factor taps a construct related to a child’s strengths, or what the child is doing well. Often overlooked in therapy settings, knowing a client’s strengths (particularly a child’s) can be especially important in providing appropriate care. **Strength: Resiliency**

### Separation Anxiety (SEPAX)

This factor taps a construct related to a child’s discomfort in being away from his/her caretaker. **Strength: Secure Attachments**

### Sexual Acting Out (SEXWR)

This factor relates to worrisome sexualized behavior in children.  
**Strength: Appropriate Boundaries**

### Eating Issues (UNEAT)

This factor taps a construct related to a child’s reluctance to eat.  
**Strength: Good Eating Habits**

## Adolescent TOP

### Mania (MANIC)

This factor taps a construct that may be related to manic or hypomanic symptoms. All of this factor’s items relate to elevated mood or behaviors associated with elevated mood.

**Strength: Balanced Emotions**  
(at a score of zero; negative scores indicate Depression)

### Substance Abuse (SA)

This factor uses the six items from Norm Hoffman’s UNCOPE questionnaire and has excellent sensitivity and specificity for substance abuse and dependency issues.

**Strength: Good Control of Substance Use**

### Poor School Functioning (SCHOOLF)

This factor relates to adolescent functioning at school. The items on this factor relate to missing school for any reason and several items about problems at school. **Strength: Good School Functioning**

### Social Conflict (SCONF)

This factor taps a construct that relates to how well an adolescent relates to others. **Strength: Positive Relationships**

## Both

### ADHD Symptoms (ADHDC)

This factor relates to a child or adolescent's pattern of paying attention. Many of the items from this factor directly ask about attention and impulsivity. **Strength: Ability to Focus**

### Conduct Disorder (CNDCT)

This factor relates to a child or adolescent's conduct or behavior problems. **Strength: Adherence to Rules**

### Depression (DEPRS)

This factor taps a construct that relates to many of the symptoms of clinical depression. The items from this factor on the Child TOP are child-specific; the Adolescent TOP uses items from the Adult clinical scale.

**Strength: Happiness**

### Psychosis (PSYCS)

This factor taps a construct related to psychotic symptoms.

**Strength: Ability to Face Reality**

### Sleep Problems (SLEEP)

This factor relates to difficulty sleeping.

**Strength: Healthy Sleep Habits**

### Suicidality (SUICD)

This factor relates to suicidal ideation.

**Strength: Handles Sadness**

### Violence (VIOLN)

This factor relates to physical violence or anger.

**Strength: Deals with Anger Well**



## Child TOP Factor Scoring

**Child ADHD Symptoms (ADHDC)** (7 items, theoretical minimum: -1.98, theoretical maximum: 5.78) This factor taps a construct that relates to a child's pattern of paying attention. Many of the items from this factor directly asks about attention (e.g. had trouble paying attention in class, had trouble staying still, had trouble finishing things, lost things), and being impulsive. This factor cannot diagnose or rule out ADHD, but an elevated score can be a sign that further clinical investigation is warranted.

**Child Assertiveness (ASRTV)** (3 items, theoretical minimum: -1.26, theoretical maximum: 5.53) This factor taps into potential problems with assertiveness (e.g. had trouble standing up for himself/herself, seemed scared around people, been too shy.)

**Child Accident (BOWEL)** (2 items, theoretical minimum: -0.40, theoretical maximum: 11.17) This factor taps a construct related to a child's bowel and bladder functioning. The two items are (wet clothes, soiled underwear). In the validation paper, this factor is labeled Elimination (ELMAT).

**Child Conduct (CNDCT)\*** (3 items, theoretical minimum: -0.20, theoretical maximum: 27.01) This factor taps a construct that relates to a child's conduct or behavior problems. Items include: had trouble with the police, run away, stolen or shoplifted. Due to low endorsement of the items in this factor among the general population, scores in this factor can be elevated quite quickly, even with only minor endorsement of some items.

**Child Depression (DEPRS)** (8 items, theoretical minimum: -1.00, theoretical maximum: 9.23)

This factor taps a construct that is most consistent with child depression. The principal questions on the factor are: looked down or depressed, and had little or no interest in things that were enjoyable before. In addition, there are questions that tap into Attachment Theories connection to this construct (e.g. not wanted to be touched, been able to talk, but refused to do so, and shown little emotion when you expected some type of reaction). As we have known for decades, depression in children can take different forms (e.g. Bowlby, Ainsworth, etc.) and be harder to detect than depression in adults and the variety of items on this factor reflects that.

**Child Psychosis (PSYCS)** (3 items, theoretical minimum: -0.25, theoretical maximum: 9.80)

This factor taps a construct related to child psychosis with two key questions: heard things that were not there, and seen things that were not there. It also contains a minor loading on hurt him/herself.

**Child Separation Anxiety (SEPAX)** (4 items, theoretical minimum: -0.97, theoretical

maximum: 5.51) This factor taps a construct related to a child's discomfort with being away from his/her caretaker. While this factor should not be used to diagnosis or rule out separation anxiety disorder, it can aid the clinical process by alerting the clinician to symptoms consistent with problems around being away from caretakers. Items include: needed someone nearby in order to fall asleep, been afraid of being alone or did not want to be alone, and had nightmares. This factor has a moderate correlation with the sleep factor (.47).

**Child Sexual Worry (SEXWR)** (2 items, theoretical minimum: -0.23, theoretical maximum:

7.66) This factor has two items related to worrisome sexualized behavior in children: made sexual comments, and caused you to worry about his/her sexual activity.

**Child Sleep (SLEEP)** (4 items, theoretical minimum: -0.86, theoretical maximum: 6.29) This

factor taps a construct that relates to difficulties in sleeping: had trouble falling asleep, had nightmares, woke up during the night, and had trouble getting back to sleep in the night.

**Child Eating (UNEAT)** (3 items, theoretical minimum: -1.30, theoretical maximum: 3.68) This

factor taps a construct related to a child's reluctance to eat. The items on this factor are: eaten a variety of foods (vegetables, fruits, grains, meat) (reverse scored), eaten too little, and been a picky eater.

**Child Strengths (STRNG)** (6 items, theoretical minimum: -2.19, theoretical maximum: 5.45)

This factor taps a construct that relates to a child's strengths, or what the child is doing well. Often overlooked in therapy settings, knowing a client's strengths (particularly a child's) can be especially important in providing appropriate care. The items on this factor ask about a range of possible strengths and include: done what was asked of him/her, been able to

complete something after complaining that it was boring, gotten along well with others, been easy to live with, looked to share interests and exciting things with others, and followed rules to your satisfaction. Consistent with other factors, a high score on this factor indicates more problems in strengths/assets. In other words, a high score can be interpreted as having relatively few strengths and a lower score can be interpreted as having relatively many strengths compared to the general population. In the validation data, this factor is labeled Resiliency (RSLNT) and it is suspected that this factor taps strongly into a healthy protective factor, helping children cope with stress.

**Child Suicidality (SUICD)\*** (2 items, theoretical minimum: -0.23, theoretical maximum: 22.62)

This factor taps a construct related to suicidal ideation: thought about killing himself/herself or wished to be dead, hurt himself/herself. As with all TOP factors, the score provided is based upon the client's self-report or a parent's report. We cannot guarantee that the reporter is accurate, nor can we predict future behavior. Due to low endorsement of the items in this factor among the general population, scores on this factor can be elevated quite quickly, even with only minor endorsement of some items. Any elevation in this score should be assumed to be serious and immediate, appropriate clinical action is recommended.

**Child Violence (VIOLN)\*** (6 items, theoretical minimum: -0.95, theoretical maximum: 14.86)

This factor taps a construct that relates physical violence or anger. Some of items indicate that the child has actually done something violent (e.g. physically hurt a person or an animal, seriously hurt someone), while other items indicate that the client has had some kind of violent thought (e.g. had thoughts of killing someone else, had desires to seriously hurt someone). Given recent research on bullying and school violence it should be emphasized that two other items load on this factor: been too shy, and hurt himself/herself. As with all TOP factors, the score provided is based upon the client's (or parent's) self-report or a parent's report. We cannot guarantee that the reporter is accurate, nor can we predict future behavior. Any elevation in this score should be assumed to be serious and immediate, appropriate clinical action is recommended.

### **Adolescent TOP Factor Scoring**

**Adolescent ADHD Symptoms (ADHDC)** (8 items, theoretical minimum: -0.47, theoretical maximum: 5.78) This factor taps a construct that relates to a child's pattern of paying attention. Many of the items from this factor directly asks about attention (e.g. had trouble paying attention in class, had trouble staying still, had trouble finishing things, lost things), and being impulsive. This factor cannot diagnose or rule out ADHD, but an elevated score can be a sign that further clinical investigation is warranted.

**Adolescent Conduct (CNDCT)\*** (3 items, theoretical minimum: -0.20, theoretical maximum: 27.01) This factor taps a construct that relates to a child's conduct or behavior problems.

Items include: had trouble with the police, run away, stolen or shoplifted. Due to low endorsement of the items in this factor among the general population, scores in this factor can be elevated quite quickly, even with only minor endorsement of some items.

**Adolescent Depression (DEPRS)** (10 items, theoretical minimum: -1.04, theoretical maximum: 5.48) This factor taps a construct that relates to many of the symptoms of clinical depression, although an elevated score is not necessarily diagnostic of clinical depression because such diagnosis involves certain time frames (i.e. most of the days – more days than not for at least two weeks), impairment in functioning/high subjective distress, and certain numbers of certain symptoms. The factor correlates very highly with the Beck Depression Inventory (.91). It includes such items as felt down or depressed, felt little or no interest in most things, felt guilty, and felt tired, slowed down, or had little energy. In addition, several of the items represent some of the cognitive components of anxiety (e.g., worried about things, had trouble concentrating or making decisions, noticed your thoughts racing ahead.) This is consistent with recent literature that indicates a high link between anxiety and depression.

**Adolescent Mania (MANIC)** (5 items, theoretical minimum: -1.19, theoretical maximum: 5.35) This factor taps a construct that may be related to manic or hypomanic symptoms. All of this factor's items relate to elevated mood or behavior associated with elevated mood: noticed your thoughts racing ahead, felt rested after only a few hours of sleep, felt you were better than other people, felt on top of the world. Very high scores on this factor are more likely to represent mania or hypomania. It is possible that extremely high scores on this factor as well as extremely low scores are associated with some form of psychological problem (mania or depression), while moderate scores are associated with psychological health.

**Adolescent Psychosis (PSYCS)\*** (6 items, theoretical minimum: -0.65, theoretical maximum: 12.26) This factor taps a construct relating to psychotic symptoms. Items include: seen or heard something that was not really there, felt someone or something was controlling your mind, and worried that someone might hurt you. Items relating to this factor, but carrying less weight, include: felt rested after only a few hours' sleep, and had nightmares.

**Adolescent Social Conflict (SCONF)** (4 items, theoretical minimum: -0.70, theoretical maximum: 5.41) This factor taps a construct that relates to how well someone relates to other people. Endorsement of most of the items on the factor indicates some kind of social conflict (been emotionally hurt by someone, felt someone else had too much control over your life, felt too much conflict with someone, worried someone might hurt you, and felt sexually incompatible with your partner).

**Adolescent Sleep (SLEEP)** (4 items, theoretical minimum: -1.06, theoretical maximum: 4.63) The factor taps a construct that relates to difficulties in sleeping. While the items do not

specify the cause of any sleep disturbance, they do specify the symptoms. The sleep problems asked about include: having difficulty falling, staying, or returning to sleep, and having nightmares.

**Adolescent Suicidality (SUICD)\*** (5 items, theoretical minimum: -0.20 theoretical maximum: 16.31) This factor taps a construct related to suicidal ideation, recent suicide attempts, or recent suicidal gestures: thought about killing yourself or wished you were dead, planned or tried to kill yourself, inflicted pain on yourself, felt worthless, and felt you were going to act on your violent thoughts. As with all TOP factors, the score provided is based upon the client's self-report or a parent's report. We cannot guarantee that the reporter is accurate, nor can we predict future behavior. Due to low endorsement of the items in this factor among the general population, scores on this factor can be elevated quite quickly, even with only minor endorsement of some items. Any elevation in this score should be assumed to be serious and immediate, appropriate clinical action is recommended.

**Adolescent Substance Abuse (SA)\*** (6 items, theoretical minimum: -0.34, theoretical maximum: 18.91) This factor uses the six items from Norm Hoffmann's UNCOPE questionnaire and has excellent sensitivity and specificity for substance abuse and dependency issues. According to Dr. Hoffman's research a patient who positively answers two or more questions is likely to have a substance abuse issue. With three or more questions there is greater than 90% chance of a substance dependency.

**Adolescent Violence (VIOLN)\*** (4 items, theoretical minimum: -0.28, theoretical maximum: 20.47) This factor taps a construct that relates physical temper and violence. More serious and focused than previous TOP violence factor scores, this factor now clearly focuses on serious actions and plans, not just angry feelings. Items include: physically hurt someone else or an animal, had desires to seriously hurt someone, had thoughts of killing someone else, and felt that you were going to act on violent thoughts). As with all TOP factors, the score we provide you is based on the client's self-report. We cannot guarantee that the reporter is accurate, nor can we predict future behavior. Due to low endorsement of the items in this factor among the general population, scores on this factor can be elevated quite quickly, even with only minor endorsement of some items. Any elevation in this score should be assumed to be serious and immediate, appropriate clinical action is recommended.

**Adolescent Work/School Functioning (WORKF)** (6 items, theoretical minimum: -1.12, theoretical maximum: 6.33). This factor taps a construct that relates to functioning at work or school. The items on this factor include one item about missing work or school for any reason and several items about problems at work (e.g. had conflicts with others at work or school regardless of fault, had not been acknowledged for your accomplishments, had your performance criticized); and an item on fulfillment (not been excited about your work or school work).

## TOP Score Ranges

The healthy range for any domain is any score under 1.5. A mild problem is defined as a domain score between 1.5 and 2.0, while a score between 2.0 and 3.0 is considered a moderate case. Any domain over 3.0 standard deviations is considered to be severe.

### Using Theoretical Minimum and Maximum Scores

If a domain was normally distributed, you might expect to see theoretical minimum and maximum scores in the negative five to positive five range. When one of these scores is a lot higher, you can conclude that the distribution of scores within the general population does not look like a normal bell curve. Knowing these theoretical minimums and maximums is important for several reasons:

- When the theoretical maximum score for a particular factor is in the high teens or twenties, it indicates that almost everyone in the general population clusters around the mean of zero, with a few, rare cases out near the extreme. People who score very high on these scales may be acutely aware of how different they feel, and may be desperately seeking relief, but reluctant to discuss it fully.
- You can be confident that TOP was developed to measure change beyond the range of traditional bell curves. However, in the rare event that a client scores at the theoretical maximum, you should wonder if their distress is even greater than reported, or whether they are greatly exaggerating their symptoms.
- TOP scores are not designed to go very far into the healthy range (usually just 1-2 standard deviations below the general population average). A client at the theoretical minimum could indicate that this domain may be a strength for them and you could explore how to use this strength during the course of treatment. The only factor that does not follow this rule is Mania, where very low scores might be a sign of depression.

## **Appendix 5 – Child and Adolescent Needs and Strengths Domains and Scoring**

### **THE CANS**

The CANS is a multiple purpose information integration tool that is designed to be the output of an assessment process. The purpose of the CANS Comprehensive is to accurately represent the shared vision of the youth/youth serving system—children, youth, and families. As such, completion of the CANS Comprehensive is accomplished in order to allow for the effective communication of this shared vision for use at all levels of the system. Since its primary purpose is communication, the CANS Comprehensive is designed based on communication theory rather than the psychometric theories that have influenced most measurement development. There are six key principles of a communimetric measure that apply to understanding the CANS Comprehensive.

### **SIX KEY PRINCIPLES OF THE CANS**

1. Items were selected because they are each relevant to service/treatment planning. An item exists because it might lead you down a different pathway in terms of planning actions.
2. Each item uses a 4-level rating system. Those levels are designed to translate immediately into action levels. Different action levels exist for needs and strengths. For a description of these action levels please see below.
3. Rating should describe the youth, not the youth in services. If an intervention is present that is masking a need but must stay in place, this should be factored into the rating consideration and would result in a rating of an “actionable” need (i.e. ‘2’ or ‘3’).
4. Culture and development should be considered prior to establishing the action levels. Cultural sensitivity involves considering whether cultural factors are influencing the expression of needs and strengths. Ratings should be completed considering the youth’s developmental and/or chronological age depending on the item. In other words, anger control is not relevant for a very young youth but would be for an older youth or youth regardless of developmental age. Alternatively, school achievement should be considered within the framework of expectations based on the youth/youth’s developmental age.
5. The ratings are generally “agnostic as to etiology”. In other words this is a descriptive tool; it is about the “what” not the “why”. Only one item, Adjustment to Trauma, has any cause-effect judgments.
6. A 30-day window is used for ratings in order to make sure assessments stay “fresh” and relevant to the youth/youth’s present circumstances. However, the action levels can be used to over-ride the 30-day rating period.

## MEASUREMENT PROPERTIES

### Reliability

Strong evidence from multiple reliability studies indicates that the CANS can be completed reliably by individuals working with youth and families. A number of individuals from different backgrounds have been trained and certified to use the CANS assessment reliably including health and mental health providers, youth welfare case workers, probation officers, and family advocates. With approved training, anyone with a bachelor's degree can learn to complete the tool reliably, although some applications or more complex versions of the CANS require a higher educational degree or relevant experience. The average reliability of the CANS is 0.78 with vignettes across a sample of more than 80,000 trainees. The reliability is higher (0.84) with case records, and can be above 0.90 with live cases (Lyons, 2009). The CANS<sup>®</sup> is auditable and audit reliabilities demonstrate that the CANS<sup>®</sup> is reliable at the item level (Anderson et al., 2001). Training and certification with a reliability of at least 0.70 on a test case vignette is required for ethical use. In most jurisdictions, re-certification is annual. A full discussion on the reliability of the CANS assessment is found in Lyons (2009) *Communimetrics: A Communication Theory of Measurement in Human Service Settings*.

### Validity

Studies have demonstrated the CANS' validity, or it's the ability to measure and their caregiver's needs and strengths. In a sample of more than 1,700 cases in 15 different program types across New York State, the total scores on the relevant dimensions of the CANS-Mental Health retrospectively distinguished level of care (Lyons, 2004). The CANS<sup>®</sup> assessment has also been used to distinguish needs of children in urban and rural settings (Anderson & Estle, 2001). In numerous jurisdictions, the CANS has been used to predict service utilization and costs, and to evaluate outcomes of clinical interventions and programs (Lyons, 2004; Lyons & Weiner, 2009; Lyons, 2009). Five independent research groups in four states have demonstrated the reliability and validity of decision support algorithms using the CANS (Chor, et al, 2012, 2013, 2014; Cardall, et al, 2016; Epstein, et al, 2015; Israel, et al, 2015, Lardner, 2015).

## RATING NEEDS & STRENGTHS

The CANS Comprehensive is easy to learn and is well liked by children, youth and families, providers and other partners in the services system because it is easy to understand and does not necessarily require scoring in order to be meaningful to the youth and family.

- ★ Basic core items – grouped by domain - are rated for all individuals.
- ★ A rating of 1, 2 or 3 on key core questions triggers extension modules.
- ★ Individual assessment module questions provide additional information in a specific area

Each CANS Comprehensive rating suggests different pathways for service planning. There are four levels of rating for each item with specific anchored definitions. These item level definitions, however, are designed to translate into the following action levels (separate for needs and strengths):

**Basic Design for Rating Needs**

Rating	Level of Need	Appropriate Action
0	No evidence of need	No action needed
1	Significant history or possible need that is not interfering with functioning	Watchful waiting/prevention/additional assessment
2	Need interferes with functioning	Action/intervention required
3	Need is dangerous or disabling	Immediate action/Intensive action required

**Basic Design for Rating Strengths**

Rating	Level of Strength	Appropriate Action
0	Centerpiece strength	Central to planning
1	Strength preset	Useful in planning
2	Identified strength	Build or develop strength
3	No strength identified	Strength creation or identification may be indicated

## CORE ITEMS

### Life Domain Functioning

Family Functioning  
Living Situation  
Social Functioning  
Recreational  
  
Developmental/Intellectual\*  
Job Functioning  
Legal  
Medical/Physical  
Sexual Development  
Sleep  
School Behavior  
  
School Attendance  
School Achievement  
Decision Making

### Strengths

Family Strengths  
Interpersonal  
Optimism  
Educational Setting  
Vocational  
Talents and Interests  
Spiritual/Religious  
Community life  
Relationship Permanence  
Resiliency  
Resourcefulness  
Cultural Identity  
Natural Supports

### Cultural Factors/Acculturation

Language  
Traditions and Rituals  
Cultural Stress

### Caregiver Needs and Resources

Supervision  
Involvement with Care  
Knowledge  
Organization  
Social resources  
Residential stability  
  
Medical/Physical  
Mental Health  
Substance Use  
Developmental  
Safety

### Behavioral/Emotional Needs

Psychosis  
Impulsivity/Hyperactivity  
Depression  
Anxiety  
Oppositional  
Conduct  
Adjustment to Trauma\*  
Anger Control  
Substance Use\*

### Risk Behaviors

Suicide Risk  
Non-Suicidal Self-Injurious Behavior  
Other Self-Harm (Recklessness)  
Danger to Others\*  
  
Sexual Aggression\*  
Runaway\*  
Delinquent Behavior\*  
Judgment\*  
Fire Setting\*  
Intentional Misbehavior

## Appendix 6 – Trauma Screening Checklists



Ages 0–5

### CTAC Trauma Screening Checklist: Identifying Children at Risk

**1. Are you aware of or do you suspect the child has experienced any of the following:**

- |   |  |
|---|--|
| <input type="checkbox"/> Physical abuse   | <input type="checkbox"/> Pre-natal exposure to alcohol/drugs or maternal stress during pregnancy |
| <input type="checkbox"/> Neglectful home environment                              | <input type="checkbox"/> Lengthy or multiple separations from parent                             |
| <input type="checkbox"/> Emotional abuse  | <input type="checkbox"/> Placement outside of the home (foster care, kinship care, residential)  |
| <input type="checkbox"/> Exposure to domestic violence                            | <input type="checkbox"/> Loss of significant people, places, etc.                                |
| <input type="checkbox"/> Exposure to other chronic violence                       | <input type="checkbox"/> Frequent/multiple moves; homelessness                                   |
| <input type="checkbox"/> Sexual abuse or exposure                                 | <input type="checkbox"/> Other _____   |
| <input type="checkbox"/> Parental substance abuse                                 |  |
| <input type="checkbox"/> Impaired parenting (mental illness)                      |  |
| <input type="checkbox"/> Exposure to drug activity <i>aside from parental use</i> |  |

**Even if no areas are checked above, but multiple concerns are present below, further assessment may still be indicated, as there is a strong relationship between the following areas and trauma exposure.**

**2. Does the child show any of these behaviors:**

- |  |   |
|--|---|
| <input type="checkbox"/> Aggression towards self; self-harm              | <input type="checkbox"/> Social/developmental delays in comparison to peers               |
| <input type="checkbox"/> Excessive aggression or violence towards others | <input type="checkbox"/> Repetitive violent and/or sexual play (or maltreatment themes)   |
| <input type="checkbox"/> Explosive behavior (going from 0-100 instantly) | <input type="checkbox"/> Unpredictable/sudden changes in behavior (i.e., attention, play) |
| <input type="checkbox"/> Hyperactivity, distractibility, inattention     | <input type="checkbox"/> Other _____  |
| <input type="checkbox"/> Excessively shy                                 |   |
| <input type="checkbox"/> Oppositional and/or defiant behavior            |   |
| <input type="checkbox"/> Sexual behaviors not typical for age            |   |
| <input type="checkbox"/> Difficulty with sleeping, eating, or toileting  |   |

**3. Does the child exhibit any of the following emotions or moods:**

- |  |   |
|--|---|
| <input type="checkbox"/> Excessive mood swings   | <input type="checkbox"/> Flat affect, very withdrawn, seems emotionally numb or 'zoned out' |
| <input type="checkbox"/> Frequent, intense anger   | <input type="checkbox"/> Other _____  |
| <input type="checkbox"/> Chronic sadness, doesn't seem to enjoy any activities, depressed mood |   |

**4. Does the child have any of the following relational/attachment difficulties:**

- |  |  |
|--|--|
| <input type="checkbox"/> Lack of eye contact, or avoids eye contact                            | <input type="checkbox"/> Doesn't reciprocate when hugged, smiled at, or spoken to                                |
| <input type="checkbox"/> Sad or empty-eyed appearance  | <input type="checkbox"/> Doesn't seek comfort when hurt or frightened; shakes it off, or doesn't seem to feel it |
| <input type="checkbox"/> Overly friendly with strangers (lack of appropriate stranger anxiety) | <input type="checkbox"/> Has difficulty in preschool or daycare  |
| <input type="checkbox"/> Vacillation between clinginess and disengagement and/or aggression    | <input type="checkbox"/> Other _____   |

**Ages 6–18**

**CTAC Trauma Screening Checklist: Identifying Children at Risk**

**1. Are you aware of or do you suspect the child has experienced any of the following:**

- |   |  |
|---|--|
| <input type="checkbox"/> Physical abuse   | <input type="checkbox"/> Pre-natal exposure to alcohol/drugs or maternal stress during pregnancy |
| <input type="checkbox"/> Neglectful home environment                              | <input type="checkbox"/> Lengthy or multiple separations from parent                             |
| <input type="checkbox"/> Emotional abuse  | <input type="checkbox"/> Placement outside of the home (foster care, kinship care, residential)  |
| <input type="checkbox"/> Exposure to domestic violence                            | <input type="checkbox"/> Loss of significant people, places, etc.                                |
| <input type="checkbox"/> Exposure to other chronic violence                       | <input type="checkbox"/> Frequent/multiple moves; homelessness                                   |
| <input type="checkbox"/> Sexual abuse or exposure                                 | <input type="checkbox"/> Other _____   |
| <input type="checkbox"/> Parental substance abuse                                 |  |
| <input type="checkbox"/> Impaired parenting (mental illness)                      |  |
| <input type="checkbox"/> Exposure to drug activity <i>aside from parental use</i> |  |

**2. Does the child show any of these behaviors:**

- |  |   |
|--|---|
| <input type="checkbox"/> Aggression towards self; self-harm              | <input type="checkbox"/> Social/developmental delays in comparison to peers               |
| <input type="checkbox"/> Excessive aggression or violence towards others | <input type="checkbox"/> Repetitive violent and/or sexual play (or maltreatment themes)   |
| <input type="checkbox"/> Explosive behavior (going from 0-100 instantly) | <input type="checkbox"/> Unpredictable/sudden changes in behavior (i.e., attention, play) |
| <input type="checkbox"/> Hyperactivity, distractibility, inattention     | <input type="checkbox"/> Other _____  |
| <input type="checkbox"/> Excessively shy                                 |   |
| <input type="checkbox"/> Oppositional and/or defiant behavior            |   |
| <input type="checkbox"/> Sexual behaviors not typical for age            |   |
| <input type="checkbox"/> Difficulty with sleeping, eating, or toileting  |   |

**3. Does the child exhibit any of the following emotions or moods:**

- |  |   |
|--|---|
| <input type="checkbox"/> Excessive mood swings   | <input type="checkbox"/> Flat affect, very withdrawn, seems emotionally numb or 'zoned out' |
| <input type="checkbox"/> Frequent, intense anger   | <input type="checkbox"/> Other _____  |
| <input type="checkbox"/> Chronic sadness, doesn't seem to enjoy any activities, depressed mood |   |

**4. Does the child have any of the following problems in school:**

- |   |  |
|---|--|
| <input type="checkbox"/> Low or failing grades            | <input type="checkbox"/> Difficulty with authority/frequent behavior referrals |
| <input type="checkbox"/> Attention and/or memory problems | <input type="checkbox"/> Other _____   |
| <input type="checkbox"/> Sudden change in performance     |  |

**5. Does the child have any relational/attachment difficulties?**

- Lack of eye contact, or avoids eye contact
- Lack of appropriate boundaries in relationships
- Does not seek adult help when hurt or frightened

## Appendix 7 – Trauma Assessment Measures and Elements

<b>Level I (High Intensity) Trauma Assessments</b>
Assessment Preparation
<ul style="list-style-type: none"> <li>• Review of abuse/neglect history, Educational Records/IEP, prior assessments, medical/health</li> <li>• Ethnographic interview with current caregiver and birth parent</li> <li>• Caregiver Forms – Trauma Symptom Checklist for Young Children (TSCYC), Child Behavior Checklist (CBCL), Teacher Report Form (TRF), Sensory Profile Caregiver Questionnaire, Dissociative Scale, Alexithymia Scale, BRIEF-P</li> <li>• Pre Assessment Meeting with child’s team</li> </ul>
Assessment (5-6 hours with the child)
<ul style="list-style-type: none"> <li>• Assessment completed by multiple disciplines (OT, Speech/Language, Physician/Nurse, Clinician)</li> <li>• Neurodevelopmental testing – VMI (Visual-Motor Integration), consider also CELF, QNST, MVPT</li> <li>• Psychosocial Interview</li> <li>• Assess Verbal and Nonverbal Cognitive ability with the K-Bit (Kaufman Brief Intelligence Test), quick estimate of intelligence</li> <li>• Pragmatics Protocol (Speech/Language)</li> <li>• CELF language screener</li> <li>• MIM (Marschak Interaction Method) parent/child observation to assess parent/child relationship and guide treatment planning (Training available by Theraplay Institute)</li> <li>• Child Forms/Tools – TSCC, Resiliency Scales, BRIEF-SR</li> <li>• Brief Physical and FAS screen</li> </ul>
Post Assessment
<ul style="list-style-type: none"> <li>• Post Assessment meeting with the child’s team address immediate recommendations</li> <li>• Develop written report</li> <li>• Debrief recommendations using a Family Meeting with the caregivers and child, if appropriate</li> </ul>
<b>Level II (Lower Intensity) Trauma Assessment</b>
Pre Assessment
<ul style="list-style-type: none"> <li>• Review of abuse/neglect history, Educational Records/IEP, prior assessments, medical/health</li> <li>• Abbreviated Ethnographic interview with current caregiver</li> <li>• Caregiver Forms – TSCYC, CBCL, TRF, Sensory Profile Caregiver Questionnaire</li> </ul>
Assessment (2-3 hours with the child)
<ul style="list-style-type: none"> <li>• Assessment completed by an individual</li> <li>• Assess Verbal and Nonverbal Cognitive ability with the K-Bit (Kaufman Brief Intelligence Test), quick estimate of intelligence</li> <li>• CELF language screener</li> <li>• Psychosocial Interview</li> </ul>
Post Assessment
<ul style="list-style-type: none"> <li>• Develop written report</li> <li>• Debrief of recommendations using a Family Meeting with the caregivers and child, if appropriate</li> </ul>