Texas Children Recovering from Trauma

Annual Evaluation Report

Grant Year 3

Texas Institute for Excellence in Mental Health

Advancing Resilience and Recovery in Systems of Care

Molly A. Lopez
Emerald Adler

Texas Institute for Excellence in Mental Health
School of Social Work
University of Texas at Austin
1717 West 6th Street, Suite 335
Austin, Texas 78703
Phone: (512) 232-0616
Fax: (512) 232-0617
E-mail: [email address]
http://sites.utexas.edu/mental-health-institute/

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Texas Institute for Excellence in Mental Health

Advancing Resilience and Recovery in Systems of Care

Texas Children Recovering from Trauma

Overview of Project

The Texas Department of State Health Services (DSHS), along with key partners at Heart of Texas MHMR Center and other community agencies, have undertaken an initiative to improve the behavioral health service system for children and youth who have been impacted by exposure to traumatic events. Funded by the Substance Abuse and Mental Health Services Administration (SAMHSA), the partners collaborate with the National Child Traumatic Stress Network (NCTSN) to improve service delivery and develop products and tools for dissemination. The goal of the initiative is to implement evidence-based screening, assessment, and treatment practices within the service delivery system and transform systems to provide care that is consistent with the values of trauma-informed care.

The second year of the initiative focused on continuing the implementation of Trauma-Focused CBT (TF-CBT), including targeted training to providers working with military families. In addition, a second evidence-based practice was added to the system, with the first training cohort for Parent Child Interaction Therapy (PCIT). In the second year of the grant, implementation of both treatment models extended beyond Heart of Texas MHMR to include public mental health clinics and other non-profit providers across the state. In preparation for the third year's focus on trauma-informed care, planning activities were augmented with an initial survey of the workforce on trauma knowledge, attitudes, and perceptions of readiness for trauma-informed care activities. This initial survey was conducted within the children's mental health program at the Department of State Health Services and Heart of Texas MHMR. A statewide survey, encompassing staff within multiple areas of the behavioral health system was conducted at the end of the project year.

Evaluation Overview

Federally required reporting data was collected quarterly to demonstrate the impact of the grant on key infrastructure outcomes. These are reported to SAMHSA and the state advisory committee quarterly. This report will focus on the local evaluation conducted to inform state and local decision-making, document the impact of activities on systems, youth, and families, and guide continuous quality improvement activities. Evaluation data is collected at both the service level and the system level. At the service level, children and adolescents who are referred for trauma-focused treatment are assessed with several measures of child and family characteristics. These measures are repeated every 3 months if the child is still receiving these services and at program discharge. In addition, therapists complete information about the content of treatment sessions to assess adherence to the treatment model. At the system level, measures are collected on individual providers of trauma treatments to assess their attitudes

toward evidence-based treatments and experiences with training. In addition, agency wide measures are collected to assess overall system readiness and impact.

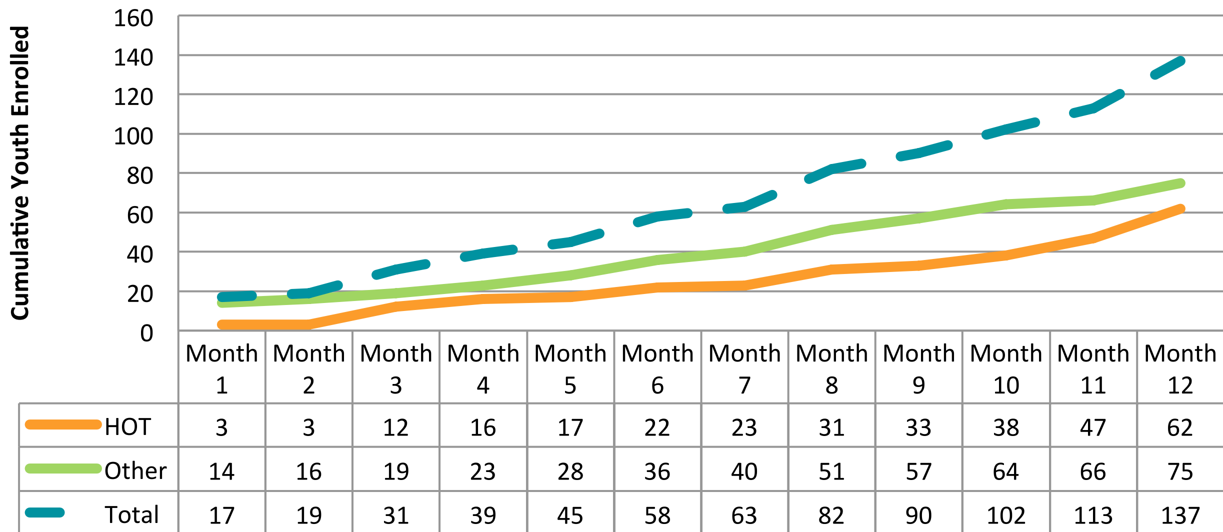
Results
Child, Adolescent, and Family Level

Screening for Trauma and Other Behavioral Health Needs

A standardized screening process has been implemented across all contracted mental health authorities, using the Child and Adolescent Needs and Strengths Assessment (CANS), which includes an overall rating on trauma and several modules. During the grant year, providers screened a total of 24,484 unique children and adolescents for trauma symptomatology necessitating care.

Access to Trauma Treatments

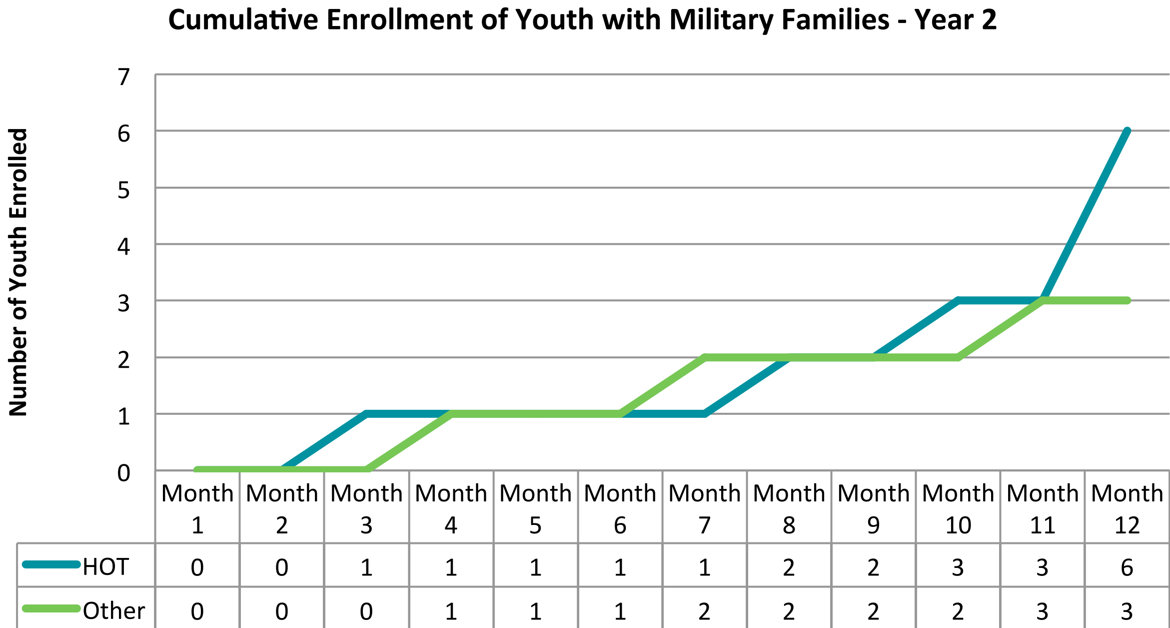
One hundred and thirty-seven youth were enrolled in the trauma services over the grant year, which is slightly fewer than the number served in Grant Year 2 (GY2). Heart of Texas MHMR is the primary service site for the project. Additional sites have been engaged across the state when they have chosen to participate in provider training in TF-CBT or PCIT and implement the treatments within their organization. As indicated by the rate of enrollment presented in Figure 1, this has been an effective strategy for expanding the reach of the project and has allowed the project to exceed the overall recruitment goals of 100 youth.



	Month 1	Month 2	Month 3	Month 4	Month 5	Month 6	Month 7	Month 8	Month 9	Month 10	Month 11	Month 12
HOT	3	3	12	16	17	22	23	31	33	38	47	62
Other	14	16	19	23	28	36	40	51	57	64	66	75
Total	17	19	31	39	45	58	63	82	90	102	113	137

Note: HOT=Heart of Texas; Other=Additional sites enrolling families.

The initiative has purposefully set out to engage families with military ties into the project. Enrollment of families with military ties reached 13 families in GY 2. In the current grant year, nine families with military involvement were enrolled. The number of youth with military ties engaged in services is tracked monthly in Figure 2.



	Month 1	Month 2	Month 3	Month 4	Month 5	Month 6	Month 7	Month 8	Month 9	Month 10	Month 11	Month 12
HOT	0	0	1	1	1	1	1	2	2	3	3	6
Other	0	0	0	1	1	1	2	2	2	2	3	3

Other child and family-level information is presented on all 202 children served during GY3. This includes some youth that were enrolled in the first or second year of the project, but remained in treatment in the third year.

Characteristics of Youth Served in Year 3

Interviews were conducted with both youth (38.8%) and caregivers (61.2%). Demographics of the youth served are presented in Table 1. The samples are similar, but the Heart of Texas sample has a greater proportion of African-American youth and smaller proportion of Caucasian youth. The Heart of Texas sample was also older than the youth served within other sites. Thirty-seven children served in GY3 had a family member with military affiliation.

Table 1. Demographics of Youth Served in Year 3

	Heart of Texas	Other Sites*	Total
	n=92	n=110	n=202
Gender – Female	44 (47.8%)	47 (42.7%)	91 (45.0%)
Gender - Male	48 (52.2%)	62 (56.4%)	110 (54.5%)
Ethnicity – Hispanic	27 (29.3%)	37 (33.6%)	64 (31.7%)

Race – African American	28 (30.4%)	18 (16.4%)	46 (22.8%)
Race – Asian	0 (0%)	1 (0.9%)	1 (0.5%)
Race – Native Hawaiian	1 (1.1%)	3 (2.7%)	4 (2.0%)
Race – Alaska Native	0 (0%)	1 (0.9%)	1 (0.5%)
Race – White	57 (62.0%)	86 (78.2%)	143 (70.8%)
Race – American Indian	5 (5.4%)	3 (2.7%)	8 (4.0%)
	Mean (SD)	Mean (SD)	Mean (SD)
Age of Child	11.2 (4.4)	7.5 (4.6)	9.2 (4.9)

The race and ethnicity of the youth served in GY3 show some differences when compared to the estimated demographics of the population of children in Texas in 2014. While 32% of those served identified as Hispanic or Latino, 49% of the children in Texas are Hispanic. However, there is a greater representation of African American youth in those served by the grant (22.2%), while 12% of the Texas children are African American. The non-Hispanic White alone served group (37.9%) is similar to the population in Texas (33%). The youth identifying as Native American (3.5%) are small, but slightly larger than the Texas population (<.5%).

Nature of Traumatic Exposure

Parents, adolescents and children each provided information on the traumatic experiences that have impacted the youth through the UCLA PTSD Index. Data is only available for a subset of youth, as younger children were assessed with a different instrument. Parents reported the youth have experienced an average of 3.1 different types of trauma (*sd*=1.7; range 0 to 7), while the youth reported an average of 3.8 different trauma types (*sd*=2.2; range 0 to 10). Table 2 illustrates the percentage of children and youth who have had various traumatic experiences. The most commonly reported experiences were witnessing domestic violence, traumatic death of a loved one, and being physically abused or assaulted.

Table 2. Trauma Experiences by Respondent Type

Trauma Types	Parent Report	Youth Report
	N (%) (n=81)	N (%) (n=83)
Being in a big earthquake that badly damaged the building the child was in.	0 (0%)	3 (%)
Being in another kind of disaster, like a fire, tornado, flood, or hurricane.	11 (%)	19 (%)
Being in a bad accident, like a very serious car accident.	13 (%)	15 (%)
Being in a place where a war was going on around your child.	1 (0%)	3 (%)
Being hit, punched, or kicked very hard at home.	20 (%)	26 (%)

Seeing a family member being hit, punched or kicked very hard at home.	38 (%)	33 (%)
Being beaten up, shot at or threatened to be hurt badly in your town.	21 (%)	33 (%)
Seeing someone in your town being beaten up, shot at or killed.	16 (%)	27 (%)
Seeing a dead body in your town (not at funeral).	9 (%)	10 (%)
Having an adult or someone much older touch the child's private sexual body parts when your child did not want them to.	21 (%)	25 (%)
Hearing about the violent death or serious injury of a loved one.	31 (%)	42 (%)
Having painful and scary medical treatment in a hospital when your child was very sick or badly injured.	11 (%)	18 (%)
Other situation that was really scary, dangerous or violent.	41 (%)	43 (%)

Note. Respondents can indicate more than one trauma type.

Functioning of Children Served

Several measures of baseline functioning are available to describe the population of youth served. The majority of youth completed the UCLA PTSD Reaction Index, as did the parents of these youth. Responses to these measures indicate that youth have moderate trauma-related distress at entry to services. Parents reported an average UCLA symptom score of 31.7 (*sd*=14.0; range 1-62), while children and adolescents reported average symptom scores of 32.2 (*sd*=15.2, range 3-67). Symptom severity scores of 25 are generally considered clinically elevated, with scores of 39 or higher being the optimal cut-off for a diagnosis of PTSD. Younger children were assessed with the Trauma Symptom Checklist for Young Children (TSCYC). The children had a mean baseline score of 49.3, which translates into an age and gender-adjusted T-score of 76.1. A T-score within this range suggests that, on average, these youth scored higher on traumatic stress than 96% of the normative population.

Table 3. Trauma Symptom Severity at Enrollment

	Mean	**Standard Deviation**	**Percent above Clinical Cut-off >24 / >38**
UCLA Parent Symptom Total (n=58)	31.7	14.0	65.5% / 37.9%
UCLA Child/Youth Symptom Total (n= 82)	32.2	15.2	69.5% / 37.8%
			T-Score Cutoff >65T / >70T
TSCYC PTS Raw Score (n=45)	50.3	13.7	64.4% / 60.0%

TSCYC PTS T-Score (n=38)	78.3	20.4	64.4% / 60.0%

Note: The UCLA was completed on youth older than 7, while the TSCYC was completed on younger youth.

The majority of respondents indicated that the youth's overall health was good to excellent (n=158, 86.3%). Only three youth were reported to have "poor" overall health (1.6%), with 18 (9.8%) reported to have fair health. Respondents also indicated their agreement with several statements measuring overall daily functioning during the previous 30 days, and responses are reported in Table 2. Youth were generally reported to be functioning well. However, the majority of respondents did indicate difficulty with coping (64.1%). Additionally, a substantial number (41.1%) identified being unsatisfied with their family life. Seventeen youth had one or more emergency room visits for a behavioral health problem (9.3%) in the thirty days before entry.

Table 4. Youth Functioning

Item	Strongly Disagree/ Disagree	Undecided	Strongly Agree/ Agree
I am [my child is] handling daily life. (179)	47 (26.3%)	24 (13.4%)	118 (65.9%)
I get [my child gets] along with family members. (n=181)	56 (30.9%)	27 (14.9%)	98 (54.1%)
I get [my child gets] along with friends and other people. (n=180)	44 (24.4%)	25 (13.9%)	111 (61.7%)
I am [my child is] doing well in school and/or work. (n=167)	51 (30.5%)	24 (14.4%)	92 (55.1%)
I am [my child is] able to cope when things go wrong. (n=181)	116 (64.1%)	30 (16.6%)	35 (19.3%)
I am satisfied with our family life right now. (n=180)	74 (41.1%)	19 (10.6%)	87 (48.3%)

Fifty-eight youth (42.3%) were reported to have no absences from school, with 35 youth (25.5%) reporting absences for 1 or 2 days out of the last 30, 38 youth (27.7%) reporting between 3 and 10 days absent, and 6 youth (4.4%) reporting more than 10 days absent. Forty-four percent of those reporting absences indicated that they were unexcused. Four of the participating youth (1.8%) reported arrests within the past month.

Residential Stability

Fourteen youth or families reported being homeless (7.7%) at some time during the month before entry into the program. Most of those who were homeless were without a home more than half of the month (71.4%). This is a much larger percentage of homeless youth than

previous years and may reflect the inclusion of additional partners focused on responding to family violence. The majority of participating youth (84.7%) had no out-of-home days during the past month, with thirteen youth (7.1%) reporting between one and ten days outside the home and fifteen (8.2%) reporting more than 10 days outside the home. Psychiatric hospital stays were the most common reason for an out-of-home stay with 14 youth reporting a hospital stay. Four youth reported a stay in a detention center.

Eighty-four percent of the youth lived in a caregiver's home, apartment, or room as the primary residence in the past month, with others reporting someone else's home/apartment (7.0%), homeless (6.0%), as well as a small number of other arrangements. Although the majority of the population appears to have some stability to their residence, a growing number of youth are reporting both out-of-home events and/or homelessness at program entry.

Treatment Sessions

Session forms were submitted for most youth served over the GY; however providers did not report individual sessions for 32.7% of children. The majority of youth (n=91; 64.1%) received TF-CBT and a smaller number (n=51, 35.9%) received PCIT. For youth who have been discharged from care, the average number of TF-CBT sessions is 8.3 (*sd*=7.3) and the average number of PCIT sessions is 8.1 (*sd*=7.6). Table 5 presents information about the total number of sessions completed by youth discharged from care. Despite the very different structuring of the two treatment models, retention in treatment is similar across the two models, with the majority of participants completing ten or fewer sessions of care.

Table 5. Number of Sessions Received for Youth Discharged from Care

Number of Sessions	TF-CBT N=70	PCIT N=39
1 Session	11 (15.7%)	6 (15.4%)
2 – 5 sessions	19 (27.1%)	12 (30.8%)
6 – 10 sessions	14 (20.0%)	8 (20.5%)
11 – 15 sessions	8 (11.4%)	4 (10.3%)
16 – 20 sessions	12 (17.1%)	5 (12.8%)
More than 20 sessions	6 (8.6%)	5 (12.8%)

Adherence to Trauma Focused Cognitive Behavioral Therapy

Ninety-one youth who were served in GY3 had documentation of TF-CBT sessions. These youth had a total of 713 documented sessions. Therapists are expected to utilize home assignments at most sessions to ensure children and their parents are practicing newly learned skills and generalizing these new skills in their home, school, and community environments. Therapists appear to be assigning homework somewhat more frequently than in GY2, with homework

assigned 69.3% of sessions (up from 50.4%). When homework was assigned, 45.8% of youth or parents completed the assignment fully and another 30.3% partially completed it.

Information on adherence to the TF-CBT model was collected through a therapist checklist of core treatment elements. The results are presented in Table 6. Analyses are focused on only those 70 youth discharged from care to provide further information about treatment adherence. The core component is reflected as covered if any sessions included that component, so the data will not reflect whether the component activities were completed or the quality of the intervention.

Table 6. Frequency of TF-CBT Components Conducted During Treatment Sessions – Discharged Youth

Core Component	Number N=70 (%)	Percent
Psychoeducation	63	90.0%
Parenting Skills	33	47.1%
Relaxation	47	67.1%
Affective Regulation	54	77.1%
Cognitive Coping	48	68.6%
Trauma Narrative	26	37.1%
In Vivo Desensitization	7	10.0%
Conjoint Sessions	16	22.9%
Safety Planning	19	27.1%
Skill Development	27	38.6%

Results would suggest that many of the core components of TF-CBT are being used regularly with youth. As would be expected, the components that tend to occur in the earlier phases of treatment - the skills development components - tend to be conducted with a majority of youth. Other components may be less reliably provided because some youth are not completing the full course of care. Results do suggest that therapists may not be providing the parenting skills components of care with all youth. These components occur early in treatment, yet only 47.1% of families had any sessions focused on parenting skills. In addition, a minority of youth participated in developing a trauma narrative or reviewing the narrative with a caregiver, suggesting most youth experience is limited to the skills development component of TF-CBT, with more limited exposure to the desensitization elements.

Adherence to PCIT Treatment Components

Fifty-one youth served in GY3 had documentation of receiving PCIT sessions. A total of 408 PCIT sessions were provided to these families. PCIT therapists are expected to provide caregivers with homework assignments to be practiced every day between sessions. Results indicated that

PCIT therapists provided homework assignments 91.0% of the time (excluding initial appointments), so this component of the treatment structure was adhered to. Although a minority of parents (23.0%) completed the homework all seven days of the week, 89.8% completed the assignment three or more days of the week. Only 5.1% of the time did parents fail to complete any of the homework assignments.

Since the sample of youth receiving PCIT remains small at this time and few youth have been discharged from care (n=10; 27.8%), the PCIT components being used with families will be presented for the full sample. Therefore, it would be expected that more families will have experienced the early components of the treatment and that families may still receive additional components as they progress through care. When the sample size is larger, information will be presented on families who have been discharged from care.

Information on adherence to the PCIT model was collected through a therapist checklist of specific session tasks. The results are presented in Table 7. Analyses are focused on only those 51 youth discharged from care to provide further information about treatment adherence. Each session identified has a specific list of tasks to accomplish, but a provider may work on one session over two meetings if needed to complete the tasks. The data will not reflect the quality of the intervention.

Table 7. Frequency of PCIT Core Components Conducted During Treatment Sessions – All Families

Core Component	Number N=51	Percent
Therapy Orientation Session	41	80.4%
CDI Teaching Session	37	72.5%
First CDI Coaching Session	33	64.7%
Second CDI Coaching Session	27	52.9%
Third CDI Coaching Session	22	43.1%
Fourth or Later CDI Coaching Session	22	43.1%
PDI Teaching Session	18	35.3%
First PDI Coaching Session	19	37.3%
Second PDI Coaching Session	14	27.5%
Third PDI Coaching Session	12	23.5%
Fourth PDI Coaching Session	10	19.6%
Fifth PDI Coaching Session	7	13.7%
Sixth PDI Coaching Session	5	9.8%
Seventh or Later PDI Coaching Session	6	11.8%
Graduation Session	7	13.7%

As illustrated in the table above, families are progressing through the components of treatment in the recommended order. While most families are receiving a significant number of the child directed coaching sessions, the majority are not remaining long enough to receive the parent directed (or parenting skills) coaching sessions. Seven children and families (13.7%) have reached the graduation session. As mentioned previously, the retention rate is similar across both PCIT and TFCBT.

Impact of Treatment

Treatment outcomes are assessed at 3 months and 6 months after program entry. Depending on the youth's age, either the UCLA PTSD Reaction Index or the Trauma Symptom Checklist for Young Children (TSCYC) is obtained. Results of those youth with both pre-test and post-test scores are provided in Table 8. Although the sample size is small, these results support a significant improvement in trauma symptom scores between baseline and the last available assessment. The small sample of young children assessed with the TSCYC shows improvement in PTSD approaching significance. Since many young children receiving PCIT are likely to have externalizing symptoms, changes on the Anger scale were also examined. Children made significant improvement on anger symptoms over time.

To increase the opportunity to gather outcome information at all points in time, therapists are asked to complete a Clinical Global Improvement (CGI) scale at each treatment session. Based on the last reported session, TF-CBT therapists reported 32.4% of youth had no significant change, 40.8% were a little better and 19.7% were significantly better. A small percentage (7.0%) was identified as a little worse. PCIT therapists reported that 33.3% of the youth had no significant change, while 16.7% were a little better and 37.5% were significantly better. No youth in TF-CBT or PCIT were reported to be significantly worse.

Table 8. Outcomes of Children Receiving Trauma Care

Item	Mean Baseline Scores	Mean Follow-up Scores	Dependent t-test
UCLA PTSD Reaction Index – Parent Report (n=16)	31.2	20.6	t=3.06, p<.01
UCLA PTSD Reaction Index – Youth Report (n=38)	35.0	22.9	t=7.00, p<.0001
TSCYC PTSD Raw Score (n=14)	49.2	43.1	t=1.98, p=.07
TSCYC Anger Raw Score (n=14)	20.0	13.4	t=5.57, p<.0001

Clinical Global Impression Scale	Significantly Worse	A Little Worse	No Significant Change	A Little Better	Significantly Better
TF-CBT Participants (n=71)	0 (0%)	5 (7.0%)	23 (32.4%)	29 (40.8%)	14 (19.7%)

PCIT Participants (n= 48)	0 (0%)	1 (2.1%)	16 (33.3%)	8 (16.7%)	18 (37.5%)

Perceptions of Care

During follow-up or discharge interviews, parents or youth were asked to respond to several questions related to their perceptions of the care they received. Table 9 provides the results of the 70 families served during GY3 with a completed survey. Results were overwhelmingly positive, with all respondents indicating satisfaction with all items. One or two respondents occasionally indicated that they were undecided if they were satisfied on specific items.

Table 9. Perception of Care

Item	Strongly Disagree/ Disagree	Undecided	Strongly Agree/ Agree
Staff here treat me with respect. (n=70)	0 (0%)	0 (0%)	70 (100%)
Staff reflected my family's religious/spiritual beliefs. (n=69)	0 (0%)	0 (0%)	69 (100%)
Staff spoke to me in a way that I understand. (n=70)	0 (0%)	1 (1.4%)	69 (98.6%)
Staff was sensitive to my cultural/ethnic background. (n=70)	0 (0%)	2 (2.9%)	68 (97.1%)
I helped choose my [my child's] services. (n=70)	0 (0%)	2 (2.9%)	68 (97.1%)
I helped choose my [my child's] treatment goals. (n=70)	0 (0%)	2 (2.9%)	68 (97.1%)
I participated in my [my child's] treatment. (n=70)	0 (0%)	1 (1.4%)	69 (98.6%)
Overall, I am satisfied with the services I [my child] received. (n=70)	0 (0%)	1 (1.4%)	69 (98.6%)
The people helping me [my child] stuck with me [us] no matter what. (n=70)	0 (0%)	1 (1.4%)	69 (98.6%)
I felt I had my [my child had] someone to talk to when I [he/she] was troubled. (n=70)	0 (0%)	1 (1.4%)	69 (98.6%)
The services I [my child and/or family] received were right for me [us]. (n=70)	0 (0%)	1 (1.4%)	69 (98.6%)
I [my family] got the help I [we] wanted [for my child]. (n=70)	0 (0%)	1 (1.4%)	69 (98.6%)
I [my family] got as much help as I [we] wanted [for my child]. (n=69)	0 (0%)	1 (1.4%)	68 (98.6%)

Results
System Level

Overall Training Activities

The TCRFT initiative seeks to enhance the capacity of child-serving providers and organizations to meet the needs of children and families who have experienced trauma through training and workforce development. The initiative has both supported trainings conducted by external experts on issues related to trauma and provided trauma presentations to others. A summary of the trainings and reach for these trainings is presented in Table 10.

Table 10. Trainings Occurring During the Grant Year

Training Topics	Number of Trainings	Number of Participants
Screening for Trauma	1	29
Trauma-Focused CBT*	2	32
Parent Child Interaction Therapy*	1	32
Advanced Topics for Trauma-Focused CBT	1	2
Attachment, Self-Regulation, and Competency*	1	2
Integrative Treatment for Complex Trauma*	1	2
General Training on Impact of Traumatic Stress	2	229
Trauma Informed Care	10	687
Trauma and IDD Toolkit Training of Trainers	1	2
Needs of Unaccompanied Minors	4	238
Addressing Secondary Traumatic Stress	3	150
Engagement of Children and Families having Experienced Trauma	1	104
Trauma Informed Care and Suicide Prevention	2	46

*Denotes an evidence-based treatment approach

Trauma-Informed Care Learning Collaborative

The primary goal of GY3 was to begin a statewide transformation of the behavioral health system aimed at implementing trauma-informed approaches to care. Behavioral health contractors were invited to participate in a year-long learning collaborative through a competitive application process. The learning collaborative is being facilitated by the National Council for Behavioral Health, with additional support provided through the TCRFT initiative and NCTSN partners. During GY3, the competitive application was released, reviewed by a panel, and sites were selected. The organizations identified implementation teams, including

parents, youth, and adults with lived experience, and teams attended a 2-day training event in Austin. The event included training on the impact of trauma and the core components of trauma-informed care, and allowed implementation teams to plan for initial transformation activities. Ninety-nine participants responded to an evaluation survey at the end of the second day.

Respondents were asked a variety of questions regarding their experience with the training and planning event. Table 11 reflects responses to the survey. Participant ratings reflected overall satisfaction with the event. Ratings generally reflected agreement with all responses, with a fairly even distribution between those indicating Strongly Agree and Agree. The highest rated items included “I am feeling positive about the team we have created to implement trauma-informed care” with 64.4% reporting Strongly Agree, “I feel confident that our team will be able to develop a vision statement that reflects how we want our organization to look and feel” with 61.9% indicating Strongly Agree, and “I am leaving this meeting feeling energized to adopt TIC” at 60.9%. The most negatively rated items included “The kick-off meeting met my expectations.” with 15.8% indicating disagreement and “I found the time I had to interact with other learning community members adequate.” with 16.7% indicating disagreement. In addition, most participants indicated that they could benefit from additional information about the Organizational Self Assessment, the Project Management Tool, and guidance on how to communicate for buy-in.

Table 11. Participant Perceptions of the Trauma Informed Care Kick-Off Event

	Strongly Agree	Agree	Disagree	Strongly Disagree
The kickoff webinar provided me with a good understanding of trauma, its impact and prevalence and a beginning understanding of trauma informed care.	51.6%	41.9%	6.5%	0%
The kickoff meeting increased my understanding of what it means to be trauma-informed.	54.2%	37.3%	8.4%	0%
I am feeling positive about the team we have created to implement trauma-informed care throughout our organization.	64.4%	34.5%	1.1%	0%
The kick-off meeting was well-organized.	34.5%	51.2%	11.9%	2.4%
The kick-off meeting met my expectations.	35.4%	48.8%	14.6%	1.2%
I now have a better understanding of how the learning community can assist	44.3%	47.7%	8.0%	0%

my organization in adopting trauma-informed care.				
I now have an increased understanding of the steps involved in creating culture change in our organization.	42.7%	47.6%	9.8%	0%
I feel better prepared to take the steps necessary to begin the change process.	41.7%	52.4%	6.0%	0%
I feel confident that our team will be able to develop a vision statement that reflects how we want our organization to look and feel.	61.6%	37.2%	1.2%	0%
I would like to have additional guidance on using the OSA.	40.5%	41.8%	16.5%	1.3%
I could benefit from additional guidance on how to communicate for buy-in.	43.0%	39.2%	16.5%	1.3%
I found the time I had to interact with other learning community members adequate.	31.0%	52.4%	13.1%	3.6%
I could use more information on using the PMT.	50.7%	38.0%	11.3%	0%
I am leaving this meeting feeling energized to adopt TIC.	60.9%	33.3%	5.7%	0%
I think I got everything I need from this meeting to get started with my team.	38.3%	48.1%	13.6%	0%

Participants were also asked to provide qualitative feedback and common themes were identified based on the questions asked.

What was the most helpful aspect of the Kick-off Meeting?

- Binder contents and resources
- Videos, which provoked empathy
- Bringing consumers/individuals with lived experience to the meeting; youth input
- Instructors
- Connections, networking, engaging with each other; team work
- Practical aspects of implementation; discussion of steps
- Hands on experience with tools; OSA

What would you like to get from participating in this learning community?

- Competencies in TIC; organizational change

- Tools for implementation; “nuts and bolts”
- Skills for advocating and training others
- More connection with other organizations, both in community and across state
- Recognition of the value of lived experience

Survey of Trauma Informed Care in Child Welfare

Overview. During this grant year, TCRFT staff partnered with Texas Court Appointed Special Advocates (Texas CASA) to develop and distribute a survey examining perceptions around trauma-informed care within the child welfare system in the state. This organization was interested in building on the mental health workforce survey developed in the second year of the TCRFT grant by the evaluators. TCRFT evaluators participated in the development committee, sponsored the review by the Institutional Review Board (IRB) at the University of Texas, hosted the survey on a web-based survey tool, and assisted with analysis of the results. Texas CASA released a report on the findings in October 2015.

Methodology. To accomplish their goal of gaining a better understanding of the current state of trauma-informed care training, interventions and services across the Texas child welfare system, Texas CASA deployed a system-wide survey. The survey was distributed to the following stakeholders: (a) Attorneys ad litem, (b) CASA volunteers and staff, (c) Children’s Advocacy Centers staff, (d) Child Protective Services (CPS) caseworkers, (e) Foster parents, (f) Family law judges, (g) Medical health providers, (h) Mental or behavioral health providers, (i) Kinship caregivers, and (j) Residential treatment center, shelter or group home staff. Recipients were encouraged to share the survey with other stakeholders through a snowball methodology. A total of 1,758 individuals responded to the survey, with CASA volunteers representing 50% of the sample. Respondents represented all geographic regions of the state.

Summary of Results. The majority of respondents (83%) indicated that they have received training on trauma and its impact on children, and 72% feel that they feel confident that they have the tools and skills that they need to help children heal from trauma. Half of all individuals who have participated in training on the impact of trauma have received 10 or more hours of training. The majority of respondents participated in face-to-face workshops or conferences. The Department of Family and Protective Services is the primary training agency for respondents, with “other” being the second most common. Trauma Focused CBT and TBRI were two most common specific trainings noted by respondents. The biggest reported barrier to training was a lack of awareness of available trainings.

The majority of respondents indicated that either “no” or “not sure” to a question about the adequate availability of trauma-informed services. Interestingly, foster parents were the least likely to feel services were inadequate (27%) or were unsure (27%). Up to 14% of CASA volunteers and 18% of caseworkers indicated that they do not include information about trauma or needs related to trauma within their court reports, and the majority of judges and

attorneys indicated they do not inquire about a placements capacity to provide trauma informed care. The majority of mental health providers in the survey reported that they had received training in trauma-focused practices, and many had received training in multiple practices; however they reported that they only “sometimes” (44%) or never (19%) used the model with fidelity.

Conclusions

Significant project accomplishments that occurred in the third year of the project include:

- There was continued support of implementation of TF-CBT and PCIT in multiple organizations across the state.
- Sixteen organizations were chosen through a competitive process to participate in a year-long Trauma Informed Care Learning Collaborative.
- A two-day kick off event and training was held with approximately 175 participants. Participants received training in trauma informed care and began planning for organizational changes.
- Heart of Texas MHMR developed a “one-stop” location for veteran’s and active duty service member services that houses a therapist who provides TF-CBT to families of military personnel.
- All project goals for the year were surpassed, including 137 new families receiving evidence-based trauma treatments.
- All outcome measures show significant reductions in trauma symptoms for those youth receiving follow-up assessments.
- All families report satisfaction with the services they have received.

The evaluation of Year 4 of the grant will focus on the following activities:

- Examining the differences in outcomes by treatment approach;
- Documenting the accomplishments and barriers experienced by organizations participating in the Trauma Informed Care Learning Collaborative;
- Examining factors that impact the implementation of trauma-informed care practices within organizations;
- Documenting the inclusion of persons with lived experience in planning and implementation activities; and
- Examining the reach and impact of a statewide trauma summit.