Trauma Program – Program Overview

Stream One: Trauma Clinic

CASA's Trauma Clinic uses trauma-informed approaches and evidence-based practices for children experiencing or affected by attachment disorders and/or complex developmental trauma.

This specialized program offers individual therapy sessions for children/youth and their caregivers. It is designed to support children to resolve trauma symptoms through healthy attachment to their caregivers. Trauma and Attachment Groups (TAG) may be available as part of treatment in the Trauma Clinic, should criteria be met.

The Program:

- Treatment focuses on resolving the symptoms of trauma by supporting healthy parent-child relationships.
- Families may take part in individual, play, and group therapy.
- Treatment time varies with individual needs.

Who it is for:

- Children and youth aged 5-17 years.
- Children and youth with primary challenges associated with complex developmental trauma and/or attachment concerns.
- They are living in a secure, safe home for a minimum of 6 months with committed parents/guardians.
- They have parents/guardians that are able to commit to attending dyadic therapeutic sessions with their child.
- Children and Youth must have current or previous mental health therapy involvement at the time of referral.
- Referrals must be made by a mental health professional or a physician.

Stream Two: Trauma and Attachment Group (TAG)

CASA's Trauma and Attachment Group (TAG) uses trauma-informed approaches and evidence-based practices for children experiencing or affected by attachment disorders and/or complex developmental trauma.

This specialized program is designed to promote healthy attachment between children and caregivers living in biological, adoptive, foster, or kinship families.

The Program:

- A 32-week program, offered twice per year in September and January for the 5-12 year cohort, and once per year in September for the 12-17 year cohort.
- Treatment focuses on resolving the symptoms of trauma by supporting healthy parent-child relationships.

Who it is for:

- Children and youth aged 5-17 years.
- They have been diagnosed with an attachment disorder.
- They are living in a secure safe home for a minimum of one year with committed non-biological parents or guardians or biological parents not involved in the trauma story.
- Families should be relatively stable and able to participate in treatment for up to two years.
- Children and Youth must have current or previous mental health therapy involvement at the time of referral.
- Referrals must be made by a mental health professional or a physician.

Patient Label

Trauma and TAG Referral Package

Note: Collecting this information from parents/guardians allows us to determine whether CASA Trauma Program is appropriate for this child or adolescent. Providing this information is voluntary and it will be held in confidence. If you choose to not supply the information you will not be eligible to participate in the Trauma Program.

Looking to refer to:

☐ Trauma Clinic

☐ Trauma and Attachment Group Program

Please note TAG referrals will be routed to Trauma Clinic for assessment on group suitability and to complete initial therapy work.

Has the caregiver(s) and child consented to the referral? ☐ Yes ☐ No

Patient Information:

Legal First Name:		Legal Last Name:	
Preferred Name:		Health Care Number:	
Gender: ☐ Male ☐ Female ☐ Transgender ☐ Two Spirit ☐ Other			
DOB: (dd-mmm-yyyy)	Age:	Phone:	Alternate Phone:
Address:		City:	Postal Code:
Does the patient have a regular physician involved in their care? ☐ Yes ☐ No			
Family Physician: (if applicable)	Pediatrician: (if applicable)	Psychiatrist: (if applicable)	
School:		Grade:	

Caregiver / Guardian Information:

Name:		Name:	
Relationship:		Relationship:	
Address: (if different from above)		Address: (if different from above)	
City:	Postal Code:	City:	Postal Code:
Phone:		Phone:	
Email:		Email:	
Custody: ☐ Sole ☐ Joint ☐ N/A Please provide legal documents		Custody: ☐ Sole ☐ Joint ☐ N/A Please provide legal documents	

Legal documents attached: ☐ Yes ☐ No

Referral Source:

Mental Health Professional Name:	☐ Primary Health Physician ☐ Psychiatrist ☐ Mental Health Therapist (CASA) ☐ Mental Health Therapist (private) ☐ Mental Health Therapist (AHS)	
External Program:		
Address:	City:	Postal Code:
Email:	Phone:	Fax:

Has the child lived in a secure, safe home for a minimum of 6 months with committed parents or guardians? ☐ Yes ☐ No

Has the child lived in a secure, safe home for a minimum of 1 year with committed non-biological parents or guardians, or biological parents not involved in the trauma story? ☐ Yes ☐ No

Child's Guardianship Status (if applicable)

☐ Custody Agreement Expiry date: _____
☐ Interim Custody Expiry date: _____
☐ Temporary Guardianship Order (TGO) Expiry date: _____
☐ Permanent Guardianship Order (PGO)

To the best or your knowledge, is the child actively exposed to trauma presently? ☐ Yes ☐ No
If yes, please explain.

List everyone living in the home and their relation to the child (please attach a genogram if available).

Child and Family Services Involvement: ☐ Yes ☐ No ☐ Past	Child and Family Services Worker:
Phone:	Fax:

If the answer is "yes" or Past involvement," what services were received?

Family Support for Children with Disabilities (FSCD) support: ☐ Yes ☐ No	FSCD Worker:
Phone:	Fax:
Supports for Permanency (SFP) support: ☐ Yes ☐ No	SFP Worker:
Phone:	Fax:

Please indicate any school-related difficulties the child may be experiencing.

Main contact at school: (eg. Teacher/ VP/ Principal/ Success Coach)	Phone:

Has a psychoeducational assessment been completed? ☐ Yes ☐ No ☐ Waitlisted
If yes, please attach assessment to this document.

If waitlisted for an assessment, please indicate the organization that the child is waitlisted at.

Please indicate the risk issues present in the child:

Risk to Self:

Self-Harm:	☐ Yes ☐ No ☐ Past	Date of last episode:	
Suicidal Ideation (SI):	☐ Yes ☐ No ☐ Past	Date of last episode:	
History of suicide attempts:	☐ Yes ☐ No ☐ Past	Date(s) of last attempt:	
Restrictive eating:	☐ Yes ☐ No ☐ Past	Date of last episode:	
Substance use:	☐ Yes ☐ No ☐ Past	Substance of choice:	

Please attach the most recent safety plan completed or reviewed with the child and family (if applicable).

Risk to others:

Aggression towards adults:	☐ Yes ☐ No ☐ Past
Aggression towards peers:	☐ Yes ☐ No ☐ Past
Aggression towards animals:	☐ Yes ☐ No ☐ Past
Destruction of property:	☐ Yes ☐ No ☐ Past

What are the current trauma-related symptoms and diagnoses (if available) for this child or youth?

Is this child currently prescribed any medication? ☐ Yes ☐ No
If yes, please specify medication and dosage.

Please list any presenting issues within the family system (i.e., existing dynamics that may destabilize the family system, known or queried mental health and physical health challenges for caregivers).

Please describe in chronological detail the client's trauma history:

In-Utero History: (i.e., birth mother's physical and mental health, exposure to domestic violence, transient living conditions, etc., use of any substances during pregnancy).

Birth and Delivery: (i.e., indicate any difficulties around birth and delivery, low Apgar scores, emergency procedures, premature births, low birthweight, etc.)

Infancy: (Ages 0-1)

Toddlerhood: (Ages 1-3)

Early Childhood: (Ages 4-8)

Middle Childhood: (Ages 8-10)

Adolescence: (Ages 11-17)

Were there any delays with the child's developmental milestones? ☐ Yes ☐ No
If yes, please provide further details below.

Please list the mental health supports the child/youth has received or is currently receiving (i.e., community mental health, in-home behavioral consultant).

For referring mental health therapists: What therapeutic approaches have been trialled? What has or has not worked?

Supporting document checklist:

To complete the referral package, please ensure that the required supporting documents are attached to this referral package.

- ☐ Legal Custody documentation (**required** for kinship, foster, adoptive families or if biological parents are no longer together.
- ☐ Current Safety Plan (**required** if there is a current risk of suicidal ideation or self-harm at the time of referral.
- ☐ Recent Psychiatric Assessment (if available).
- ☐ Psychoeducational Report (highly recommended if an assessment has been completed prior).
- ☐ Genogram (optional).

Signature of Referrer:	Date:

Referral Pathways:

Internal CASA Referrals: Submit this form by placing it in the Intake Basket at a CASA location.

External Provider Referrals:

- **Edmonton Program**:
  - Recovery Alberta Mental Health Therapist or Psychiatrists: Follow Recovery Alberta's Centralized Intake Referral process with this completed form attached.
  - Mental Health Therapist or Psychiatrist referring from a private practice: Please submit this completed form to the CASA Intake Team Fax: 780-435-6261 Email: Intake@casaservices.org
- **Calgary Program**: Submit this form to CASA Intake Team Fax: 780-435-6261 or Email: Intake@casaservices.org

CASA Mental Health protects the privacy of individuals requesting or receiving health services in accordance with the *Health Information Act (HIA)*. Personal and/or health information collected on this form will be used for the purpose of providing health services and determining or verifying eligibility for those health services as authorized by sections 27(1)(a) and (b) of the HIA. Information is collected pursuant to section 20(b) of the HIA and will occur directly from the individual accessing services except in specific circumstances in accordance with section 22(2)(b). For more information or if you have any questions about this collection, please contact CASA's Privacy Office by email at privacy@casaservices.org or by phone at 780-400-2271.