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Integrated Practice Program (IPP) Workers' Opinions on Trauma Symptomology Tools

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Abstract

The Integrated Practice Program (IPP) is a Ministry of Children and Family Development initiative which targets intervention for the most traumatized children in care. Determined to improve children's outcomes of permanency and reduce risk, this program was created using a trauma-informed model in an attempt to obtain better outcomes. The IPP has existed across British Columbia for approximately ten years, with it being piloted in Campbell River just over two years ago. To date, no data has been received in regard to the program's efficacy and as a result it is difficult for IPP workers to know whether their efforts have had an effect. The purpose of this research study was to obtain data of the efficacy of the IPP program by finding a tool that could accurately measure pre and post trauma symptomology in the desired demographic. As such, researchers sought to obtain IPP workers' opinions on trauma symptomology tools to determine if there was a preferred tool and what the perceived strengths and weaknesses of that tool were. Researchers used purposive sampling in order to gain feedback from IPP workers through a quantitative and qualitative questionnaire. This consisted of 19 questions which had workers within the IPP across British Columbia (n=10) rank tools using a Likert-scale which ranged from strongly oppose to strongly support to determine their views on specific qualities of each tool. This was complemented by qualitative question boxes which sought specific information regarding why tools were chosen and preferred, strengths and weaknesses as well as suggestions for other tools. The quantitative data was analysed using descriptive statistics and univariate analyses while the qualitative data was analysed using thematic analysis. The preferred tool was CANS with 60% of participants rating it as their first choice. Worker feedback stated it included a child's strengths, looked at multiple contexts and was thorough. The perceived limitations of this tool were that it needed to be completed too frequently. All participants viewed caregiver feedback as positive, with 80% stating it was very important and 20% stating it was somewhat important. Participants were more divided on the topic of self-reporting with 40% viewing it as very important, 40% viewing it as somewhat important, 10% being neutral on the topic and 10% viewing it as somewhat unimportant. All suggested tools located by the literature review proved to be an adequate option for use with the IPP based on the criteria provided by MCFD. Researchers produced three recommendations based on this research study: (1) for the IPP to ultimately choose an evidence-based tool with high internal and external validity that incorporates caregiver feedback, adequately measures child symptomology and accounts for worker time restrictions in terms of assessment and grading; (2) for the IPP to standardize some components of the program and workers' practice so results can be better generalizable; (3) research to continue to bridge the gap between academia and practice for collaborative research efforts to meet the needs of the identified population.

Keywords: Integrated Practice Program (IPP), Trauma Symptomology Tools, Standardized Measures, Childhood trauma, Ministry of Children and Family Development (MCFD)



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Introduction

The Ministry of Children and Family Development (MCFD) is a government agency dedicated to ensuring children and families' safety and wellbeing. A main component of MCFD's work is statutory child protection. This involves government intervention when children are at risk of harm and in some situations the removal of children from their family home into foster care. The children MCFD places in foster homes have often experienced abuse, neglect, and exposure to violence which contributes to experiences of complex trauma. Experiences of trauma in childhood and adolescence can result in the exhibition of difficult to navigate behaviours which contribute to foster placement breakdowns. MCFD has also found that often caregivers and teachers are ill-equipped to deal with trauma-related behaviours and mental health issues in children. Low chances of placement permanency and trauma experiences are resulting in high overall risk for poor life outcomes in the children MCFD work with. The Integrated Practice Program (IPP) was created as a response to the complex trauma epidemic MCFD was observing and as a way to increase the longevity and success of foster placements and overall life outcomes.

Context

The IPP aims to increase the long-term success of the children MCFD work with by addressing trauma symptomology and increasing stability in the children's lives. Campbell River MCFD has been part of the wider MCFD IPP for over two years. They have modeled their IPP on Bruce Perry's Neurosequential Model of Therapeutics (NMT) to provide interventions to vulnerable children in care who are at high risk for poor life outcomes. This program has now been in place since March 2017, but little is known about its effectiveness. Due to the gap in empirical information, MCFD requested a research project from the University of British Columbia (UBC) with the hopes of finding an assessment tool that would be able to measure trauma symptomology among IPP participants and determine the efficacy of the program.

This research project is explorative in nature and meant to be the first step in collaborative research

into the efficacy of the IPP. Collaborative research aims to diminish the divide between the academic production of social work knowledge and its actual integration into social work practice (Steen, Regenmortel & Hermans, 2018). It increases the speed in which important information can be translated into both policy and practice by using a model of co-production and engaging stakeholders in meaningful ways throughout the research process. This study will allow researchers to measure the variable opinions of the IPP clinicians and team leads on trauma symptomology measurement tools and by doing so allow IPP stakeholders to participate with the research process. This study will thus be integral for stakeholder collaboration in a second phase large scale quantitative program evaluation of the IPP program, which will take place at a later date.

Key Concepts

Trauma. This research project uses the American Psychiatric Association's (APA) definition of trauma. The APA defines trauma as exposure to extraordinary experiences that present physical or psychological threats to oneself or others and generates a reaction of helplessness and fear (APA, 2013). Trauma symptoms can be acute or long term and have been related to poorer life outcomes in a variety of areas including health and wellbeing (Larkin, Felitti, & Anda, 2014). Approximately 1/3 of Canadians reported experiencing some form of child maltreatment (Afifi et al., 2016).

Trauma informed practice. Developmental Trauma Disorder is a specific term used to define childhood trauma caused by abuse or neglect. The stress of such maltreatment is either not alleviated by the caregiver or is caused by the caregiver (Portico Network, n.d.). Developmental Trauma is also referred to as Adverse Childhood Experiences (ACE). These are divided into three categories: Abuse, Neglect and Household Dysfunction. The higher number of ACE's a child experiences, the greater the risk for negative health outcomes. These outcomes last throughout one's lifetime and can include a variety of things such as physical health ailments, mental health issues and substance use disorders. Due to the severity of the outcomes and what professionals now know about

trauma, there has been an emphasis on addressing it as early and as effectively as possible. Given the prevalence of child abuse and neglect, the issue of complex trauma will be prevalent across the country and evident in all social institutions. Regardless of what area of social work one chooses to work in, chances are they will come across someone who has experienced trauma. It is important then to understand what trauma is and how it can affect clients both in the short and long term, and what may be helpful in reducing impacts of trauma on people's lives.

Children. For the purpose of this study children were defined as being aged 19 and under thus under the jurisdiction of MCFD. Nineteen is the age of majority in British Columbia (BC). The initial demographic provided by MCFD for the purpose of this research project was 5-10 years of age, however researchers later discovered this was not consistent with the other IPP across the province.

NMT. NMT is a neuroscience informed approach to clinical trauma work with children. NMT is based on Bruce Perry's (2009) principle that the brain develops sequentially, or from the bottom up and that trauma can impact development (2009). The NMT model states that in order to address noticeable presenting trauma symptoms of higher level functioning the issues occurring at lower levels must be addressed first. The NMT model reviews children's developmental challenges, relational milieu, protective factors, and current functioning (Perry, 2009). NMT then estimates which parts of the brain are involved in the presenting trauma symptomology and recommends a unique sequence of interventions that can help the child "re-approximate a more normal developmental trajectory" (Perry, 2009, p. 251). Often a functional brain map is used as a visual representation of this work. The NMT model was used as a basis for the IPP interventions.

Literature Review

This literature review examined existing information on trauma informed research and focused on narrowing available trauma measurement tools to those that were appropriate for the IPP's demographic. All tools included were capable of

detecting post-traumatic stress disorder symptoms as outlined by the DSM-5. This literature review will also provide an overview of the strategy for review and will justify the trauma measurement tools that have been selected for the research survey.

Overview of Subjects under Consideration

Search strategy. We researched the available data related to culturally appropriate instruments used to measure trauma and distress with 5 to 10-year-old children in state care. There were no specific instruments created for this purpose. This required us to broaden our search to instruments used to measure trauma in children. We examined both academic journals and grey literature to select appropriate tools and excluded any not meant for our specific demographic. We also examined literature regarding the efficacy of NMT programs in order to understand what measurement tools had been used in similar studies in the past. The full list of resources used to narrow our search can be found in the reference list.

Research Tools Assessments

Trauma tools. There are a number of tools available to measure trauma. The UCLA PTSD-Reaction Index created by Pynoos and Steinberg is intended for children and youth aged 6-18. The function of the tool is to assess for exposure to trauma and frequency of symptoms. This is a 22-item tool made up primarily of Likert-scale questions which takes approximately 20 minutes to complete. The creators found this tool to have a score of 0.84 for test-retest reliability and an internal consistency score of 0.90. This tool is appropriate for working with children; however, it is tied to experiences of specific events. Using this tool could be confusing for children in this age group who are suffering complex trauma as a result of cumulative abuse or neglect (Steinberg, Brymer, Decker, & Pynoos, 2004) as they are continually asked about information related to "the incident." There is a cost associated with the tool, \$3.00 per administration and the child/adolescent tool and the parent/caregiver report are sold separately.

One of the most common tools used to measure trauma symptomology and history is the Child PTSD Symptom Scale (CPSS). This is an adaptation of the Foa et al. (2001) Post-traumatic Diagnostic Scale (PDS) for

adults. It is a 24-item tool which takes approximately 15 minutes to complete. As this is a rendition of the original PDS tool, it was not possible to find psychometrics for this specific tool. That being said as per Foa et al. (2001), the PDS has a high face validity due to the items directly reflecting the individual's experience of PTSD. The internal consistency is .92 and test-retest was at .74 over a two to three-week period. The tool is available for free. This tool is intended for an older population of 8-18-year old's and this is evident in both the language and reading skills (grade level 3 to 8.5) required to complete this child self-report (Foa, Johnson, Feeny, & Treadwell, 2001). As such, this tool would not be appropriate in the specific demographic MCFD is servicing.

Symptomology tools. The Child Report of Post-Traumatic Symptoms (CROPS) and Parent Report of Post-Traumatic Symptoms (PROPS) is a two-part tool that includes a child self-reporting component as well as a caregiver component, created by Dr. Ricky Greenwald. The tool has high internal consistency reliability with an average of .91 and test-retest reliability of .8 (Greenwald & Rubin, 1999). However, there is a cost associated with the tool (a one-time cost of approximately \$200 with unlimited reproduction) and children must have a seven-year-old reading comprehension to complete the self-reporting section. There can also be discrepancies between the child self-report and parent report format used by this tool (Saylor, Cowart, Lipovsky, Jackson, & Finch, 2003); however, this would provide a more holistic view of the child's behaviour for the practitioner. This tool would not be an option as it is meant to be administered either by a psychologist or a mental health professional that is overseen by a psychologist which is not a possibility within MCFD.

The Trauma Symptom Checklist for Young Children (TSCYC) is useful for measuring symptoms over a period of time. It was created by Dr. John Briere and is intended for ages 3-12. This tool has been used in child welfare situations and is appropriate for children who have been exposed to multiple traumas. It is a 90-item parent or caregiver report and takes approximately 15 minutes to complete. Multi-site analysis suggests good internal reliability with an

average of .87 across all scales (Briere et al., 2001). There is a cost associated with the tool which may prove challenging for MCFD. This can start at \$300 for an introductory kit, to upwards of a \$1000 if software is purchased as well. According to the National Child Traumatic Stress Network (NCTSN), due to the relatively new nature of this measure, it lacks substantive validation studies (n.d.). NCTSN reported this measure showed internal consistency as acceptable with an alpha range of .81 to .93 for the clinical scales, average alpha of .87.

The Achenbach Child Behaviour Checklist (CBCL) was developed to work with children 6-18 years old. It is one of the most widely used caregiver reporting measures in both clinical and research settings and is used to evaluate behavioural and emotional issues. The CBCL has been found to be a psychometrically sound system for obtaining information on behaviors in children (Konold et al., 2006). The internal consistency is .8 and test-retest was at .88 (NCTSN, n.d.). The CBCL has been found to have high reliability and validity across cultures and has been translated into over 10 languages including Spanish, Tagalog, French, and Chinese (Hernandez, 2012). The CBCL form has 120 questions and takes approximately 15 minutes to complete. It costs between \$90 and \$230 (NCTSN, n.d.). The checklist has been used as a quantitative measure in two studies examining the efficacy on NMT programs with children (Barfield, 2012). Some critiques of the CBCL are that it uses caregiver information, which is subjective, and that the numerical scale does not allow for a nuanced understanding of behaviour.

The Paediatric Emotional Distress Scale (PEDS) was developed for 2-10-year-olds. This 21-item parent report measure was created by Dr. Conway Saylor and takes approximately seven minutes to complete. The PEDS is free of cost and is used to measure the impact of childhood trauma. It has been rigorously evaluated with diverse populations and has exhibited consistency in reliability and validity (Spilsbury, 2005). It shows an average internal consistency of .77 and an average test-retest of .58 after six to eight weeks. Critiques are that PEDS was initially tested on a majority white middle-class sample. It was also not

originally designed to test for PTSD and does not reliably test for all PTSD symptoms as represented in the DSM 5 (Feeney, Foa, Treadwell, & March, 2004).

The Child and Adolescent Needs and Strengths (CANS) tool has an adaptation that was created to specifically include trauma. It looks at trauma history as well as symptomology and behaviour. It is an interview-based tool for 4- to 18-year-olds and is ideally completed every six months (Kisiel et al., 2011). The audit reliability of the CANS has been reported to be .85. The average reliability of the CANS is .75 with vignettes, .84 with case records, and can be above .90 with live cases. While the tool is free, training and certification are required for the use of the CANS. This can cost around \$10 per certification (per person) and access to the online training platform while the process can take approximately six to eight hours to become fully certified. Certification is valid for two years before requiring recertification. This tool incorporates a child's strengths and can be used to link treatment planning. The CANS has also been used for evaluating program effectiveness in prior research (Lyons et al., 2003; 2004) and has previously been used in a large study to assess trauma in children and adolescents involved in the child welfare system (Kisiel et al., 2009). Adaptations of this tool are currently used in 50 American states for use within child welfare, youth justice, mental health and early intervention (Praed Foundation, 2015).

NMT Brain Map. The functional brain map, or the NMT metric, visually represents estimates of clients' development functioning (Perry, 2009). It uses tools such as Weschler Intelligence Scale for Children, Wide Range Achievement Test, Child and Adolescent Functional Assessment Scale, CANS, CBCL, TSCYC and the Parenting Stress Index to collect quantitative data. It also uses qualitative methods such as direct observations, interviews and parent/teacher reports to measure multiple domains of development (Ford, 2013). The NMT model then uses both the ongoing quantitative and qualitative information and translates it into visual graphic formats. The functional brain map would be an intuitive tool for our research purposes as it is a core piece of the NMT model. However, brain mapping has not been empirically.

tested nor previously used in quantitative studies (Caplis, 2014). There is little information regarding the cultural appropriateness of this tool and the expertise levels needed to extract the data for a brain map may be beyond the typical clinicians' scope.

Literature Review Discussion

While researching the tools available to measure trauma in children, a number of immediate issues presented. The first issue was that many tools were created for the purpose of determining whether the child had experienced trauma. Given that IPP clinicians are already in an intervention phase with their clients, they are likely more interested in changes in symptomology as a measure of success rather than a diagnosis of trauma or PTSD (which the children are likely to already have).

The second issue was that there are very few tools intended for use directly with young children. Most tools utilize a self-reporting or questionnaire type format that would be difficult for young children, especially those developmentally impacted by trauma, to read and comprehend.

The final major issue was a distinct lack of culturally appropriate tools. More than 65 percent of children in care in Canada are of Indigenous descent, but according to a report written by the Ontario Centre of Excellence for Child and Youth Mental Health (2013) presently there is not a Canadian-developed mental health intake questionnaire intended specifically for, and created by, First Nation, Inuit or Métis. This report states, "even though instruments may be created within the context and in terms relevant to the community for which they were developed, they still measure a Western definition of illness" (Drew et al., 2010; Kowal, 2007).

Literature Review Conclusion

In order to determine the effectiveness of the IPP a valid study must be conducted using appropriate tools of measurement. Despite the above-mentioned issues, we did find three tools we believe would be appropriate for a quantitative review of the PCT program: the PEDS, CANS and CBCL. These fit the intended age group, are cost efficient, timely and thorough. The TSCYC would also be appropriate but due to issues around cost and attainability, a decision

was made to exclude this tool from the options. To further narrow down and select a tool, researchers would endeavour to present these options to the IPP workers and perform a mixed methods study to determine which tool was preferred and have them scale the tools in areas such as ease of use, required information obtained, timeliness, etc. Researchers would then elicit feedback from the workers regarding use of the tools.

Research Questions

1. What quantitative research tool is preferred by IPP workers for use in the measurement of possible trauma symptom reduction among clients?
2. What are the strengths and limitations of the tools as perceived by IPP workers?

Theoretical Framework

Given that the focus of this research study is the IPP which works directly with trauma-affected children, it makes sense to work from a trauma-informed framework. A trauma-informed approach involves understanding the child's previous experiences of trauma and how this could be contributing to their current behaviours and presentation (Knight, 2015). While it does not include focusing specifically on the incidents experienced, it involves amending professionals and caregivers approaches to working with these children by using sensitivity, patience and understanding. It involves acknowledging that children's previous experiences of trauma may lead to increased hostility and aggression, an inability to form positive attachments, mistrust of others and difficulty in regulating emotions (Poole & Greaves, 2012). That requires responding to those behaviours in a different way than one would if it was simple noncompliance. Working under a trauma-informed lens means ensuring that all adults involved with the children understand what trauma is, what the impacts of it are and work collaboratively and consistently in addressing the symptomology of it (Lang, Campbell, Shanley, Crusto, & Connell, 2016).

Methodology

Ethics Approval

This research project received ethics approval from

the UBC Behavioural Ethics Review Board through an expedited Master of Social Work program evaluation course approval process. This process was completed by the principal investigator/course instructor. Researchers also submitted ethics proposals to MCFD and received approval for the methods used in the research process including recruitment, consent, data security and confidentiality.

Sampling Procedures

For this study non-probability purposive sampling was used, as random sampling was not possible because the research questions involved a small population size. The population included in this study was all MCFD IPP clinicians and their team leads, as their expertise and experience in the IPP was necessary to gain stakeholder input and opinions on trauma symptomology tools. All MCFD IPP clinicians and team leads were invited to participate in this survey. The only inclusion criterion was that all participants were working in the IPP program with MCFD in BC. Due to the small population size, there was no exclusion criteria applied in terms of amount of time employed in current position etc. It should be noted that there was a change in terminology from the initial research questions which mentioned clinicians. The term clinicians was changed to workers to reflect team leads' involvement in this study.

Recruitment

To recruit for this study researchers forwarded a recruitment letter via email to a MCFD liaison. This recruitment email included study information, a link to the study survey that was used for data collection (see Appendix A for the study survey), and information packages on the CANS, CBCL and PEDS tools. The initial recruitment email was forwarded by the MCFD liaisons to all IPP clinicians and team leads via MCFD IPP email listserv on Monday February 25, 2019. The survey was initially meant to be open for two weeks and close on Friday March 8, 2019, but due to low participation numbers, an extension email was instead sent out to IPP clinicians and team leads on March 8th. The survey was not closed until March 15, 2019. Despite the possible participants being contacted via a MCFD liaison it was made clear that the survey would

be anonymous and that they did not have to participate if they did not wish to.

Data Collection Methods

This research project used a mixed method electronic survey that included a Likert-scale closed question section and open-ended qualitative questions section (see Appendix A for survey). The electronic survey was created using the UBC Qualtrics platform. Participants were given information packages on the CANS, CBCL and PEDs tools via the study recruitment email to review before they participated in the online questionnaire. All surveys were identical. As previously noted, the survey was open for three weeks between February 22, 2019 and March 15th, 2019. Participants received emails including the survey and information packages on both February 22 and March 8th, 2019. Consent was given by participants at the beginning of the survey and participants were made aware through the study information that due to the anonymity of the survey that after beginning the survey they would no longer be able to withdraw from the study.

Researchers attempted to remove all bias and leading wording in the survey questions and the survey received external feedback on the format and content of questions from the principal investigator before it was distributed. Both Likert-scale and open-ended questions were used to account for the full range of possible sentiments on the issues researched. Researchers used the survey data collection method because it was time efficient and allowed for anonymity. Also, as this research project was exploratory in nature, the mixed method survey allowed researchers to measure the variable opinions of the IPP workers and quantify the results while still creating a broader understanding of stakeholder views which will be integral to the second phase larger scale quantitative program evaluation of the IPP program to take place at a later date.

The first portion of the survey asked close-ended, Likert-scale questions to determine the workers' opinions of the CBCL, PEDS, and CANS. This portion of the survey allowed researchers to determine which of the three tools was preferred. The Likert-scale was chosen because it is an appropriate tool to assess

attitudes of workers toward the trauma measurement tools and the relative strength of those attitudes. It also ensured that the answers given were mutually exclusive and exhaustive, and allowed for a neutral option. Agreement bias was accounted for in the survey questions by rephrasing the Likert-scale questions to remove the terms agree/disagree and instead use the terms support and oppose.

The second portion of the survey asked open ended questions about IPP workers' opinions on the tools and allowed them to provide a more in-depth description of the strengths and weaknesses they perceived in the tools and their rationale for their rankings of tools. The qualitative section was meant to complement the Likert-scale and allowed researchers to better understand the nuances of the workers' attitudes towards the tools and account for unanticipated answers. The format also allowed researchers to more fully understand the workers' conceptualization of the trauma measurement tools. Because of the uniformity in education levels, profession and small size of the sample population, it was assumed by researchers that language in the survey would be understood and culturally appropriate for all participants. The open-ended questions were also meant to mitigate fence sitters and floaters by allowing for explanation of undetermined or changing opinions. Multiple questions to measure each concept were used in order to lessen the impacts of possible idiosyncratic variation.

Method of Analysis

This study used ordinal measurement for the Likert five-point scale section of the survey. This portion of the survey was rank ordered, and a number was assigned to the corresponding answer value: 1 indicating strongly oppose, 2 indicating oppose, 3 indicating neutral, 4 indicating support and 5 indicating strongly support. Researchers had participants rate each tool based on the same five criteria: The assessment would be appropriate to use with IPP clients, the information gained from the assessment would be helpful to IPP workers' practice, IPP workers would have enough time to complete and grade the assessment tool, IPP workers could easily

understand how to grade/mark the assessment tool and the assessment would be an adequate measure of child trauma symptomology. Based on these criteria, descriptive univariate analysis was conducted using SPSS software and the mean (average of data) and mode (most common answer in data) were collected for each of the tools in each of the above stated criteria.

Researchers also asked for descriptive information including if the participant was an IPP clinician or team lead, and how long the participant had worked in the IPP. Position of participant was measured at a nominal level and length of time worked in the IPP was measured at a ratio level. The mean was also determined for the length of time worked in the IPP.

Researchers attempted to use chi square analysis to establish if a statistical relationship existed between any of the study variables. Researcher began by splitting data into mutually exclusive categories. The data regarding years worked in the IPP was broken into two categories: participants who worked in the IPP under two years and participants who worked in the IPP for two years or more. These two categories were decided on by researchers due to the small size of the research population and relative newness of the IPP program (10 years) as they allowed researchers to divide the sample while still protecting anonymity of participants. . Two was the mean of years worked which is why it was chosen as the cut-off point.

Other categories used for chi square analysis were: IPP clinicians and team leads; participants who preferred CANS (which was the most preferred tool) as their first choice and those who chose either the CBCL or PEDS as their first choice; participants with positive opinions of caregiver feedback (ranked caregiver feedback as somewhat important or very important in the survey) and those with negative opinions (ranked caregiver feedback as neutral, somewhat unimportant or very unimportant in the survey); and participants who had positive opinions on self-reporting (ranked self-reporting as somewhat important or very important in the survey) and those who had negative opinions (ranked self-reporting as neutral, somewhat unimportant or very unimportant in the survey). Neutral was included in the not important categories of the final two category divisions as most of the answers in the surveys skewed

toward the positive so researchers hypothesised that neutral would be more representative of a negative sentiment.

For the qualitative data in the survey researcher used Nvivo software and the Braun and Clarke method of thematic analysis (2006). This is a flexible analysis of qualitative data looking for themes. Themes are defined in this method as capturing something important about the data in relation to the research question and representing some form of patterned response within the dataset. Researchers further used theoretical analysis at an explicit level to analyse data and derived a detailed and nuanced account of themes related to specific trauma tools and opinions of caregiver feedback and self-reporting in relationship to trauma research. The analysis and coding were done with the study research question in mind and researchers looked at what participants explicitly wrote. Researchers used this technique because the qualitative survey questions were specifically created to gather information regarding the trauma symptomology tools selected for this study, so an inductive review of qualitative data would not have been appropriate.

To analyse the data researchers used the six-step method described by Braun and Clarke (2006). First researchers read through and became familiar with the data; next, initial codes were generated including codes for caregiver feedback and self-reporting, and the CANS, CBCL and PEDS tools. Researchers then searched for themes and reviewed the themes that had been determined. Finally, the themes were defined and named as the perceived strengths and weaknesses of the CANS, CBCL, and PEDS tools and the perceived strengths and weaknesses of caregiver feedback and self-reporting and a report on these finding was created.

Findings

With a total sample size of 10 (n=10), there was an even division between clinicians and team leads. The average (M) years of experience was 2.15. With the option of rating tools from 1 to 3, the mode (Mo) for tool preference was CANS, PEDS and CBCL respectively. This equated to 60% preferring CANS as their first choice, 30% preferring PEDS as their first

choice and 10% preferring CBCL as their first choice. The respective means were 1.70, 2.20 and 2.10 (see Table 1).

Table 1. Mean (M) and mode (Mo) rates for tool preference

	CANS Preference	PEDS Preference	CBCL Preference
Mean	1.70	2.20	2.10
Mode	1	2	3

Analyzing participants' responses for the CANS tool, appropriateness had a mean of 3.90 and a mode of 4; Helpfulness had a mean of 4.20 and a mode of 4; Timeliness scored a mean of 3.70 and a mode of 4; Ease of Grading produced a mean of 3.80 and a mode of 3; lastly adequacy of symptomology produced a mean of 3.70 and a mode of 4. Overall this tool rated highly, particularly in the area of helpfulness. The lowest rated category was ease of grading. Analyzing the qualitative data, overall participants felt the strengths of the CANS tool included it being comprehensive, that it considered a child's strengths and looked at multiple contexts. Participants felt the major weakness was that it needed to be completed too often.

Analyzing participants' responses for the PEDS tool, Appropriateness had a mean of 3.30 and a mode of 4; Helpfulness had a mean of 3.20 and a mode of 4; Timeliness scored a mean of 4.10 and a mode of 4; Ease of Grading produced a mean of 3.00 and a mode of 3; lastly adequacy of symptomology produced a mean of 3.70 and a mode of 4. Overall, the PEDS tool scored pretty consistently. Its highest score was in the area of timeliness while the lowest score was in the category of ease of grading. Analyzing the qualitative data, overall participants felt the strengths of the PEDS tool included it being brief and focusing on the here and now. Participants felt the major weakness was that it was not comprehensive enough.

Analyzing participants' responses for the CBCL tool, Appropriateness had a mean of 3.40 and a mode of 3; Helpfulness had a mean of 3.60 and a mode of 3; Timeliness scored a mean of 3.00 and a mode of 2; Ease of Grading produced a mean of 4.00 and a mode of 4; lastly adequacy of symptomology produced a mean of 3.40 and a mode of 2. This tool rated average overall. The highest rated category was the ease of grading while the lowest rated was timeliness. Analyzing the qualitative data, overall participants felt the strengths

of the CBCL tool included its use of caregiver feedback and providing a good amount of information and detail. Participants felt the major weaknesses were that it was too long, asked for information the caregivers may not have and is not trauma specific.

Researchers attempted to use a chi square analysis to determine if either IPP position or amount of time worked in the IPP program had a statistical relationship to CANS as the preferred tool, but unfortunately frequencies in the cross tabulations were always less than five and because of this the results were not valid. Researchers also conducted chi square analysis on both position and amount of time in the IPP and both opinions of caregiver feedback and self-reporting, but again because of frequencies under five these analyses were invalid. Finally, researchers attempted to use a Fisher's Exact Test regarding clinicians and team leads rankings of the CANS tool as most preferred. The results showed that 80% of team leads chose CANS as their first choice, while only 40% of clinicians preferred CANS. However, the Fisher's Exact Test (Table 2) indicated that the results were not statistically significant, giving the p-value of .524.

Researchers queried participants' feedback on the importance of a caregiver feedback component in a tool and data reflected that 80% felt it was very important where 20% felt it was somewhat important (Table 3). Several participants noted through the qualitative data that caregiver feedback was especially important in the context of the IPP, as placement stability is a major goal of the program. Caregivers are the ones who are spending time with the children, so they will have insight and perspective that clinicians and other members of the team will not. One participant felt the drawback of caregiver feedback is that some caregivers have not been caring for the children long enough to give an accurate report due to short placement times. In this case caregiver feedback will not reflect the child's history and can be limited. Overall, participants all rated the importance of caregiver feedback highly.

Researchers queried participants' feedback on the importance of a self-reporting component in a tool and the data was more varied: 40% felt self-reporting was very important, 40% felt it was somewhat important, 10% were neutral and 10% felt it

was somewhat unimportant (Table 4). Analyzing the qualitative data, respondents repeatedly noted that they see benefits in self-reporting and its ability to increase their understanding of the child; however, the majority of respondents noted that trauma can impact a child's ability to have active insight into their own behaviours and that this could impact the self-reported information. The age of the service was also seen as important for feedback, as adolescents would be able to more accurately self-report than younger children.

Table 2. Fisher's exact test: Clinicians vs team leaders who chose CANS as their preference

		First Choice	Other Preference	Total
Position	Clinician	2	3	5
	Team Lead	4	1	5
Total		6	4	10

Table 3. Participants opinions on caregiver feedback.

	Frequency	Percent (%)
Very Important	8	80.0
Somewhat Important	2	20.0
Total	10	100.0

Table 4. Self-reporting results

	Frequency	Percent (%)
Very Important	4	40.0
Somewhat Important	4	40.0
Neutral	1	10.0
Somewhat Unimportant	1	10.0
Total	10	100.0

Discussion

The information found in the literature review showed that the IPP clinicians and team leads believed that CBCL, CANS, and PEDS would all be appropriate tools for use within the IPP. All three tools rated average or higher in the five categories queried in the research survey (appropriateness, helpfulness, timeliness, ease of use and grading, and adequacy of trauma symptom measurement). This information supports the researchers' findings in the existing literature that each of the CANS, CBCL, and PEDS tools would be an appropriate candidate as a measure of trauma symptomology in a quantitative analysis of the IPP. Due to attainability and cost issues, the TSCYC

was removed from this research study. However, as 20% of participants wrote that they believed TSCYC would also be an appropriate tool in the qualitative section, it would be important for future research on the IPP to also considers this tool.

This study found evidence that the overall CANS was a tool that could be beneficial for use in the IPP as was suggested from the information found during the literature review. The literature review suggested that CANS advantages were that it considers strengths and that it was an accurate measure of trauma symptomology within a child welfare system. These ideas were supported in this study in which participants stated that CANS incorporated strengths, was comprehensive, and looked at multiple contexts. A finding researchers had in this study regarding CANS that contradicted information found in the literature review was that participants felt that CANS needed to be completed too often.

One participant noted that trauma recovery takes time and if a tool was used too often it could be demoralizing for clients. Also, although this study did find that CANS was the most preferred tool overall with 60% of participants selecting it as their first choice, due to the small sample size of this research project this result should not be used alone as a basis to select a tool for a larger quantitative study. More research should be done into CANS to ensure its appropriateness before a decision is made.

Although the CBCL had the lowest average rating in the five quantitative criteria in the survey and had the lowest mode in first preference, it did rank second in overall choice when the average mean of ranking was considered instead of the mode. These findings are consistent with the literature review which named it as appropriate tool for trauma symptomology measurement, especially in a context when NMT is being used. In the literature a common critique of the CBCL was that it used caregiver information, which is subjective, however in the qualitative portion of this study the use of caregiver feedback was actually considered a strength. This difference could have occurred because a goal of the IPP is to increase permanency in placements and caregiver engagement in considered a key way to achieve this goal.

In accordance with the literature review, most participants rated PEDS above average in the five categories in the survey and saw it as a feasible trauma symptomology measurement tool. The literature on this tool stated that it was not created to measure PTSD symptoms as listed in the DSM 5. This is consistent with this study in which participants ranked PEDS lowest in its ability as a trauma symptomology measure. The literature on PEDS also stated that it would take seven minutes to complete. This was consistent with the finding of this study, which named PEDS brevity as one of its main strengths. However, it should be noted that the brevity of this tool was also considered a weakness as the PEDS lack of comprehensiveness was considered its main flaw in the qualitative analysis of this study.

Caregiver feedback was considered by all participants to be important. This was interesting as in the literature caregiver feedback was considered subjective and not always a reliable indicator of trauma symptomology. The data in this study on self-reporting was more divided. Although 80% of participants still felt it was very important, the other 20% were neutral or felt it was somewhat unimportant. This finding is actually consistent with the literature as in some offices the IPP worked with younger children (below 10). The literature did note that self-reporting wasn't always appropriate for younger children. The qualitative data in this study also stated that self-reporting isn't always accurate for people who have experienced trauma, as trauma can actually prevent insight into one's own behavior. This finding is consistent with overall literature on trauma; however, was not something researchers found in the literature regarding critiques of self-reporting and trauma symptomology measurement tools. This concept is worthy of more consideration in future research.

Overall researchers were able to find the answers to the researcher questions. CANS was the most preferred tool by 60% of participants. Important strengths of tools were that they provided a comprehensive picture of trauma symptomology and could be completed in a timely manner. Notable weaknesses in the tools were an inability to consider

the context of the children, asking for unavailable information and taking too much time to complete.

Study Limitations

A major limitation of this study is the limited sample size. Due to the small and specific sample population, researchers will be unable to generalize this study to other populations. Another limitation of the study was the purposive sampling method. Due to the small sample size, researchers were not able to obtain a sense of completeness (i.e. all opinions on the concepts) or saturation (ie. confidence that little more could be learned from subsequent surveys). Also, because of the small sample, researchers made a decision to open the survey to both clinicians and team leads. Because of this although the term clinician was used in initial survey and recruitment materials the term IPP worker is the one used throughout the final report. Lastly, researchers were unable to confirm whether this sample was representative of the population (Grinnell & Unrau, 2014).

Researchers hypothesized from evidence in the qualitative data and information gained on the IPP through discussion with MCFD liaisons that the IPP workers in BC were working with different age groups, cultures, work hours, caseloads, and possibly from different clinical intervention modalities. Researchers theorized that the differences among the IPP in different offices may have impacted IPP workers' opinions on the tools as what each community office needed from the tools was different.

Another limitation of this study was that the definitions of trauma and selection of possible tools was subject to researchers' opinions and biases. Similarly, there was a risk of bias in question formulation and coding of data. Researchers could not find an established tool for data collection in relation to trauma workers' opinions on trauma measurement tools and thus created their own. Some external feedback was given on the survey however it was not rigorously tested. Additionally, although the study information letter stated clearly that participation was not mandatory and would be anonymous it is possible that participants felt professional pressure to complete the survey. Lastly, as previously discussed there were major limitations to the tools: There were

no culturally specific tools available for work with Indigenous children, many tools were intended for an older population group (above 10) with a large self-reporting section, and many of the tools only measured whether trauma was present, not the ongoing symptomology.

Implications

There is a current drive within the social work field to ensure that client interventions are evidence based. In order to ensure that their programming is meeting the standard of evidence based and remaining accountable to the communities they work in, MCFD need to ensure they are integrating established research with clinical experience and core social work ethics. This research project was the first step in evaluating the IPP in relation to evidenced based programming and has laid groundwork for stake holder engagement and continued collaborative research into the program. However, in order to evaluate the IPP and examine if their methodologies for trauma treatment are working MCFD needs to proceed with their initially planned quantitative research project into the efficacy of the IPP.

If MCFD proceeds with a quantitative research project into the efficacy of the IPP this project has suggested that the IPP work to standardize some components of its practice as currently there are too many variables and one quantitative tool will not be appropriate to use with all programs province-wide. Consideration should be given to a trauma symptomology measurement tools that: have high established internal and external validity; uses caregiver feedback; and balances the need for comprehensive information on trauma symptomology with the needs of clients and the realities of time restrictions and caregiver knowledge in practice settings. It is unlikely there will be a perfect tool, but there can be a best fit.

Researchers would also recommend MCFD to consider the TSCYC. Throughout the literature, it was identified as an acceptable tool based on the criteria provided by MCFD but was eliminated due to cost and attainability issues. Through the qualitative analysis, it was mentioned twice by participants as an alternative tool to consider and therefore should be included in future considerations.

Finally, researchers need to continue to work collaboratively with practitioners to bridge the gap between academia and practice. Both client and IPP worker input are necessary to ensure ethical and applicable research.

Conclusion

There were two major reasons for completing this research study. The first was to find a preferred trauma measurement tool that could be used to measure the IPP's effectiveness. Once this was completed, MCFD planned to conduct a large-scale quantitative study regarding the efficacy of their program with an attempt to improve outcomes to the children they are servicing, as well as the caregivers and greater community. However, while the research study has provided MCFD with a preferred tool, CANS, as well as information on the strengths and limitations of each proposed tool, this study will not be able to be generalized as the IPP is not operated in the same way nor does it have the same demographic B.C. wide, and the sample size for this project was too small.

The second major reason for this study was to explore IPP workers' opinions of trauma tools and to begin research on the IPP in a collaborative fashion. There has been a long-standing gap between the academic production of research and the translation of that research into practice. This gap stems from the linear process of academics creating knowledge that is disseminated to field social workers without realizing that the knowledge does not easily or adequately translate to the real world (Steen et al. 2017). UBC partnering with MCFD for research purposes in itself was a move to push beyond the stubborn research-practice gap in social work, and by gaining meaningful insight into IPP workers' opinions on the trauma symptomology tools and getting feedback on the methodologies for a quantitative analysis this research project has continued the move into research collaboration.

This study has supported IPP clinicians and team leads in contributing substantive input into the research of their program. This is the first step to ongoing collaborative research into the IPP and will help disrupt practices that allow academic researchers to be the knowledge brokers in social work. This project will help social work research become more

attuned with the social work values of equality and integrity and help research be transferred into evidenced-based programming more efficiently. Researchers are hopeful that due to collaborative methods the knowledge gained on the IPP through research will be more easily translated into improved or substantiated IPP practices where it can be used to support children who have experienced trauma.

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Appendix A

Study Survey

1. Are you an IPP Clinician or Team Leader?
 - a. I am an IPP Clinician
 - b. I am an IPP Team Leader
2. How many years have you been working as part of the IPP for MCFD?

3. **Paediatric Emotional Distress Scale (PEDS).**

Please let us know your opinions on the following statements.

	Strongly Oppose (1)	Oppose (2)	Neutral (3)	Support (4)	Strongly Support (5)
PEDS would be appropriate to use with IPP clients (1)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
The information gained from the PEDS measurement would be helpful to IPP clinicians' practice. (2)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
IPP clinicians would have enough time to complete and grade the PEDS tool. (Completion take approx. 8 minutes, scoring takes approx. 5 minutes, administered every month). (3)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
IPP clinicians could easily understand how to grade/mark the PEDS tool. (4)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
The PEDS tool would be an adequate measure of child trauma symptomatology. (5)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

4. Child and Adolescent Needs and Strengths (CANS)

Please let us know your opinions on the following statements.

	Strongly Oppose (1)	Oppose (2)	Neutral (3)	Support (4)	Strongly Support (5)
The CANS assessment would be appropriate to use with IPP clients (1)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
The information gained from the CANS assessment would be helpful to IPP clinicians' practice. (2)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
IPP clinicians would have enough time to complete and grade the CANS assessment tool. (Completion take approx. 10 minutes, scoring takes approx. 5 minutes, administered every 30 days) (3)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
IPP clinicians could easily understand how to grade/mark the CANS assessment tool. (4)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
The CANS assessment would be an adequate measure of child trauma symptomatology. (5)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

5. Child Behaviour Check List (CBCL)

Please let us know your opinions on the following statements.

	Strongly Oppose (1)	Oppose (2)	Neutral (3)	Support (4)	Strongly Support (5)
The CBCL assessment would be appropriate to use with IPP clients (1)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
The information gained from the CBCL assessment would be helpful to IPP clinicians' practice. (2)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
IPP clinicians would have enough time to complete and grade the CBCL assessment tool. (Completion takes approx. 10-20 minutes, scoring takes approx. 10 minutes, administered every six months) (3)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
IPP clinicians could easily understand how to grade/mark the CBCL assessment tool. (4)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
The CBCL assessment would be an adequate measure of child trauma symptomatology. (5)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

6. How important is caregiver feedback as a measurement of trauma symptoms to your practice?

- Very important (1)
- Somewhat Important (2)
- Neutral (3)
- Somewhat unimportant (4)
- Not important (5)

7. Please explain why you feel caregiver feedback is or isn't important:

8. How important is self-reporting as a measurement of trauma symptoms to your practice?

- Very important (1)
- Somewhat important (2)
- Neutral (3)
- Somewhat unimportant (4)
- Not important (5)

9. Please explain why you feel self-reporting is or isn't important:

10. Please rank the tools in order of your preference. Please rank your tools with 1 being the most preferred and 3 being the least preferred.

_____ CANS (4)
_____ PEDS (5)
_____ CBCL (6)

11. Why did you prefer your first choice tool?

12. Why was your third choice your least preferred tool?

13. Did you perceive any major strengths in a measurement tool included in the survey? If applicable please state the tool and strengths connected to the tool.

14. Did you perceive any major flaws in the measurement tools included in the survey? If applicable please state the tool and flaws connected to the tool.

15. Is there a tool not included in the survey that you would prefer to use over the PEDS, CBCL and CANS tools? Please name the tool and explain why.
