



Screening for Trauma in the Child Welfare System

*A Study to Determine the Validity of the Minnesota Department
of Human Services' Trauma Pre-screen Tool*

S E P T E M B E R 2 0 1 7

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Acknowledgments

The authors of this report wish to thank the Minnesota Department of Human Services for providing valuable insights and guidance throughout this project. In particular, we would like to thank Rebecca Wilcox, Sue Krinkie, Jackie Pederson, Greg Rafn, and Yer Chang, as well as the project's Advisory Committee members.

We would like to thank the staff at participating counties across Minnesota (Anoka, Mahnommen, Morrison, Olmsted, and Scott), including the caseworkers who recruited families to participate, as well as workers' supervisors who provided support and direction for the study. We would also like to thank families for taking the time to participate in this study and their willingness to share their experiences, especially given the difficult subject matter.

Finally, we would like to thank the following Wilder Research staff members who contributed to the data collection, analysis, and production of this report:

Mark Anton
Jen Collins
Cheryl Holm-Hansen
Nora Johnson
Sera Kinoglu
Heather Loch
Ryan McArdle
Kerry Walsh

Introduction

Approximately 85% of youth involved in the child welfare system have been exposed to at least one potentially traumatic event (PTE), and these children are nearly four times as likely to have experienced four or more PTEs and related adverse experiences as youth not involved in the child welfare system (Lang, Campbell, Shanley, Crusto, & Connell, 2016, p. 1).

Experiences of trauma can have a crippling effect on children and families. Chronic traumatic situations cause an array of symptoms, “including loss of trust in others, guilt, shame, a decreased sense of personal safety, and hopelessness about the future” (Gerrity & Folcarelli, 2008, p. 12). Trauma comes from a wide range of sources and affects children and youth in a variety of ways. This complexity is compounded by the age of the child; the earlier the trauma is experienced, the more global and pervasive the consequences (Hodas, 2006).

Context for this study

In April 2012, the United States Department of Health and Human Services Administration on Children, Youth and Families (ACYF) issued a bulletin with the following purpose:

To explain the Administration on Children, Youth and Families priority to promote social and emotional well-being for children and youth receiving child welfare services, and to encourage child welfare agencies to focus on improving the behavioral and social-emotional outcomes for children who have experienced abuse and/or neglect (p. 1).

Included within the bulletin was the recommendation that all states screen children placed in out-of-home care for trauma. Therefore, in October 2012, the Minnesota Department of Human Services (DHS) contracted with National Council on Crime and Delinquency (NCCD) Children’s Research Center (CRC) to examine if the Structured Decision Making® (SDM) safety and risk assessment, currently used by child protection workers during maltreatment assessments, could also be used to accurately screen children for trauma (Johnson, Bogie, Kerwin, Fischer, & Stellrecht, 2014). DHS hoped to use an existing assessment in order to ease the burden on caseworkers who are already required to complete a large amount of paperwork.

To this end, CRC conducted an exploratory study that “examined the concurrent relationship between safety and risk factors identified during a family investigation response and child emotional and/or behavioral needs recorded by DHS caseworkers at case initiation or after” (Johnson et al., 2014, p. i). Based on this analysis, CRC created an index of safety and risk factors that had a significant relationship with children’s emotional or behavioral needs, as identified by the caseworker. The resulting index, or SDM trauma pre-screen tool, consists

of 16 questions – 8 from the SDM risk assessment, 6 from the SDM safety assessment, and 2 from Minnesota’s Social Service Information System (SSIS) (i.e., child age at case start and prior placement history) (Johnson et al., 2014). The 16-item pre-screen tool is located in the Appendix of this report.

It is important to note that, shortly after the ACYF issued its bulletin “to promote social and emotional well-being for children and youth receiving child welfare services,” Minnesota experienced a highly publicized and tragic child fatality involving a 4-year old boy. At the time of his death in February 2013, 15 child maltreatment reports had been filed on his behalf (Stahl, 2014). The fatality resulted in the creation of the Governor’s Task Force on the Protection of Children with the goal of advising the governor and legislature on system and practice improvements in the child protection system. The Task Force released final recommendations in March 2015, which included guidelines around screening:

Complete trauma pre-screenings on any child during a child protection response. DHS should pilot a trauma pre-screen tool in 2015 and expand statewide in 2016. Implementation of trauma pre-screening should be consistent with research on best practices (Minnesota Department of Human Services, Governor’s Task Force on the Protection of Children, 2015, p. 17).

This recommendation and the 2012 federal mandate were the driving factors in prioritizing this validation study. Ultimately, DHS wants to identify children who have experienced high levels of trauma and then provide them with referrals or research-based interventions that might mitigate the impact of trauma exposure.

Methodology and study activities

In 2016, DHS contracted with Wilder Research to determine if the 16-item trauma pre-screen tool, developed by CRC, accurately identifies children who have experienced trauma – that is, are the items on the SDM trauma pre-screen a valid measure of trauma? To answer this question, the study identified existing valid measures of trauma and assessed the correlation between an individual’s scores on the SDM trauma pre-screen and the valid trauma measures.

DHS invited a sample of Minnesota counties to participate in this pilot and five county child welfare agencies chose to participate: Anoka, Mahnomon, Morrison, Olmsted, and Scott. The following section provides an overview of the activities conducted and methods used during the study; a fuller description, including research challenges and limitations, is located in the Appendix.

Study population and timeline

The population for this study included **all families with an open child protection case involving children age 3 through 17**. Eligible families were required to live in one of the five pilot counties and have an open child protection case between September 1, 2016 and January 31, 2017.

Key activities

The pilot study included the following key activities:

- **Consultation with stakeholders:** Throughout the project, Wilder consulted with DHS and county staff, including experts from the Child Safety and Permanency and Children’s Mental Health Divisions. Project stakeholders were able to review all materials (e.g., consent forms, web survey) before they were finalized.
- **Validated tool selection:** To determine the validity of the trauma pre-screen tool, Wilder and DHS staff selected an established tool, already validated to identify trauma. The main criteria for such a tool were that it: screen for traumatic events *and* symptoms in general (i.e., not PTSD specific); have demonstrated validity and reliability; be relatively brief and easy to administer; and work for a wide range of ages. After an extensive search, Wilder and DHS staff chose the Trauma Symptom Checklist for Young Children (TSCYC) and its companion tool, the Trauma Symptom Checklist for Children (TSCC). The Appendix includes more detail about this selection process and resulting challenges.
- **Development of consent forms and protocols:** Wilder created consent forms to ensure that families understood the purpose of the study and their rights as participants, as well as a study protocol to ensure that county workers knew all steps of the recruitment and consent process for families. All study forms and tools were approved through Wilder’s Institutional Review Board.
- **County training and ongoing technical assistance:** After choosing the tools and developing corresponding consents and protocols, Wilder held trainings with pilot counties to facilitate consistent data collection across sites. These trainings were held both in person with county staff and via video conference. The majority of respondents (89%) in a web survey administered by Wilder said that they took part in one of the trainings. In addition, DHS made a refresher training available to all pilot county workers on the SDM tools to ensure workers understood all the items on the safety and risk assessment and completed the tools accurately.

- Data collection (SDM trauma pre-screen, TSCYC, and TSCC):** In addition to completing the SDM trauma pre-screen for all families, caseworkers were asked to invite all eligible families on their caseload to complete either the TSCYC or TSCC. The tool was selected based on the ages and cognitive abilities of the children involved in the pilot study; parents or caregivers completed the TSCYC for children age 3 through 7, and children age 13 through 17 could complete the TSCC tool themselves. Caseworkers could choose either tool for children age 8 through 12, depending on the child’s reading ability and general maturity. Ultimately, Wilder received **186** completed tools (TSCYC and TSCC combined) from all five counties, **152** of which had enough complete and matched data (with SSIS) to be used in the analysis (Figure 1). Of the 152 tools used in the analysis, 104 were TSCYCs and 48 were TSCCs. The original goal of the project was for counties to complete 385 tools, in order to have a sufficient sample size to conduct robust analysis on subgroup populations. In the end, Wilder achieved 48 percent of the goal.

1. Tools completed, by county

	Number of tools received from county	Number of tools with valid (usable) scores*
Anoka	111	90
Mahnomen	3	3
Morrison	17	15
Olmsted	52	41
Scott	3	3
Total	186	152

* Although Wilder received 186 tools from counties, 34 were excluded from analysis either because those cases could not be matched with SSIS data, there was a missing consent or assent form, or the child was too young (under 3 years old) to be included in the study.

- Administrative data collection:** Wilder also worked with DHS to collect data on participating families from Minnesota’s Social Service Information System (SSIS), including demographics, case information (e.g., date the case opened, allegation type), and SDM scores (to validate against the TSCYC and TSCC scores). All data shared between DHS and Wilder were de-identified and sent on password-protected spreadsheets via encrypted email.

- **Process evaluation:** In order to hear feedback from counties about the pilot study itself, Wilder sent a web survey to 65 county staff, including caseworkers and supervisors. Any eligible worker could take the survey, even if they had not successfully recruited any families to the study. The survey was open February 8-28, 2017; 28 staff, including six supervisors, completed the survey for a response rate of 43 percent. In addition, Wilder asked survey participants if they would be willing to do a follow-up interview; six people said “yes” and Wilder conducted follow-up interviews with three of them. Finally, after the results of the validation study were complete, Wilder spoke with the supervisors of two counties to hear reactions to the findings; supervisors from the other three counties chose not to participate.
- **Data analysis:** To test the validity of DHS’ trauma pre-screen tool, Wilder correlated children’s scores on the SDM trauma pre-screen instrument with those on the TSCYC and TSCC. This involved determining the correlation between instruments, at both the item and subscale levels, assessing the internal consistency of the SDM pre-screen instrument, and correlating scores on the TSCYC and TSCC with other available SSIS data.

This report

The primary audience for this report is the staff at DHS’ Child Safety and Permanency Division. We hope that our study findings and recommendations help guide the state in its next steps toward fulfilling the 2012 federal mandate and 2015 recommendations from the Governor’s Task Force on the Protection of Children.

Wilder and DHS will also be releasing this information in the form of a webinar to take place in fall 2017. The audience for the webinar will include all counties and tribal agencies; members of the Governor’s Task Force on the Protection of Children; the sites that participated in the pilot; and DHS staff, including Adolescent Services, Adoption Operations, American Indian Child Welfare, Child Safety and Permanency Administration, Child Safety, Children’s Mental Health, Family Support and Placement Services, Quality Assurance, Research and Evaluation, and Workforce Development and Training.

Findings

Description of participants

As noted above, TSCYC and TSCC scores were available for 152 children across the five participating pilot counties. Most children were either white (67%), multi-racial (15%), or African American (12%); 18 percent identified their ethnicity as Hispanic. Slightly more males (57%) than females (43%) participated. Children's ages at the time of the report ranged from 3 through 17, with half (51%) being age 8 or younger.

Figure 2 summarizes the types of allegations in the 152 cases (although no allegation data were entered into SSIS for 29 cases). Most of the allegations were related to neglect, followed by physical abuse, sexual abuse, mental injury, and medical neglect. Of the 141 children for whom this information was available, 31 percent had their case opened for case management following the child protection report. One-third of children had a prior screened-in report, while 38 percent had a prior screened-out report. Only 10 of the 152 children included in the pilot had a prior placement episode.

2. Child protection history and allegations (N=152)

Child protection allegation	N	%
Neglect	93	61%
Physical abuse	68	45%
Sexual abuse	28	18%
Mental injury	4	3%
Medical neglect	3	2%
Threatened injury	0	0%
No allegation(s) entered into SSIS	29	19%
Prior reports and placements		
Prior history of screened-in reports	48	32%
Prior history of screened-out reports	57	38%
Prior placement episode	10	7%
1 prior placement episode	7	--
2 prior placement episodes	3	--

Validation results

Results from the validation study indicate that the SDM trauma pre-screen is **not** a valid or reliable measure for screening for trauma in children. That is, there is no positive correlation between SDM trauma pre-screen scores and scores on a standardized trauma assessment tool. Furthermore, the results suggest that the SDM trauma pre-screen may be under-identifying children who have been exposed to trauma. Key findings from the relevant analyses are presented below, followed by recommendations for next steps.

Correlations: SDM trauma pre-screen and TSCYC/TSCC scores

Background

The primary method for determining the extent to which the SDM pre-screen items were a valid measure of trauma was to correlate children's scores on the SDM pre-screen with their scores on one of two validated measures of trauma, the TSCYC and the TSCC, depending on the child's age. This type of analysis produces correlation coefficients that indicate the strength of the relationship between the items or instruments. Typically, a correlation coefficient (or effect size) of .10 minimally is considered a "small" (or weak) effect size, a correlation coefficient of .30 minimally is considered a "medium" (or moderate) effect size, and a correlation coefficient of .50 minimally is considered a "large" (or strong) effect size (Cohen, 1992).

For this pilot, subscale scores on the TSCYC and TSCC were correlated with: the total score on the 16-item SDM trauma pre-screen; the trauma exposure "level" on the SDM trauma pre-screen (i.e., either a "low" level of trauma exposure, defined as a score between 0-5, or a "high" level of trauma exposure, defined as a score of 6-16); and the 16 SDM trauma pre-screen individual items. The correlations with the pre-screen total scores and trauma levels are presented in Figures 3 and 4. The correlations with the individual items are presented in the Appendix.

Results

As indicated in Figures 3 and 4, none of the subscale scores on the TSCYC or the TSCC were highly correlated with the pre-screen total score, or the trauma level. In fact, on the TSCYC, few subscales were even weakly correlated with the SDM trauma pre-screen. Furthermore, none of the correlations with the TSCYC subscales were statistically significant.

On the TSCC, some of the subscales showed a weak correlation with the SDM trauma pre-screen and one subscale – fantasy dissociation – was moderately correlated with the pre-screen instrument. However, given that only 1 of the 10 TSCC subscales was significantly correlated with the SDM trauma pre-screen, and this correlation was just barely moderate in strength, the overall pattern of results suggests that the SDM trauma pre-screen does not effectively identify trauma symptoms.

The correlational analyses were also examined for differences by age, gender, and race. With the exception of one subscale (fantasy dissociation) on the TSCC, which was significantly correlated with age and gender ($p < .05$), none of the subgroup analyses showed that scores were related to the respondent’s age, gender, or race.

3. Correlations between the TSCYC subscale scores and the SDM trauma pre-screen total score and trauma level (N=103-104)

TSCYC subscale	Pearson Correlation (r) ^a	
	SDM trauma pre-screen total score	SDM trauma pre-screen trauma level
Anxiety	-.026	-.149
Depression	-.071	-.140
Anger/aggression	.107	.072
Posttraumatic stress – intrusion	-.052	-.063
Posttraumatic stress – avoidance	-.017	.020
Posttraumatic stress – arousal	.089	.034
Posttraumatic stress – total	.031	.018
Dissociation	.018	-.027
Sexual concerns	-.129	-.085
Mean of 6 main subscale scores ^b	-.008	-.068

Note. Subscale scores were converted to T-scores, which were correlated with the SDM trauma pre-screen scores and the pre-screen trauma level (i.e., a potentially “low” level of trauma exposure [score of 0-5 on the trauma pre-screen tool] or a potentially “high” level of trauma exposure [score of 6-16 on the trauma pre-screen tool]). None of the correlations were statistically significant at the $p < .05$ level.

^a The Pearson Correlation is a measure of the strength of the relationship between two variables, and ranges from 0 (no relationship) to 1.0 (perfect linear relationship). Typically, a correlation coefficient (or effect size) of .10 minimally is considered a “small” (or weak) effect size, a correlation coefficient of .30 minimally is considered a “medium” (or moderate) effect size, and a correlation coefficient of .50 minimally is considered a “large” (or strong) effect size (Cohen, 1992).

^b The 6 main subscales include: anxiety, depression, anger/aggression, posttraumatic stress – total, dissociation, and sexual concerns.

4. Correlations between the TSCC subscale scores and the SDM trauma pre-screen total score and trauma level (N=45-48)

TSCC subscale	Pearson Correlation (r) ^a	
	SDM trauma pre-screen total score	SDM trauma pre-screen trauma level
Anxiety	.125	.094
Depression	.169	.115
Anger	.220	.179
Posttraumatic stress	.149	.098
Dissociation	.140	.188
Overt dissociation	.081	.122
Fantasy dissociation	.304*	.290*
Sexual concerns	-.009	-.026
Sexual preoccupation	-.071	-.059
Sexual distress	.111	.038
Mean of 6 main subscale scores ^b	.133	.113

Note. Subscale scores were converted to T-scores, which were correlated with the SDM trauma pre-screen scores and the pre-screen trauma level (i.e., a potentially “low” level of trauma exposure [score of 0-5 on the trauma pre-screen tool] or a potentially “high” level of trauma exposure [score of 6-16 on the trauma pre-screen tool]). Correlations were statistically significant at: *p<.05.

^a The Pearson Correlation is a measure of the strength of the relationship between two variables, and ranges from 0 (no relationship) to 1.0 (perfect linear relationship). Typically, a correlation coefficient (or effect size) of .10 minimally is considered a “small” (or weak) effect size, a correlation coefficient of .30 minimally is considered a “medium” (or moderate) effect size, and a correlation coefficient of .50 minimally is considered a “large” (or strong) effect size (Cohen, 1992).

^b The 6 main subscales include: anxiety, depression, anger, posttraumatic stress, dissociation, and sexual concerns.

SDM trauma pre-screen and SDM safety and risk scores

In addition to the results presented above, we examined the SDM trauma pre-screen scores in relationship to the overall SDM safety and risk assessment levels. Figure 5 summarizes these levels for the 152 children who participated in the pilot, including their level of trauma exposure based on the SDM trauma pre-screen. Based upon the pilot data, the SDM trauma pre-screen identified a relatively low proportion of children with potentially high levels of trauma exposure (24%). In contrast, based upon these same children’s scores on the SDM risk assessment, 42 percent were at “high” risk for future maltreatment. According to the SDM Policy and Procedures Manual (2015), “high risk families have significantly higher rates of subsequent referral and substantiation than low risk families, and they are more often involved in serious abuse or neglect incidents” (p. 21). One might reasonably expect, therefore, that the children in these high-risk families are also likely to have experienced

trauma. The fact that the trauma pre-screen appears to potentially *under-identify* the number of children with exposure to trauma – when a screening tool, if anything, should *over-identify* such children – is problematic.

5. SDM levels for children participating in the pilot (N=152)

SDM trauma pre-screen total level	N	%
Low (score of 0-5)	116	76%
High (score of 6-16)	36	24%
SDM risk level		
Low	11	7%
Moderate	77	51%
High	64	42%
SDM safety assessment level		
Unsafe	6	4%
Conditionally safe	70	46%
Safe	76	50%

Internal consistency and structure of the SDM trauma pre-screen tool

We conducted additional analysis of the 16 items that make up the SDM trauma pre-screen to determine its internal consistency, or reliability – that is, how closely related the items are as a group and thus, the extent to which they measure the same construct (in this case, trauma). Cronbach’s alpha – the metric for internal consistency – was .57. Generally, a reliability coefficient of .70 or higher is considered “acceptable” in social science. Therefore, the findings suggest that the 16-item SDM trauma pre-screen does not meet the standards for reliability. Furthermore, removal of any one of the items from the instrument does not substantially increase Cronbach’s alpha (the highest reliability coefficient obtained was .61 if the item about the child’s age at the time the child protection assessment workgroup was opened was removed). See the Appendix for additional information.

In addition to measuring internal consistency, we conducted a factor analysis (Principal Components Analysis). Principal Components Analysis is a statistical technique used to reduce the number of variables in a dataset. It does this by grouping together variables that are highly correlated with one another into distinct “principal components”, or subscales. Principal components are not correlated with each other. This analysis yielded six principal components. Taken together, these components accounted for 66 percent of the total variance in the data set, meaning there is still a fair amount of variability that is unaccounted for; the higher the percentage of variance a proposed model manages to explain, the more confidence we can have in the model’s validity. In addition, upon examining each component, it did not appear as though any of the components had a theoretical basis. That is, while there

were some mathematical relationships among items within each components, it was difficult to classify these groups of items into meaningful constructs, suggesting that there are not meaningful subscales within the SDM trauma pre-screen tool.

Process evaluation

In addition to assessing the validity of the trauma pre-screen tool, Wilder gathered feedback from pilot agencies about their experiences with the study, including thoughts on the training provided by Wilder, the process of inviting families to participate, reactions to the results of the validation study, and potential next steps for the State of Minnesota. Wilder used two methods to collect this feedback:

- A survey of county workers and supervisors, including follow-up phone interviews with three staff who indicated they were willing to discuss the questions further.
- A facilitated phone discussion with county supervisors.

Findings from both methods are detailed below.

Survey of county workers and supervisors

One of the primary challenges in this pilot was recruiting enough families to participate in order to collect a sufficient number of completed tools. As mentioned previously, the original goal was to collect 385 validated tools from all five counties; however, Wilder only received 186 (48% of the goal). Survey feedback indicates that many caseworkers had a difficult time recruiting families to participate, and some caseworkers chose not to invite all of their eligible families. Only one of the 22 caseworkers who took the web survey invited *all* of their eligible clients to participate in the study; 41 percent said they invited *some* of their clients (Figure 6). Most respondents (86%) had at least one client refuse to participate in the study.

6. Number of clients invited to participate (N=22)

[Caseworkers only] How many of your eligible clients did you invite to participate in the trauma pre-screen validation study?	N	%
All of them	1	5%
Most of them	7	32%
Half of them	5	23%
Some of them	9	41%
None of them	0	0%

Survey respondents said that the most common barrier to participation was clients’ ineligibility to participate (e.g., the child was under age 3) (55%). More than one-third said they did not have enough time to ask families to participate in the study (41%) or they felt uncomfortable asking families to participate (36%). Anecdotally, Wilder heard feedback from county supervisors that caseworkers felt uncomfortable using the TSCC and TSCYC because they contain difficult questions related to sexual abuse.

The three caseworkers who completed follow-up interviews with Wilder seemed to have more success in recruiting participants to the study. They said that they took the time to go through the tool with families and explained the process and purpose of the study. However, they also indicated that major barriers to doing the pilot study were time and the additional paperwork. When asked about the difficulty of asking families to respond to questions on sexual abuse, they expressed less concern than other caseworkers, and said that, after they explained the purpose of the study to families, families had no problems completing the tools.

The survey also asked respondents about the helpfulness of the Wilder training in preparing them for the pilot study. Of those who attended a training, most agreed that they understood their role in the pilot study (88%), that they were prepared for the study (76%), and that the information provided by Wilder was clear and understandable (72%; Figure 7).

7. Perspectives of training (N=25)

How much do you agree or disagree with the following statements regarding the training?	Strongly agree	Somewhat agree	Somewhat disagree	Strongly disagree
Overall, the Wilder training helped prepare me to be involved in the study.	28%	48%	20%	4%
Wilder staff provided information in a clear and understandable way.	32%	40%	28%	0%
After the training, I understood my role in the study (e.g., how to recruit families).	28%	60%	8%	4%

Note. Three people did not complete a training; therefore n=25.

When asked about the factors to consider in selecting a trauma pre-screen tool, respondents most often cited length and conciseness, meaning that the tool should not be too long or repetitive with its questions (48%; Figure 8).

8. Factors in a new tool (N=21)

If the trauma pre-screen tool is not valid, what are the most important factors you want DHS to consider before they design or choose a new tool?	N	%
Short in length/not redundant	10	48%
Able to gather complex information (e.g., ACEs, historical trauma, etc.)	4	19%
Can be used with a variety of cultures/languages	3	14%
Easy to use for caseworkers	3	14%
Can be done during case management	2	10%
Doesn't need parental consent	1	5%
Eligibility criteria are clear	1	5%

Note. Open-ended responses were coded into the above categories. Seven respondents did not respond to this question.

Respondents had mixed opinions about who should administer the trauma pre-screen and when. Half said that the best person to complete a trauma pre-screen is the child's parent or legal guardian, while one-quarter each said it should be completed by a caseworker (27%) or the child (if their legal guardian gives consent) (23%). Three-quarters said that children should be pre-screened during case management, while 25 percent said it made more sense to complete during the assessment phase.

Regardless of the tool and process, half of the respondents said that their county does *not* have the necessary resources to follow up with children who receive a high trauma score. When asked what additional tools they need, the most common response was more therapists and mental health practitioners, followed by the ability to refer out to appropriate services in the community, and having staff trained in trauma (Figure 9).

9. Additional resources needed (N=12)

What additional tools or resources does your county need to work with children who screen high for trauma?	N	%
More therapists/mental health professionals	8	67%
Ability to refer out to appropriate services	4	33%
Staff trained in trauma	3	25%

Note. Open-ended responses were coded into the above categories. Respondents could identify more than one resource. Sixteen respondents did not respond to this question.

Focus group with supervisors

After completing data analysis, Wilder and DHS also wanted to host a focus group with the supervisors from all five counties to share the results and solicit reactions and suggestions for next steps. Only two supervisors participated in the focus group (from Anoka and Olmsted counties), as well as two staff from DHS. The supervisors recommended that DHS complete a deeper examination of the SDM, including the Strengths and Needs section of the tool, to determine whether there may be another combination of items that could screen for trauma. The supervisors were concerned about adding a separate screening tool, and thought that even a very brief screening tool would be too much of an administrative burden for caseworkers to complete.

Conclusions and recommendations

Overall, the Structured Decision Making[®] trauma pre-screen tool does **not** reliably identify children who have experienced trauma. As such, DHS should not use this tool to screen children for trauma and, instead, should consider the following recommendations in moving forward with identification of an alternative screening process:

- **Exchange information with other states working on a trauma pre-screen tool.** Because of the bulletin issued by the Administration on Children, Youth and Families in 2012, other states have been working to develop a reliable process for screening children for trauma. At the outset of this project (in spring 2016), no other states had established a valid tool or a process for administering one. However, over one year later, they may have made progress. DHS should connect with states that have been doing similar work to create a valid trauma pre-screen tool, such as Connecticut and Michigan, and share lessons learned from this Minnesota pilot study.
- **Explore newly developed trauma screening tools.** Since this project began, some promising trauma screening tools have been published that DHS may want to review. One of these is the University of Minnesota Ambit Network's Traumatic Stress Screening Tool for Children and Adolescents (TSSCA). The TSSCA is a five-question tool that has been validated for screening children age 5 through 18 who may have experienced a traumatic event. Another potential alternative is the set of trauma screening checklists recently developed by the Southwest Michigan Children's Trauma Assessment Center. Two versions of these checklists are available, one for children birth through age 5 (4 items) and one for children age 6-18 (5 items). Given their brevity and relevance to a wide age range, either of these screening tools may be a good alternative to the SDM trauma pre-screen.
- **Clarify the best time to administer a pre-screen instrument.** DHS should work closely with the Governor's Task Force to clarify expectations around *when* children should be screened for trauma. Workers and supervisors felt it was difficult to complete the pre-screen tool so near intake, because they did not have enough time to develop a trusting relationship with the family. Throughout the pilot, Wilder heard recommendations that pre-screening should take place during case management, when workers have a more established rapport with families.

- **Explore different SDM questions to use in creating a trauma pre-screen tool.** While the current SDM trauma pre-screen tool is not valid, it is possible that a different combination of items or questions would be valid. We understand that DHS and county workers would prefer to move forward using a tool that already exists, so as not to create more paperwork and burden for families and caseworkers. It may be helpful to conduct another pilot study (likely with a different set of counties, due to study fatigue) to see if other SDM items would be valid in screening for trauma.
- **Decide how to approach screening very young children for trauma.** There are very few valid and reliable trauma screeners or assessments for children birth through age 5. This means that even if DHS validates some combination of existing data against an established trauma tool, this validation may not apply to very young children. DHS may need to explore alternative procedures for screening very young children for trauma.
- **Explore incorporating trauma-specific questions into other existing tools.** It may be worthwhile for DHS to identify whether trauma-screening questions (validated through other studies) could be added to the existing mental health-screening tool that caseworkers currently complete for children receiving child protective services. This would alleviate the burden of asking caseworkers to complete a separate tool to screen for trauma.

Appendix

[References](#)

[Detailed methodology](#)

[Data tables: validation results](#)

[Data tables: web survey](#)

[SDM trauma pre-screen \(Cumulative Index of Relevant SDM® Factors\)](#)

[Consent/Assent forms](#)

[Data collection protocol](#)

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Detailed methodology

This section provides a detailed account of the activities and methodologies used in this study. At all phases, Wilder Research consulted with staff from DHS' Child Safety and Permanency Division, as well as staff and supervisors from five counties that volunteered to be in the pilot study: Anoka, Mahnommen, Morrison, Olmsted, and Scott.

At the beginning of the project, Wilder also consulted with experts from DHS' Children's Mental Health Division. Each group provided their expertise and input on the activities and methodologies outlined below.

Eligibility criteria

The population included in this pilot study is **all families with an open child protection case involving children age 3 through 17 years**. Eligible families had to reside in Anoka, Mahnommen, Morrison, Olmsted, or Scott County and have an open child protection case from September 1, 2016 through January 31, 2017. The selected validated trauma assessments helped determine the age range for eligible children (see the next section).

Parents and caregivers were able to complete a tool for any or all of their eligible children, as long as the appropriate consent forms were signed. If a parent or caregiver wanted to provide consent for only one or two of their children, they were asked to choose those with the most recent birthday(s) to ensure a random selection process.

In addition, families had to be able to complete a tool in either English or Spanish, as the selected validated trauma assessments are only available in those two languages.

Selecting a validated trauma instrument

In order to determine the validity of the SDM trauma pre-screen tool, Wilder and DHS staff had to identify and select a well-established tool, already validated to identify trauma. After several meetings, Wilder, DHS, and county staff determined that the top priorities for a comparison tool were that it:

- Identify trauma in general (i.e., is not PTSD specific)
- Pick up on trauma events and symptoms
- Be based in previous research (i.e., is shown to be valid and reliable)
- Be relatively brief and easy to administer
- Work for as wide an age range as possible

Researchers also hoped to find a tool that: was free or relatively inexpensive to use, could be administered by a caseworker, and was validated for use with American Indian or African American communities. However, it was not possible to find a tool that met these criteria in addition to those listed above; and Wilder was unable to find *any* tools that were validated for use with American Indian or African American communities.

Using the criteria established by project stakeholders, Wilder library staff conducted a literature review and selected nearly 20 different tools for researchers to examine in depth. Ultimately, DHS and Wilder decided to use the Trauma Symptom Checklist for Young Children (TSCYC) and its companion tool, the Trauma Symptom Checklist for Children (TSCC), because they met the criteria bulleted above.

Other top tools considered (but not chosen were):

- The Child PTSD Symptom Scale (CPSS)
- The Traumatic Events Screening Inventory for Children (TESI-C) and the Traumatic Events Screening Inventory for Parents (TESI-PRR)
- The UCLA Child/Adolescent PTSD Reaction Index for *DSM-5*

Researchers decided against using these tools for a variety of reasons: some only measured for PTSD and not trauma more broadly; there were restrictions around who could administer the tool; and the age range was not broad enough (e.g., the CPSS is not validated for children under 8 years old). In addition, the TESI had no published psychometrics at the time of review.

Data collection

After choosing the TSCYC and TSCC, Wilder staff developed data collection protocols and held trainings with pilot counties to facilitate consistent data collection across sites. Wilder also created consent forms to ensure that families understood the purpose of the study and their rights as participants. The study, including all forms and tools, was approved through Wilder Research's Institutional Review Board. The consent forms and protocol are appended to this report.

TSCYC and TSCC data collection

To help ensure that caseworkers knew the specific process and guidelines for inviting eligible families to participate in the study, and then for administering the TSCYC and TSCC to participants, Wilder staff held a training with all five pilot counties. Counties could choose to attend a training in person or through video conference. Wilder staff held in-person training

with Anoka County staff on August 23, 2016 and with Scott County staff on September 13, 2016. Training for Mahnomen, Morrison, and Olmsted counties was conducted on September 7, 2016 via DHS’ Vidyo conferencing system. In addition to training, Wilder staff also provided ongoing technical assistance to counties as needed, and checked in with counties on their progress every one or two weeks.

Caseworkers invited eligible families to complete either the TSCYC or TSCC based on the age and cognitive ability of the child involved in the study. After a family agreed to participate and signed the appropriate consent or assent forms, tools were administered as follows:

- **TSCYC:** Completed by a parent or caregiver for children age 3 through 7
- **TSCC:** Completed by children age 13 through 17

For children between age 8 and 12, caseworkers chose either the TSCYC or TSCC based upon the child’s ability to read and understand the questions, as well as their general maturity.

The original goal of the pilot study was to validate DHS’ trauma pre-screen tool for the overall population of eligible children in five counties, as well as for specific age and racial subgroups. In order to do a subpopulation analysis, Wilder staff estimated they would need 385 completed tools from counties. After several discussions at the beginning of the study, county supervisors sent their estimates for the number of tools they could complete in two months, starting on September 1, 2016 (Figure A1). For a variety of reasons, counties were unable to reach their target goals, even after data collection was extended to five months (see the Research Limitations section); therefore, Wilder could only conduct a limited subpopulation analysis.

A1. Tools to be completed, by county, relative to total number completed

	Goal number of tools to be completed	Number of tools received from county	Percentage of goal
Anoka	175	111	63%
Mahnomen	5	3	60%
Morrison	30	17	57%
Olmsted	100	52	52%
Scott	75	3	4%
Total	385	186	48%

Note. Although Wilder received 186 tools from counties, 34 were excluded from analysis either because those cases could not be matched with SSIS data, there was a missing consent or assent form, or the child was too young (under 3 years old) to be included in the study.

Administrative data collection

In addition to collecting data from the TSCYC and TSCC tools, Wilder Research worked with DHS to collect administrative data on participating children from Minnesota's Social Service Information System (SSIS), including:

- Demographic information (i.e., gender, age and date of birth, race and ethnicity, and county of residence)
- Date the child protection case was opened
- Number of out-of-home placements
- Allegation type
- If the case went to case management
- If there was a prior Child Protection report
- Structured Decision Making[®] (SDM) scores, including the safety and risk assessment scores and individual item scores

All data shared between DHS and Wilder were de-identified and sent on password-protected spreadsheets via encrypted email. To help ensure that Wilder had all of the data researchers needed for the validation study, a test data pull was done in early 2017, with a subset of cases.

Process evaluation

Beyond assessing the validity of the pre-screen tool, Wilder wanted to hear feedback from pilot agencies about their experiences with the study, including thoughts on the training provided by Wilder, the process of inviting families to participate, reactions to the results of the validation study, and potential next steps for the State of Minnesota. Wilder used two methods to obtain this feedback: a web survey of county workers and supervisors, and a facilitated phone discussion with county supervisors from the pilot sites.

Web survey of county workers: After the data collection phase of the study was complete, Wilder sent a web survey to 65 county staff, including caseworkers and supervisors. County supervisors provided Wilder with the list of workers who were asked to invite families to participate in the study; any eligible worker could take the survey, even if they had not successfully recruited any families to the study. The survey was open from February 8 through 28, 2016; 28 staff, including six supervisors, completed the survey for a response rate of 43 percent; Anoka County had the highest participation rate (Figure A2).

A2. Web survey participation, by county

	Completed surveys	Number of staff in sample	% participation
Anoka	13	20	65%
Olmsted	10	19	53%
Mahnomen	2	4	50%
Morrison	2	4	50%
Scott	1	18	6%
Total	28	65	43%

The last question of the survey asked participants if they would be willing to do a follow-up interview with Wilder staff; six people indicated that they would be willing to do an interview and Wilder conducted follow-up interviews with three of them (the other three were unavailable or declined to participate).

Supervisor focus group: After completing data analysis, Wilder and DHS also wanted to host a focus group with the supervisors from all five counties to share the results and get reactions. Only two supervisors participated in the focus group (from Anoka and Olmsted counties), as well as two staff from DHS.

Assessing the concurrent validity of the trauma pre-screen tool

To test the validity of DHS' trauma pre-screen tool, Wilder correlated the scores on the pre-screen with those on the TSCYC and TSCC. This involved the following steps:

- 1. Determining the correlation between instruments.** Individuals' scores on the two instruments were correlated at both the item and subscale levels. This produced a correlation coefficient that indicates the strength of the relationship between the items/instruments.
- 2. Assessing the internal consistency of the pre-screen instrument.** To assess how well the pre-screen tool delivers reliable scores, Wilder assessed the internal consistency of the tool using Cronbach's alpha. This measured the correlation among the individual items on the pre-screen tool and identified any items that perhaps should be excluded from the instrument.
- 3. Correlating scores with other available data.** In addition to establishing concurrent validity with an established trauma-screening instrument, Wilder correlated scores on the pre-screen instrument with other data available in SSIS, including out-of-home placements, and the child's age and gender.

Research limitations and challenges

Readers should consider the following limitations and challenges when interpreting the findings presented in this report:

- **An “imperfect” tool against which to validate the trauma pre-screen.** Prior to the beginning of this project, both DHS and Wilder Research staff conducted an extensive search for a tool proven to screen for trauma, against which researchers could validate DHS’ new trauma pre-screen tool. The goal was to find a tool that identified traumatic events and symptoms (generally), which had been previously validated and had strong psychometric properties, was brief and easy to administer, and that applied to as wide of an age range as possible (originally, DHS had hoped to find a tool that was validated for ages 0-18). Unfortunately, no such screening tool meets all of these criteria and, the reality is, if a perfect screening tool existed, states would likely already be using it with their child welfare populations. The TSCYC and TSCC were the tools (albeit assessments, rather than screeners) that most closely fit the project criteria as outlined by DHS.
- **Low buy-in from county workers and, therefore, limited sample size.** Wilder heard feedback, both through the web survey and anecdotally, that many workers did not like the TSCYC and TSCC, largely because these lengthy tools ask families to respond to difficult topics, such as potential sexual abuse. This was especially difficult given that families needed to complete the tool within the first 45 days of case opening (during assessment) when they were just getting to know their caseworker. Throughout the project, several caseworkers suggested administering the tool only to families who enter into case management (rather than assessment), with the idea that families would be more familiar with their caseworkers and feel more comfortable responding to difficult questions. However, because the DHS trauma pre-screen is intended to screen children for trauma at their first entry point into child protection, DHS and Wilder needed workers to administer the TSCYC and TSCC for all eligible children in the assessment phase. Because many workers did not like the tools or the administration process, there was less buy-in, which ultimately led to fewer completed tools. The original target for this pilot study was 385 completed tools from all five counties, with county totals proportional to the estimated number of families served by each county. The original data collection timeframe for the study was two months. After extending data collection to five months, Wilder still only received 186 completed tools, the majority of which (61%) came from Anoka County.

- **Variability across counties.** While all five county agencies (Anoka, Mahnomon, Morrison, Olmsted, and Scott) volunteered for this pilot study and received similar training on the study protocol and procedures, there are a few differences across counties in their approach to the pilot. One primary difference was the way workers within and across counties communicated with potential participants about the study and extended the invitation; some workers/counties were more apt to invite those they perceived to be a good fit for the study and would be more willing to participate, despite the established eligibility criteria.
- **Uncertainty about the population that did *not* participate in the pilot study.** In addition to the completed TSCYC and TSCC tools, Wilder also asked counties to send refusal forms for those who chose *not* to participate in the study. The refusal forms were blank consent forms (unsigned with no identifying information) on which the caseworker could mark the reason a family did not participate (i.e., language barrier, developmental delay or cognitive capacity, child was previously screened for trauma or is already being evaluated by a trauma-informed therapist, parent refused, family was not invited by the caseworker to participate). Caseworkers were supposed to ask all eligible families to participate in the pilot study and then send the completed tool (if the family gave consent) or a refusal form (if they did *not* provide consent). However, very few caseworkers sent Wilder refusal forms, or provided an estimate of the number of families who did not participate in the study. Therefore, we do not know anything about the population of non-participants and cannot calculate a response rate.

Data tables: validation results

A3. Demographic characteristics of children (N=152)

Demographics	N	%
Race		
White	102	67%
Multi-racial	23	15%
African American/Black	18	12%
Asian or Pacific Islander	4	3%
Missing	5	3%
Ethnicity		
Hispanic	27	18%
Not Hispanic	125	82%
Gender		
Male	86	57%
Female	66	43%
Age at time of report		
3 – 5	42	28%
6 – 8	36	24%
9 – 11	36	24%
12 – 14	23	15%
15 – 17	15	10%

A4. SDM trauma pre-screen items: Individual-item response (N=152)

	N	%
Q1: Prior assigned report	60	40%
Q2: Prior assigned reports of abuse	26	17%
Q3: Any placement that ended prior to the child protection assessment workgroup	8	5%
Q4: Child sexual abuse is suspected and circumstances suggest that child safety may be an immediate concern	8	5%
Q5: Caregiver describes or acts toward child in predominantly negative terms or has extremely unrealistic expectations	7	5%
Q6: Caregiver is unwilling, or is unable, to meet the child's immediate needs for food, clothing, shelter, and medical or mental health care	5	3%
Q7: Caregiver has not, or will not, provide supervision necessary to protect child from potentially serious harm	5	3%
Q8: Primary caregiver has/had mental health problem	50	33%
Q9: Primary caregiver lacks parenting skills	40	26%
Q10: Either caregiver employs harmful and/or developmentally inappropriate discipline	16	11%
Q11: Either caregiver's parenting style is over-controlling	10	7%
Q12: Child in home has a developmental disability/emotional impairment	78	51%
Q13: Child in home has a history of delinquency	9	6%
Q14: Child is fearful of caregiver(s), other family members, or other people living in or having access to the home	9	6%
Q15: The child's physical living conditions are hazardous and immediately threatening	85	56%
Q16: Child age at child protection assessment workgroup start		
0 – 4 years	30	20%
5 – 9 years	64	42%
10 – 17 years	58	38%

A5. Correlations between the TSCYC subscale scores and the individual SDM trauma pre-screen items (N=103-104) (Q1-Q8)

TSCYC subscale	Pearson correlation							
	Q1	Q2	Q3	Q4	Q5	Q6	Q7	Q8
Anxiety	.155	-.059	.008	-.089	-.121	-.112	-.121	.064
Depression	.062	.013	-.072	.021	-.001	-.031	-.001	-.137
Anger/aggression	.212*	.071	.025	-.021	-.081	-.107	-.081	.065
Posttraumatic stress – intrusion	.143	-.028	-.045	-.069	-.077	-.034	-.077	-.105
Posttraumatic stress – avoidance	.377***	-.018	-.046	-.072	-.053	-.019	-.053	-.133
Posttraumatic stress – arousal	.256**	.010	-.043	-.110	-.097	-.085	-.097	.123
Posttraumatic stress – total	.320**	.003	-.042	-.107	-.094	-.066	-.094	-.008
Dissociation	.202*	-.156	-.070	-.035	-.037	-.058	-.037	.045
Sexual concerns	.125	-.074	-.068	-.049	-.055	-.039	-.055	-.187
Mean of 6 main subscale scores ^a	.247*	-.045	-.064	-.065	-.090	-.095	-.090	-.014

Note. Subscale scores were converted to T-scores, which were correlated with the SDM trauma pre-screen items. Correlations were statistically significant at: *** $p < .001$, ** $p < .01$, and * $p < .05$.

^a The 6 main subscales include: anxiety, depression, anger/aggression, posttraumatic stress – total, dissociation, and sexual concerns.

A5. Correlations between the TSCYC subscale scores and the individual SDM trauma pre-screen items (N=103-104) (Q9-Q16)

TSCYC subscale	Pearson correlation							
	Q9	Q10	Q11	Q12	Q13	Q14	Q15	Q16
Anxiety	.014	-.005	-.047	.039	-.019	.095	-.010	-.172
Depression	-.119	.074	-.053	.054	-.007	.047	-.047	-.108
Anger/aggression	.097	-.010	-.101	.230*	.240*	.173	-.024	-.181
Posttraumatic stress – intrusion	-.072	-.060	.125	-.014	-.052	.173	.010	-.134
Posttraumatic stress – avoidance	-.130	-.075	.065	-.034	.121	.176	-.008	-.156
Posttraumatic stress – arousal	-.022	-.015	.012	.223*	.152	.158	-.107	-.092
Posttraumatic stress – total	-.079	-.041	.069	.113	.107	.204*	-.075	-.150
Dissociation	.047	-.133	-.044	.265**	.267**	.118	-.243*	-.097
Sexual concerns	-.075	-.106	.052	-.098	-.062	.045	-.020	-.097
Mean of 6 main subscale scores ^a	-.020	-.063	-.030	.151	.136	.161	-.103	-.182

Note. Subscale scores were converted to T-scores, which were correlated with the SDM trauma pre-screen items. Correlations were statistically significant at: *** $p < .001$, ** $p < .01$, and * $p < .05$.

^a The 6 main subscales include: anxiety, depression, anger/aggression, posttraumatic stress – total, dissociation, and sexual concerns.

A6. Correlations between the TSCC subscale scores and the individual SDM trauma pre-screen items (N=45-48) (Q1-Q8)

TSCC subscale	Pearson correlation							
	Q1	Q2	Q3	Q4	Q5	Q6	Q7	Q8
Anxiety	-.284*	-.077	.237	.312*	.119	.024	.148	.004
Depression	-.099	-.022	.426**	.197	.187	.156	.094	-.136
Anger	.037	.096	.164	.077	.256	.205	.027	-.064
Posttraumatic stress	-.186	-.096	.453**	.272	.102	.109	.114	-.024
Dissociation	-.262	-.169	.323*	.323*	.055	.058	.076	-.107
Overt dissociation	-.256	-.165	.321*	.245	.034	.069	.022	-.129
Fantasy dissociation	-.153	-.045	.179	.458**	.268	.176	.171	-.144
Sexual concerns	-.152	-.074	.153	.295*	.075	.075	.028	-.084
Sexual preoccupation	-.214	-.129	.017	.135	-.026	-.026	-.053	-.056
Sexual distress	-.103	.036	.324*	.504***	.228	.221	.188	-.047
Mean of 6 main subscale scores ^a	-.199	-.075	.330*	.283	.191	.110	.083	-.075

Note. Subscale scores were converted to T-scores, which were correlated with the SDM trauma pre-screen items. Correlations were statistically significant at: *** $p < .001$, ** $p < .01$, and * $p < .05$.

^aThe 6 main subscales include: anxiety, depression, anger, posttraumatic stress, dissociation, and sexual concerns.

A6. Correlations between the TSCC subscale scores and the individual SDM trauma pre-screen items (N=45-48) (Q9-Q16)

TSCC subscale	Pearson correlation							
	Q9	Q10	Q11	Q12	Q13	Q14	Q15	Q16
Anxiety	.026	.165	-.250	.235	.043	-.022	.194	-.102
Depression	.122	.227	-.170	.199	.008	-.082	.127	-.139
Anger	.323*	.218	-.277	.145	-.120	.019	.234	-.171
Posttraumatic stress	.057	.095	-.218	.240	.032	-.063	.160	-.077
Dissociation	.024	.310*	-.157	.251	.027	.048	.178	.010
Overt dissociation	.044	.275	-.165	.195	-.023	-.036	.165	-.038
Fantasy dissociation	.085	.510***	-.149	.320*	.036	.126	.145	.088
Sexual concerns	.089	-.095	-.200	-.034	-.055	.054	.160	-.298*
Sexual preoccupation	.147	-.099	-.181	-.064	.009	.130	.238	-.405**
Sexual distress	-.030	-.028	-.162	.033	-.131	-.075	.032	-.109
Mean of 6 main subscale scores ^a	.128	.149	-.259	.179	-.028	-.017	.198	-.200

Note. Subscale scores were converted to T-scores, which were correlated with the SDM trauma pre-screen items. Correlations were statistically significant at: *** $p < .001$, ** $p < .01$, and * $p < .05$.

^aThe 6 main subscales include: anxiety, depression, anger, posttraumatic stress, dissociation, and sexual concerns.

A7. TSCYC subscale T-score means (N=103-104)

TSCYC subscale	Mean	Range
Anxiety	54.7	47 – 105
Depression	52.1	41 – 90
Anger/aggression	54.9	41 – 99
Posttraumatic stress – intrusion	52.1	43 – 110
Posttraumatic stress – avoidance	52.6	44 – 110
Posttraumatic stress – arousal	56.6	39 – 110
Posttraumatic stress – total	54.9	40 – 110
Dissociation	54.1	43 – 110
Sexual concerns	49.5	46 – 110
Mean of 6 main subscale scores ^a	53.4	42 – 93

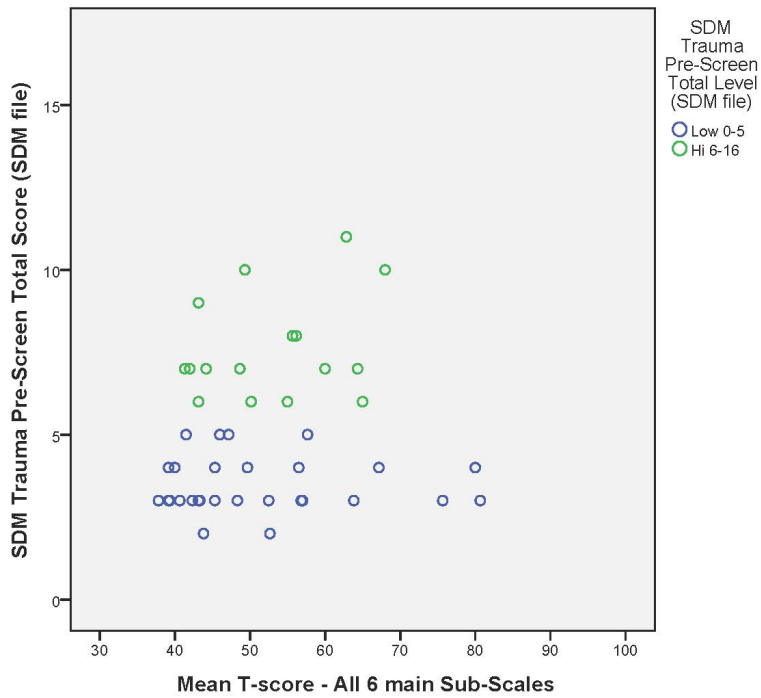
^a The 6 main subscales include: anxiety, depression, anger, posttraumatic stress, dissociation, and sexual concerns.

A8. TSCC subscale T-score means (N=45-48)

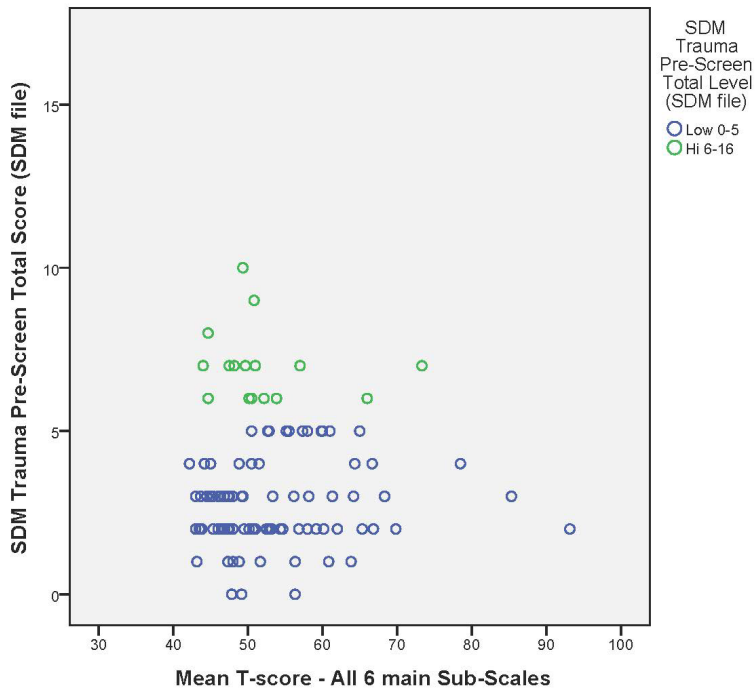
TSCC subscale	Mean	Range
Anxiety	51.3	32 – 85
Depression	53.7	36 – 91
Anger	50.5	35 – 78
Posttraumatic stress	51.5	36 – 80
Dissociation	50.4	35 – 85
Overt dissociation	52.0	37 – 84
Fantasy dissociation	47.6	37 – 85
Sexual concerns	52.9	38 – 118
Sexual preoccupation	51.2	37 – 119
Sexual distress	55.3	41 – 121
Mean of 6 main subscale scores ^a	52.1	38 – 81

^a The 6 main subscales include: anxiety, depression, anger, posttraumatic stress, dissociation, and sexual concerns.

A9. DHS Trauma TSCC T-Score - SDM Trauma Screen Scatter Plots June 5 2017



A10. DHS Trauma TSCYC T-Score - SDM Trauma Screen Scatter Plots June 4 2017



Data tables: web survey

A11. Counties in which respondents work (N=28)

In which county do you work?	N	%
Anoka	13	46%
Olmsted	10	36%
Mahnomen	2	7%
Morrison	2	7%
Scott	1	4%

A12. Supervisory status (N=28)

Are you a county supervisor?	N	%
Yes	6	21%
No	22	79%

A13. Number of clients invited to participate (N=22)

[Caseworkers only] How many of your eligible clients did you invite to participate in the trauma pre-screen validation study?	N	%
All of them	1	5%
Most of them	7	32%
Half of them	5	23%
Some of them	9	41%
None of them	0	0%

A14. Client refusal to participate (N=22)

[Caseworkers only] About how many of your eligible clients (that you invited to participate) refused to take part in the study?	N	%
None	3	14%
1 to 5	11	50%
6 to 10	3	14%
11 or more	5	23%

A15. Barriers to inviting families to participate (N=22)

[Caseworkers only] What barriers did you experience in inviting families to participate in the study? (Select all that apply)	N	%
Most of my clients were ineligible to participate (e.g., they were under 3 years old)	12	55%
I did not have enough time to ask families to participate	9	41%
It felt uncomfortable to ask families to participate	8	36%
Most of my clients spoke a primary language other than English or Spanish	2	9%
There were no barriers	1	5%
Other (please specify)	9	41%
Clients were not interested in participating	5	56%
Clients did not complete the tool on their own	3	33%
Client's eligibility was unclear	1	1%

Note. The total is greater than 100% as caseworkers could choose more than one response option. "Other" responses were coded into the above categories.

A16. Checking progress with caseworkers (N=6)

[Supervisors only] How often did you check in with caseworkers about their progress in recruiting families for the study?	N	%
Daily	0	0%
Multiple times per week	1	17%
Weekly	2	33%
Every other week	3	50%
Once per month or less	0	0%

A17. Communication from DHS staff (N=6)

[Supervisors only] The amount of communication from DHS staff about this pilot study was...	N	%
Too much	0	0%
Just right	6	100%
Not enough	0	0%
Not applicable	0	0%

A18. Training attendance (N=28)

Did you take part in one of the study trainings conducted by Wilder Research?	N	%
Yes, I attended an in-person training	12	43%
Yes, I attended a Vidyo training	13	46%
Yes, I watched the Vidyo training after it was recorded	0	0%
No	3	11%

A19. Perspectives of training (N=25)

How much do you agree or disagree with the following statements regarding the training?	Strongly agree	Somewhat agree	Somewhat disagree	Strongly disagree
Overall, the Wilder training helped prepare me to be involved in the study.	28%	48%	20%	4%
Wilder staff provided information in a clear and understandable way.	32%	40%	28%	0%
After the training, I understood my role in the study (e.g., how to recruit families).	28%	60%	8%	4%

Note. Three people did not complete a training; therefore n=25.

A20. Wilder communication (N=28)

Wilder staff addressed my questions in a timely manner.	N	%
Strongly agree	8	29%
Somewhat agree	9	32%
Somewhat disagree	1	4%
Strongly disagree	1	4%
Not applicable	9	32%

A21. Factors in a new tool (N=21)

If the trauma pre-screen tool is not valid, what are the most important factors you want DHS to consider before they design or choose a new tool?	N	%
Short in length/not redundant	10	48%
Able to gather complex information (e.g., ACEs, historical trauma, etc.)	4	19%
Can be used with a variety of cultures/languages	3	14%
Easy to use for caseworkers	3	14%
Can be done during case management	2	10%
Doesn't need parental consent	1	5%
Eligibility criteria are clear	1	5%

Note. Open-ended responses were coded into the above categories. Seven respondents did not complete this question.

A22. Completing the screening tool (N=26)

Who do you think is the best person to complete a trauma-screening tool?	N	%
The parent or legal guardian	13	50%
The caseworker	7	27%
The child (if their legal guardian gives consent)	6	23%

Note. Two respondents did not complete this question.

A23. Stage for screening (N=24)

Ideally, at which stage should workers be screening children for trauma?	N	%
Case management	18	75%
Assessment	6	25%

Note. Four respondents did not complete this question.

A24. Reason for choosing “case management” or “assessment” (N=21)

Why is that?	N	%
Case management helps build a relationship/trust	10	48%
Need to screen throughout all phases	6	29%
Generally need more time with clients (screen during case management)	4	19%
Families are in crisis/stressed at intake (screen during case management)	3	14%
Screen during assessment to assist families during case management	1	5%

Note. Open-ended responses were coded into the above categories. Three respondents did not complete this question.

A25. Sharing screening tool results (N=26)

How important is it that caseworkers be able to share the final trauma prescreen score back with families?	N	%
Extremely important	11	42%
Somewhat important	7	27%
Not very important	8	31%
Not at all important	0	0%

Note. Two respondents did not complete this question.

A26. County capacity (N=26)

Do you think your county has the capacity and necessary tools (e.g., trained mental health professionals) to follow-up with children who receive a high trauma score?	N	%
Yes	13	50%
No	13	50%

Note. Two respondents did not complete this question.

A27. Additional resources needed (N=12)

What additional tools or resources does your county need to work with children who screen high for trauma?	N	%
More therapists/mental health professionals	8	67%
Ability to refer out to appropriate services	4	33%
Staff trained in trauma	3	25%

Note. Open-ended responses were coded into the above categories. Sixteen respondents did not complete this question.

A28. Additional feedback about the pilot study (N=8)

Please share any additional feedback you have about the trauma pre-screen pilot.	N	%
Did not like TSCYC and TSCC tools	3	38%
A tool is unnecessary/already understand trauma	1	13%
Need incentives for families to complete extra tool	1	13%
Process for recruiting families was confusing	1	13%
Expectations for pilot study were too high	1	13%
Families were willing to participate	1	13%
Families were unwilling to participate	1	13%

Note. Open-ended responses were coded into the above categories. Twenty respondents did not complete this question.

SDM trauma pre-screen (Cumulative Index of Relevant SDM® Factors)

Minnesota Department of Human Services Prescreen for Trauma Exposure: Cumulative Index of Relevant SDM® Risk and Danger Factors

1.	Prior assigned report		
	a. No.....	0	
	b. Yes.....	1	_____
2.	Prior assigned reports of abuse		
	a. No.....	0	
	b. Yes.....	1	_____
3.	Any placement that ended prior to the current case		
	a. No.....	0	
	b. Yes.....	1	_____
4.	Child sexual abuse is suspected and circumstances suggest that child safety may be an immediate concern		
	a. No.....	0	
	b. Yes.....	1	_____
5.	Caregiver describes or acts toward child in predominantly negative terms or has extremely unrealistic expectations		
	a. No.....	0	
	b. Yes.....	1	_____
6.	Caregiver is unwilling, or is unable, to meet the child's immediate needs for food, clothing, shelter, and/or medical or mental health care		
	a. No.....	0	
	b. Yes.....	1	_____
7.	Caregiver has not, or will not, provide supervision necessary to protect child from potentially serious harm		
	a. No.....	0	
	b. Yes.....	1	_____
8.	Primary caregiver has/had mental health problem		
	a. No.....	0	
	b. Yes.....	1	_____
9.	Primary caregiver lacks parenting skills		
	a. No.....	0	
	b. Yes.....	1	_____
10.	Either caregiver employs harmful and/or developmentally inappropriate discipline		
	a. No.....	0	
	b. Yes.....	1	_____
11.	Either caregiver's parenting style is over-controlling		
	a. No.....	0	
	b. Yes.....	1	_____
12.	Child in home has a developmental disability/emotional impairment		
	a. No.....	0	
	b. Yes.....	1	_____
13.	Child in home has a history of delinquency		
	a. No.....	0	
	b. Yes.....	1	_____
14.	Child is fearful of caregiver(s), other family members, or other people living in or having access to the home		
	a. No.....	0	
	b. Yes.....	1	_____
15.	The child's physical living conditions are hazardous and immediately threatening		
	a. No.....	0	
	b. Yes.....	1	_____
16.	Child age at case start		
	a. 0-4 years.....	0	
	b. 5-9 years.....	1	
	c. 10-17 years.....	2	_____

Total Score _____

____ 0-5 Lower level of trauma exposure based on SDM cumulative index
 ____ 6+ High level of trauma exposure based on SDM cumulative index

**A Study to Validate the DHS Trauma Pre-Screen Tool
Parent/Caregiver Consent Form (for TSCYC)
To participate on behalf of young children**

Dear Parent or Caregiver,

The State of Minnesota has created a form to help identify children who may have experienced trauma, meaning they have had upsetting things happen in their lives. The purpose of the form is to find these youth and get them extra support. Your county is part of a study, being done by Wilder Research, to find out if this new form works. To test if it works, case workers are asking families fill out a different form that has been proven to identify children who have experienced trauma. **All** families with an open child protection case, starting on or about September 1, 2016, will be asked to participate. About 300 families from five counties will be in the study. You are not being singled out. Please read the information below.

- If you sign this consent form, you agree to be in this study. **This means you agree to complete a screening form (separate from the one completed by your case worker).**
- This study is completely voluntary. You do **not** have to be in this study if you do not want to. You can leave this study at any time.
- **Whether or not you choose to be in this study will NOT affect your relationship with the Department of Human Services, the Child Welfare system, or any other systems.** It is completely up to you whether you want to participate and your decision either way will not influence your case.
- There is no direct benefit to being in this study, but findings will help case workers identify kids who might need extra support.
- The form asks questions about your child's possible experiences and symptoms related to trauma. Some questions may be upsetting. You can skip any questions you do not want to answer. If you would like to see a copy of the form now, please ask your case worker.
- If you choose to be in this study, your county will provide Wilder Research staff with the responses from two forms – the one created by the State of Minnesota and the one you fill out about your child. Your case worker will not see your answers to the questions. You will be asked to place the completed form in an envelope addressed to Wilder Research, and then seal that envelope before giving it back to your case worker. Wilder Research will keep your name and your child's name confidential, **unless** you or your child indicates on the form that someone is in immediate danger.
- DHS will also share some information about your case with Wilder Research. This includes some demographic information, such as your child's age, date of birth, gender, race, ethnicity, and county. It also includes some information about your child protection case and history, such as the date your case opened, the reason your case was opened, your child's past experience in child protection, including out-of-home placements (if any), and their emotional/behavioral score from the SDM risk and safety assessment.
- All information sent to Wilder Research will be stored in locked cabinets or on secure, password-protected computers and will be destroyed one year after this study is complete.
- If you would like more information, please call Darcie Thomsen at Wilder Research at 651.280.2664, or email her at darcie.thomsen@wilder.org.

I have read the above information and agree to be in this study.

Client name _____

Client signature _____ Date: _____

Worker name: _____ County: _____

Please complete the backside if an eligible family did NOT participate in the pilot:

To be completed by case worker for families who do not participate

Please indicate below why a family eligible for this pilot did not participate:

- Language barrier (please specify language: _____)
- Developmental delay or limited cognitive capacity
- Child previously screened for trauma or already being evaluated by a trauma-informed therapist
- Parent refused (reason provided, if any: _____)
- Family was not invited to participate (please describe: _____)
- Other (please describe: _____)

**A Study to Validate a DHS Trauma Pre-Screen Tool
Parent/Caregiver Consent Form (for TSCC)
For children to participate**

Dear Parent or Caregiver,

The State of Minnesota has created a form to help identify children who may have experienced trauma, meaning they have had upsetting things happen in their lives. The purpose of the form is to find these youth and get them extra support. Your county is part of a study, being done by Wilder Research, to find out if this new form works. To test if it works, case workers are asking families fill out a different form that has been proven to identify children who have experienced trauma. **All** families with an open child protection case, starting on or about September 1, 2016, will be asked to participate. About 300 families from five counties will be in the study. You are not being singled out. Please read the information below.

- If you sign this form, you agree to be in this study. **This means you give permission for your child to complete a screening form.**
- We will also ask your child for their permission to be in this study. This study is completely voluntary. You, and the child in your care, do **not** have to be in this study if you do not want to. You can leave this study at any time.
- **Whether or not you choose to be in this study will NOT affect your relationship with the Department of Human Services, the Child Welfare system, or any other systems.** It is completely up to you whether you want to participate and your decision either way will not influence your case.
- There is no direct benefit to being in this study, but findings will help case workers identify kids who might need extra support.
- The form asks questions about your child's possible experiences and symptoms related to trauma. Some questions may be upsetting to you or your child. Your child can skip any questions on the form that they do not want to answer. If you would like to see a copy of the form now, please ask your case worker.
- If you choose to be in this study, your county will provide Wilder Research staff with the responses from two forms – the one created by the State of Minnesota and the one your child fills out. Your case worker will not see your child's answers to the questions. Your child will be asked to place their completed form in an envelope addressed to Wilder Research, and then seal that envelope before giving it back to the case worker. Wilder Research will keep your name and your child's name confidential, **unless** your child indicates on the form that they are in immediate danger.
- DHS will also share some information about your case with Wilder Research. This includes some demographic information, such as your child's age, date of birth, gender, race, ethnicity, and county. It also includes some information about your child protection case and history, such as the date your case opened, the reason your case was opened, your child's previous experience in child protection, including out-of-home placements (if any), and their emotional/behavioral score from the SDM risk and safety assessment.
- All information sent to Wilder Research will be stored in locked cabinets or on secure, password-protected computers and will be destroyed one year after this study is complete.
- If you would like more information, please call Darcie Thomsen at Wilder Research at 651.280.2664, or email her at darcie.thomsen@wilder.org.

I have read the above information and agree to be in this study.

Client name _____

Client signature _____ Date: _____

Worker name: _____ County: _____

Please complete the backside if an eligible family did NOT participate in the pilot:

To be completed by case worker for families who do not participate

Please indicate below why a family eligible for this pilot did not participate:

- Language barrier (please specify language: _____)
- Developmental delay or limited cognitive capacity
- Child previously screened for trauma or already being evaluated by a trauma-informed therapist
- Parent refused (reason provided, if any: _____)
- Family was not invited to participate (please describe: _____)
- Other (please describe: _____)

A Study to Validate a DHS Trauma Pre-Screen Tool
Youth Assent Form (for TSCC)
Assent for children ages 8-17

The State of Minnesota has created a form to help case workers identify youth who may have had upsetting things happen in their lives. The purpose of the form is to find these youth and get them extra support.

Your county is part of a study, being done by Wilder Research, to find out if this new form works. To test if the form works, case workers are asking youth to fill out a different form. This form has been used to identify youth who have had upsetting things happen to them before.

All families with an open child protection case, starting on or about September 1, 2016, will be asked to be in this study. About 300 families from five counties will be in the study. You are not being singled out.

Please read the information below.

- If you sign this form, you agree to be in this study. **This means that you agree to fill out a form about upsetting experiences you might have had in your life, or your feelings about these experiences.**
- This study is voluntary. You do **not** have to be in this study if you do not want to. Even if you sign this form, you can change your mind later.
- **If you decide not to take part in this study, it will NOT affect your child protection case.** It is completely up to you whether you want to participate and your decision either way will not influence your case.
- There is no direct benefit to being in this study, but findings will help case workers identify kids who might need extra support.
- Some questions might make you uncomfortable. You can skip any questions you do not want to answer. If you want to see the questions before you decide to be in this study, please ask your case worker.
- If you take part in this study, your county will send Wilder Research your answers to the questions. Your case worker will not see the answers to your questions. You will be asked to place the completed form in an envelope addressed to Wilder Research, and then seal that envelope before giving it back to your case worker. Wilder Research will keep your name private, **unless** you tell us on the form that you are in danger right now.
- Research staff will also know some information about you and your child protection case, such as your age, date of birth, gender, race and ethnicity. Researchers will also know the date and the reason your case was opened, and if you were involved in child protection before. They will not see detailed notes about the case.
- Wilder Research will keep all completed forms in locked cabinets or on secure, password-protected computers. All information will be destroyed one year after this study is complete.
- If you would like more information, please call Darcie Thomsen at Wilder Research at 651.280.2664, or email her at darcie.thomsen@wilder.org.

I have read this form and agree to take part in this study.

Youth name: _____

Youth signature: _____ Date: _____

Worker name: _____ County: _____

Data collection protocol

Trauma pre-screen pilot study: protocol for inviting families to participate

The purpose of this document is to provide caseworkers with the specific process and guidelines for administering two trauma tools to clients as part of a pilot study being conducted by Wilder Research and the Minnesota Department of Human Services. Much of the information in this document comes from the technical training manuals of the Trauma Symptom Checklist for Young Children (TSCYC) and its companion tool, the Trauma Symptom Checklist for Children (TSCC). The information in this protocol is subject to change, although Wilder staff will send counties an updated copy of the protocol as soon as possible if changes are made.

Validation

The aim of this project is to determine the validity and effectiveness of the Structured Decision Making (SDM) trauma pre-screen instrument, which is simply a compilation of 16 existing items from the SDM safety and risk assessments identified through previous research conducted by the Children’s Research Center (CRC) as potential indicators of trauma. The purpose of validation is to determine whether these 16 items, or the “pre-screen instrument” and process, accurately identify children involved in child protection cases who have experienced trauma. The impetus for this project is the result of both federal and state requirements related to screening for trauma within the child protection population.

To do the validation study, Wilder will compare scores from the pre-screen instrument to scores from a tool that has already been proven to identify children who have experienced trauma. This will help determine if the pre-screen instrument accurately screens for trauma, and is why workers are being asked to complete an additional tool. The past several months of the study have been spent carefully looking at a variety of trauma screening tools and having discussions with staff at each of the pilot counties, as well as the state. Through these discussions, stakeholders determined that the top priorities for a comparison tool are that it:

- Screens for trauma in general (e.g., not PTSD specific)
- Is based in previous research (e.g., is shown to be valid and reliable)
- Is relatively brief and easy to administer

- Works for as wide an age range as possible.

With these points in mind, Wilder selected the Trauma Symptom Checklist for Young Children (TSCYC) and its companion tool, the Trauma Symptom Checklist for Children (TSCC); together, they fulfill the priorities bulleted above. Workers will NOT have to use both tools, but will select a tool based on the age of the child.

The following sections explain how caseworkers should invite eligible families to participate, walk through the consent/assent process, and administer each tool.

Inviting families to participate in the study

Caseworkers should invite **all** families who have an open child protection case, involving children age 3 through 17, to participate in this study. If a parent or caregiver has more than one child, any or all children may participate as long as consent is given (only one consent form needs to be signed per family). If a parent or caregiver only wishes to provide consent for 1 or 2 children, the child(ren) with the most recent birthday(s) should be chosen (this ensures the selection process is random).

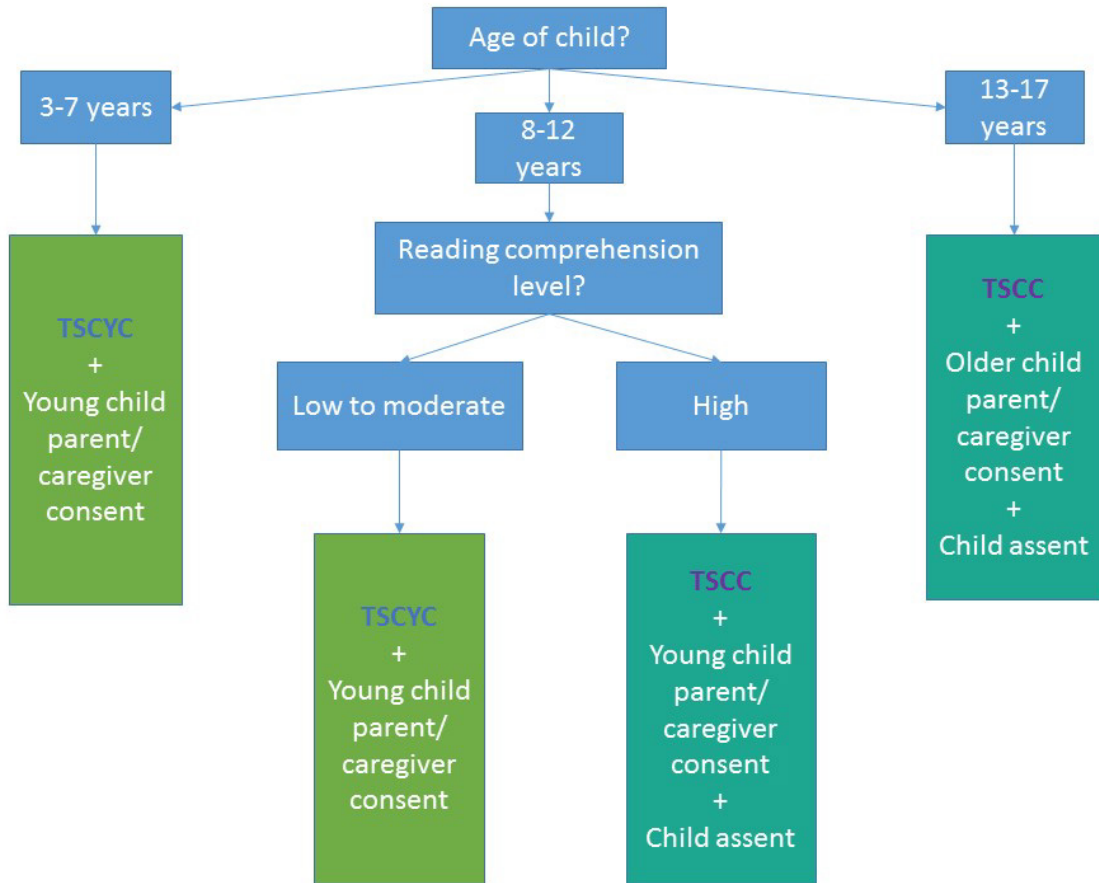
The TSCYC and TSCC are available in English and Spanish. Please feel free to offer Spanish surveys to those families for whom Spanish is their primary language; however, consent and assent forms will have to be translated by an on-site caseworker or interpreter.

Choosing the appropriate tool

Workers should choose either the TSCYC or TSCC based on the age and cognitive ability of the child who is involved in the study. If the child is:

- 3 through 7 years old, use the TSCYC (completed by parent or caregiver)
- 13 through 17 years old, use the TSCC (completed by child)
- Between age 8 and 12, either the TSCYC or the TSCC can be used. Caseworkers should choose a tool based upon the child's ability to read and understand the questions and general maturity.
 - The TSCC may be given to a child age 8-12, **if** the caseworker feels comfortable proceeding that way. Only mature 8-12 year olds with a high level of reading comprehension should complete the TSCC. (**Note:** It is important that each caseworker familiarize him/herself with the tools so they can make an informed decision).

- If the caseworker is uncomfortable with giving an 8-12 year old the TSCC, choose the TSCYC and explain to parents/caregivers that their child falls within the 3-12 year old age range for that tool. Please see the following chart as an additional guide.



An important part of research is protecting the rights of people who participate, which is why Wilder consulted an Institutional Review Board (IRB) for this study. The consent process ensures participants understand what they are agreeing to do and understand that they have the right to NOT participate without any consequences. The following sections provide detailed information about how to walk through the consent process and tools after selecting either the TSCYC or TSCC.

Trauma Symptom Checklist for Young Children (TSCYC): 3 through 12 years

The TSCYC is validated for children age 3 through 12; no children under age 3 (or their family) should participate in this study.

Materials needed

- **Consent form:** Use a GREEN consent form, titled *Parent/Caregiver Consent Form (for TSCYC): To participate on behalf of young children*.
- **Item booklet:** Item booklets can and should be reused. Respondents should **not** write on the booklet.
- **Answer sheet:** Parents should indicate their answers to the questions in the item booklet on an answer sheet. Answer sheets copy onto the next page for scoring purposes. **DO NOT** write on top of answer sheets as your words will bleed through onto the next page and could obscure respondent answers. Responses should be clearly circled. If respondents change an answer, they must put an X through the previous answer. Erasing an answer will not show through on the scoring page.
- **Pen or pencil**
- **Business Reply Envelope (BRE)**

Consent form (green)

- 1) **Explain the study.** It will be important to ensure that potential participants fully understand the project before agreeing to participate. Encourage potential participants to ask any questions about the study before agreeing to participate. This consent process and survey completion needs to happen sometime during the assessment phase, within 45 days of case opening.
- 2) **Give the potential participant a consent form to read and sign.** Provide the parent or caregiver with a GREEN consent form, titled *Parent/Caregiver Consent Form (for TSCYC): To participate on behalf of young children*. The ORANGE youth assent form is NOT needed in this particular case because the parent will be the one filling out the survey, not the youth.
 - a. It will be important to emphasize that this study is **voluntary** and participation will not affect their relationship with the state, county, child welfare systems, or any other systems.
 - b) A participant can choose to see the survey before they decide to participate.

- c) Also, if they consent to participate, Wilder will see some additional information about the family, such as the child's demographic information and some information about the family's child protection history, such as the date and reason their case was opened. Wilder will see this information for any child who has a completed TSCYC form (completed by the parent or caregiver).
 - d) The **only** people to see any identifiable information from this study will be several researchers from Wilder.
- 3) **[If consent is given] provide the participant with a copy of the consent form.** If the parent or caregiver agrees to participate in the study and signs the consent form, provide them with a second copy of the consent form to keep for themselves.
 - 4) **[If consent is given] place the signed consent form in the business reply envelope (BRE) provided by Wilder.** Do NOT seal the envelope at this point, as participants will place their completed tool in the envelope when they are finished.
 - 5) **[If consent is NOT given or client does not participate for some other reason], thank the client for their time and complete the back of the consent form.** We want to keep track of clients who do not participate in the study. For that reason, please complete the "reason for not participating" section on the back of the consent form and send it to Wilder, without the client's name included. Clients do NOT have to sign a consent form if they refuse; Wilder simply wants to keep a record of the number who did not participate.

Here are some additional things to know as you go through the consent process:

- If a parent or caregiver chooses to complete TSCYC forms for more than one of their children, they only have to complete one consent form.
- The consent and TSCYC form should be completed by a child's primary caregiver. Ideally, this will be the person who has had the most interaction with the child in the past 4 weeks. They should be familiar with the child's everyday routines and behaviors and should have had daily interaction with the child for most, if not all, of that 4-week period. If multiple caregivers are involved and have been with the child for an equal amount of time, choose the person who has taken care of the child most recently.
- It is possible for parents to receive their scores after the survey is completed; however, this is a process that may take several weeks and will require some additional training for caseworkers. If a parent indicates that they want to see their final score for the TSCYC, please tell them that we can provide that information, but it may take 3 or 4 weeks to get it back to them. Then Wilder will work with caseworkers to provide that score. Caseworkers will need training on how to interpret the score.

- If you are at all concerned about a potential participant's language or comprehension issues, read the consent form aloud and confirm that they understand everything on the form and what is being asked of them. If they indicate that they understand and agree, ask them to sign the form.
- Similarly, if you are concerned that a potential participant has limited cognitive capacity or other developmental/intellectual deficits, other than reading or advanced language comprehension, they should not be invited to participate in the study.

Filling out the TSCYC

Administration

- The TSCYC form is copyrighted by law. Please do NOT make copies of the form. As mentioned on the last page of this document, Nora Johnson at Wilder Research will order more forms when you are running low.
- As mentioned above, the TSCYC is available in either English or Spanish. Families may complete a survey in whichever language they are most comfortable; however, the consent and assent forms, and other study documents are only available in English, so they will need to be translated by a caseworker or interpreter.
- When a participant is ready to complete the TSCYC, they should be given a private, well-lit, quiet space in which to complete the form to protect their privacy and confidentiality. Their caseworker should not be able to see their responses, unless the participant has given express verbal permission that it is OK for the caseworker to see their responses. For example, if a client requests that their caseworker help them fill out the tool, then the caseworker may view their answers, as they will be completing the tool together.
- The TSCYC form instructs the participant to respond to all of the questions. This is NOT required. While we would like them to answer as many questions as they feel comfortable, it's completely up to the respondent whether or not they want to answer any of the questions. You can assure participants that they may skip over any questions they do not wish to answer.

Specific instructions

- 1) **Complete the label at the top of each Answer Sheet.** At the top of each Answer Sheet is a label with spaces for: 1) the child's date of birth, 2) whether the form was read aloud to a participant, and 3) whether the form was translated into another language for the participant. Caseworkers should complete this label before giving the Answer Sheet to the participant to complete.
- 2) **Give the participant a TSCYC Item Booklet, Answer Sheet, BRE (containing the signed consent form), and pen or pencil.** Make sure to ask participants to clearly circle each response. They should NOT mark in between response options or anywhere else on the Answer Sheet. If the participant wants to change an answer, ask them to put an X through their previous answer.
- 3) **Explain how to complete the tool to the participant.** The following paragraph provides sample language that you can use to describe the tool.

Sample script: "This survey describes a number of things that kids sometimes think, feel, or do. Please read each item carefully and then mark on the answer sheet how often it happens to your child by circling the correct number. Circling a 1 means it never happens, circling a 2 means that it happens sometimes, circling a 3 means that it happens many times, and circling a 4 means it happens almost all of the time. If there is a question that you don't feel comfortable answering, just skip it and move on to the next one. Take as much time as you need to finish the survey. Do you have any questions before you start?"

Once you have finished the survey, please review your answers to make sure you didn't unintentionally skip or mis-mark any answers, then put your completed survey in the envelope, sign over the seal, and hand it back to me. I will not open the envelope or see your answers. I will drop it right in the mail to the researchers analyzing these data."

- 4) **Ask participants to write legibly when filling out any written portions of the form.** This will affect Wilder's ability to use the data later on, so it is important that participants write legibly.
- 5) **Ask participants if they have any additional questions, or if they would prefer to complete the form together.** If you think a participant will have trouble reading the TSCYC, you can read each question and answer choices to them. If the survey is read to the participant, this should be clearly marked on the label referenced in step #1.

- 6) **Provide participants with a private, quiet space (as referenced above) and allow them to complete the TSCYC.** If a participant asks about the meaning of a given item as they are completing the form, tell them to take their best guess. If they state that they have “no idea” what an item means, tell them to leave the item blank.
- 7) **When the participant has completed the form, ask them to check over their form one last time for unintentionally missed or mismarked responses.**
- 8) **Give all participants the list of trauma resources.** After the participant has completed the TSCYC, thank them for their time and give them the list of trauma resources provided by DHS and the other handouts about trauma, as appropriate. Give this information to **every participant**, regardless of their SDM trauma pre-screen score.
- 9) **Have the participant place their completed survey in the BRE, along with their signed consent form.** Please see the “Mailing forms to Wilder” section on the last page of this document for full instructions. Instruct the participant to seal and sign the envelope before passing it back to the caseworker to be mailed.

Trauma Symptom Checklist for Children (TSCC): 8 through 17 years

The TSCC is validated for administering directly to children age 8 through 17. Please remember that the TSCC and TSCYC overlap in age ranges for 8 to 12 year olds; see the “Choosing the appropriate tool” section to determine the best method to proceed.

Materials

- **Parent consent form:** Use a BLUE consent form, titled *Parent/Caregiver Consent Form (for TSCC): For children to participate*.
- **Youth assent form:** Use the ORANGE assent form, titled *Youth Assent Form (for TSCC): Assent for children ages 8-17*.
- **TSCC Booklet:** Each child should be provided with one booklet. DO NOT write on top of the booklet as your words will bleed through onto the next page and could obscure respondent answers. Responses should be clearly circled. If respondents change an answer, they must put an X through the previous answer. Erasing an answer will not show through on the scoring page.
- **Pen or pencil**
- **Business Reply Envelope (BRE)**

Consent for parents (blue) and assent for youth (orange) forms

- 1) **Explain the study.** It will be important to ensure that potential participants fully understand the project before agreeing to participate. Encourage potential participants to ask any questions about the study before agreeing to participate. This consent and assent process and survey completion needs to happen sometime during the assessment phase, within 45 days of case opening.
 - a) It will be important to emphasize that this study is **voluntary** and participation will not affect their relationship with the State, county, child welfare systems, or any other systems.
 - b) A parent, caregiver, or child can choose to see the survey before they decide to participate.
 - c) Children completing the TSCC do **not** have to share their responses with their parent or caregiver, unless they feel comfortable doing so.

- d) Also, if all parties consent to participate, Wilder will be able to view additional information about the family, such as the child’s demographic information and some information about the family’s child protection history, such as the date and reason their case was opened. Wilder will see this information for any child who has a completed TSCC form.
- e) The **only** people to see any identifiable information from this study will be several researchers from Wilder.
- 2) **Give the potential caregiver participant a consent form to read and sign.** Provide the parent or caregiver with a BLUE consent form, titled *Parent/Caregiver Consent Form (for TSCC): For children to participate*.
- 3) **Give the potential child participant an assent form to read and sign.** Provide the potential participating child with the ORANGE youth assent form.
- 4) **[If consent and assent are given] provide participants with a copy of the consent and assent form.** If the parent or caregiver agrees to participate in the study and signs the consent form, and if the child agrees to participate in the study and signs the assent form, provide each party with a second copy to keep for themselves. Both parent/caregiver and child have to consent before moving forward.
- 5) **[If consent and assent are given] place the signed consent and assent forms in the business reply envelope (BRE) provided by Wilder.** Do NOT seal the envelope at this point, as participants will place their completed tool in the envelope when they are finished.
- 6) **[If consent or assent is NOT given or the family does not participate for another reason], thank the clients for their time and complete the back of the consent form.** We want to keep track of clients who do not participate in the study. For that reason, please complete the “reason for not participating” section on the back of the consent form and send them to Wilder. Clients do NOT have to sign a consent or assent form if they refuse; Wilder simply wants to keep a record of the number who do not to participate.

Here are some additional things to know as you go through the consent and assent process:

- Participants can leave the “Identification No.” at the top of the TSCC blank, but should complete the rest of the fields.
- If a parent or caregiver provides consent for more than one of their children to complete a TSCC, they only have to complete one consent form.

- If you are concerned about a potential participant’s language or comprehension issues, read the consent form aloud and confirm that they understand everything on the form and what is being asked of them. If they indicate that they understand and agree, ask them to sign the form.
- Similarly, if you are concerned that a potential participant has limited cognitive capacity or other developmental/intellectual deficits, other than reading or advanced language comprehension, they should not be invited to participate in the study.

Filling out the TSCC

Administration

- The TSCC form is copyrighted by law. Please do NOT make copies of the form. As mentioned on the last page of this document, Nora Johnson at Wilder Research will order more forms when you are running low.
- As mentioned above, the TSCC is available in either English or Spanish. Families may complete a survey in whichever language they are most comfortable; however, the consent and assent forms, and other study documents are only available in English, so will need to be translated by a caseworker or interpreter.
- When a participant is ready to complete the TSCC, they should be given a private, well-lit, quiet space in which to complete the form to protect their privacy and confidentiality. Their caseworker should not be able to see their responses, unless the participant has given express verbal permission that it is OK for the caseworker to see their responses. For example, if a client requests that their caseworker help them fill out the tool, then the caseworker may view their answers, as they will be completing the tool together.
- The TSCC form instructs the participant to respond to all of the questions. This is NOT required. While we would like them to answer as many questions as they feel comfortable, it’s completely up to the respondent whether or not they want to answer any of the questions. You can assure participants that they may skip over any questions they do not wish to answer.
- The light perforation at the fold of the booklet allows for separation of the entire test form into two pages if necessary (e.g., when the respondent is completing the booklet at a small desk and the size of the entire opened booklet is cumbersome). Otherwise, the booklet should be left intact until the respondent has completed all items.

Specific instructions

- 1) **Complete the label at the top of each Booklet.** At the top of each Answer Sheet is a label with spaces for: 1) the child's date of birth, 2) whether the form was read aloud to a participant, and 3) whether the form was translated into another language for the participant. Caseworkers should complete this label before giving the Booklet to the participant to complete.
- 2) **Give the youth participant a TSCC Booklet, BRE (containing the signed consent and assent forms), and pen or pencil.** Make sure to ask participants to clearly circle each response. They should NOT mark in between response options or anywhere else on the Booklet. If the participant wants to change an answer, ask them to put an X through their previous answer.
- 3) **Explain how to complete the tool to the participant.** The following paragraph provides sample language that you can use to describe the tool.

Sample script: *"This survey describes a number of things that kids sometimes think, feel, or do. Please read each item carefully and then mark on the test booklet how often it happens to you by circling the correct number. Circling a 0 means it never happens, circling a 1 means that it happens sometimes, circling a 2 means that it happens lots of times, and circling a 3 means it happens almost all of the time. If there is a question that you don't feel comfortable answering, just skip it and move on to the next one. Take as much time as you need to finish the survey. Do you have any questions before you start?"*

Once you have finished the survey, please review your answers to make sure you didn't unintentionally skip or mis-mark any answers, then put your completed survey in the envelope, sign over the seal, and hand it back to me. I will not open the envelope or see your answers. I will drop it right in the mail to the researchers analyzing these data."

- 4) **Ask participants to write legibly when filling out any written portions of the form.** This will affect Wilder's ability to use the data later on, so it is important that participants write legibly.
- 5) **Ask participants if they have any additional questions, or if they would prefer to complete the form together.** If you think a participant will have trouble reading the TSCC, you can read each question and the answer choices to them. If the survey is read to the participant, this should be clearly marked on the label referenced in step #1.

- 6) **Provide participants with a private, quiet space (as referenced above) and allow them to complete the TSCC.** If a participant asks about the meaning of a given item as they are completing the form, tell them to take their best guess. If they state that they have “no idea” what an item means, tell them to leave the item blank.
- 7) **When the participant has completed the form, ask them to check over their form one last time for unintentionally missed or mismarked responses.**
- 8) **Give all participants the list of trauma resources.** After the participant has completed the TSCC, thank them for their time and give them the list of trauma resources provided by DHS, and the other handouts about trauma as appropriate. Give this information to **every participant**, regardless of their SDM trauma pre-screen score.
- 9) **Have the participant place their completed survey in the BRE, along with their signed consent form.** Please see the “Mailing forms to Wilder” section on the last page of this document for full instructions. Instruct the participant to seal and sign the envelope before passing it back to the caseworker to be mailed.

Mailing forms to Wilder

- After the participant completes their consent or assent form, place the signed forms in the business reply envelope (BRE) provided by Wilder.
 - If the participant will be completing a TSCYC form, be sure to include the signed GREEN parent/caregiver consent form.
 - If the participant will be completing a TSCC form, be sure to include the signed BLUE parent/caregiver consent form *and* the signed ORANGE youth assent form.
- Give the BRE, with the signed consent and assent (if appropriate) forms inside, to the participant.
- Once the participant has completed the survey(s), have them insert their completed survey(s) into the envelope, seal it, and sign over the seal (if they don't want to sign their name for privacy reasons, they can simply write "DONE" over the seal). If a parent has consented for more than one child to participate, caseworker can place all forms for that family in the same envelope.
- After the envelope is sealed by the participant, he/she should give it to the caseworker, who should put the envelope in the mailbox to be sent back to Wilder.
- Please contact Nora Johnson when you are getting low on envelopes or TSCYC, TSCC, or consent forms. She will order more forms for you, though please note that they may take several days to arrive at your county.
- Wilder will check-in with counties every week at the beginning of the study, then move to bi-weekly or monthly check-ins (if needed); however, never hesitate to contact either Nora Johnson or Stephanie Nelson-Dusek with questions or concerns.
 - Nora Johnson, nora.johnson@wilder.org, 651-280-2729
 - Stephanie Nelson-Dusek, stephanie.nelson-dusek@wilder.org, 651-280-2675

Finally, thank you so much for your work on this project! We truly could not do this study without you!