TEXAS CHILDREN RECOVERING FROM TRAUMA

Bouncing Forward!
Trauma Informed Care

Final Report

Project Period: Sept. 30, 2012 to Sept. 29, 2016

This report provides an overview of the progression and accomplishments of the Texas Children Recovering From Trauma Initiative, its goals, an evaluation of the entire project, outcomes, and lessons learned with success stories that illustrate the impact of this initiative. Details of the efforts described in this report can be found in prior quarterly reports submitted to the Substance Abuse and Mental Health Administration (SAMSHA) during the project period.

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Texas Children Recovering From Trauma

PROJECT PERIOD: SEPT. 30, 2012 TO SEPT. 29, 2016

OVERVIEW

The Texas Children Recovering From Trauma (TCRFT) initiative aims to transform children mental health services in Texas into trauma-informed care services and foster resilience and recovery. Heart of Texas Region MHMR Center (HOTRMHMR) and the Mental Health and Substance Abuse (MHSA) Division of the Department of State Health Services (DSHS) are the primary pilot sites for this initiative since its inception in October 2012. In addition, the Texas Institute for Excellence in Mental Health of the University of Texas at Austin were also primary partners in this initiative in their roles of evaluators and trauma-informed care transformation consultants and coordinators. Starting on September 1, 2016 the MSHA Division was transitioned under the Texas Health and Human Services Commission. The MHSA Division is now known as Behavioral Health Services Section. The TCRFT initiative was funded by the National Child Traumatic Stress Initiative (NCTSI) of the Substance Abuse and Mental Health Administration (SAMHSA) through a Category III Community Treatment Services Grant for the entire four year period. This grant gave the Texas Department of State Health Services the status of Partner of the National Child Traumatic Stress Network (NCTSN) of SAMHSA that promotes its mission of raising the standard of care and improve access to services for traumatized children, their families and communities throughout the United States. The direct care services target population for this initiative is children ages 3 to 17 that have been exposed or witnessed a traumatic event and children of military/veteran families in the same age group.

The TCRFT initiative implemented trauma-informed best practices in the community mental health service delivery system for children and adolescents; including trauma screenings, assessments and trauma-focused evidence-based practices (EBPs). During the 3rd and 4th year, DSHS helped expand the trauma informed care (TIC) transformation pilot with state funds to impact all behavioral health services in Texas. The TIC pilot utilized implementation science to guide the stages and process of transformation. Sixteen pilot sites participated in the trauma informed care organizational transformation learning collaborative that was coordinated by TIEMH and facilitated by the National Council for Behavioral Health. During the project period, multiple community partnerships were developed at the local and state level, and project efforts enhanced the voice and partnerships of persons with lived experience (youth, families and adult consumers) in this transformation efforts. This report will summarize the progression and achievements of the first four years of this initiative under this NCTSI Category III Grant. Furthermore, it will include an evaluation of the goals and objectives of this initiative, outcomes, lessons learned, challenges

and sustainability efforts that were put in place to continue transforming behavioral health services in Texas after this grant period.

BACKGROUND

"The goal of healing has always been the relief of human suffering" (Mollica, 2011). In his Manifesto of healing a violent world, Mollica (2011) goes to the core of the mission of all mental health services. This intent to heal is also at the core of DSHS' mission to improve the health and well-being in Texas, and the vision of the Mental Health and Substance Abuse Division of hope, resilience and recovery for everyone. Unfortunately, the achievement of this mission and vision have been in constant threat by the life threatening events surrounding the lives of children in Texas. Frequent exposure to trauma has the potential to alter the trajectory of a child's development, construct of self, interpersonal relationships, and the achievement of a full potential that contributes to society (Cohen, Mannarino & Deblinger, 2006). Trauma leaves invisible wounds that require a set of specialized principles, practices, and a competent workforce that can foster effectively the recovery and resilience of all children. Children and adolescents in Texas have a pressing need for evidence-based, trauma-focused, recovery-oriented treatment and services. The rates of children impacted by traumatic events statewide and in the nation urge for the implementation of initiatives that address their needs.

Trauma is pervasive and widespread (SAMHSA, 2014). SAMHSA defines an individual trauma as a "result from an event, series of events, or set of circumstances that is experienced by an individual as physically or emotionally harmful or life threatening and that has lasting adverse effects on the individual's functioning and mental, physical, social, emotional or spiritual well-being" (2014). The perception and impact of a traumatic event is unique to each individual and thus a violent is considered traumatic when the person identifies as such after the functioning of this person is impacted. In children, the responses of traumatic events are more diverse than in adults. NCTSN utilized the concept of "childhood traumatic stress" to explain and describe the experience of trauma in children. According to NCTSN, child traumatic stress is "when children and adolescents are exposed to traumatic events or traumatic situations, and when this exposure overwhelms their ability to cope" and as a result the reactions to the traumatic experience interfere with the child/youth's daily life and ability to function and interact with others" (2003). These definitions are core concepts of the Texas Children Recovery from Trauma initiative.

The impact of childhood trauma has been found to have profound and long-lasting effects throughout the lifespan of an individual. Although not every child or individual who experiences a traumatic event will develop symptoms of child traumatic stress or post-traumatic reactions, the need to address trauma is an important component of effective behavioral health service delivery and a comprehensive healthcare system. The Adverse Childhood Experiences (ACEs) Study, a landmark study of Kaiser Permanente and the Center for Disease Control (CDC) on the impact of

childhood adverse life events, including abuse and neglect and impact on later-life health and well-being revealed how ACEs are strongly related to the development of risk factors for disease, and the mechanisms by which ACEs influence health and well-being throughout the life span (CDC, 2016). This study's finding has consistently shown that as the number of adverse childhood experienced during childhood by an individual increases, the more likely the person will develop health risks that cause chronic disease, mental illness, substance use, violence or being a victim of violence, as well as a higher risk of experiencing an early death. This public health study that started in an obesity clinic of Keiser Permanente Department of Preventive Medicine (1998) was able to relate that individuals with higher exposure to traumatic events are more likely to experience diabetes, heart disease, depression, suicide attempts, substance use and other chronic diseases that impact the use of health and human service systems by this population. Furthermore, the lifetime cost of the impact of trauma of a person that experienced maltreatment as a child is $210,012 (CDC, 2012). The lifetime productivity loses for this individual is $144,360 (CDC, 2012). In the U.S. the annual loss of productivity a year because of untreated mental illness is $100 billion (NAMI/Scientific American, 2012). The cost of the impact of unaddressed childhood traumatic experience not only impacts and individual throughout their lifetime but it impacts healthcare systems. The ACEs study findings and the pervasiveness of trauma calls for health and human serving systems to prevent, identify and address the impact of trauma in children and adults. Understanding the incidence and prevalence of child traumatic stress is foundational in order to create a comprehensive operational framework that can address this important public health issue.

In 2007, the National Child Traumatic Stress Network [NCTSN] reported that approximately 25% of all children and adolescents will experience at least one traumatic event. Texas has 7,375,862 children and adolescents which is approximately 28% of the total state population (TSDC, 2013). If the national prevalence rate of 25% is applied to the population of Texas, it is estimated that at least 1,843,965 children in the state are impacted by trauma. The Substance Abuse and Mental Health Service Administration [SAMHSA] reported in 2011 that before the age of four, an estimated 26% of all children will witness or experience a traumatic event. Up to 93% of youth entering the juvenile justice system are estimated to have experienced some trauma (Adams & Justice Policy Institute, 2010). These statistics suggest a considerable impact on the children's mental health [CMH] system. SAMHSA (2011) recently reported 84% of children and youth served through the Children's Mental Health Initiative [CMHI] experienced at least one traumatic event before entering services, and 40 % of children and youth experienced four or more traumatic events. These statistics support the need for CMH services to be delivered to the children of Texas in a trauma-informed system of care.

Texas statistics related to children and adolescents that have been exposed to or witnessed a traumatic event are profound. In 2010, 66,897 children and teens were confirmed by Child Protective Services [CPS] to be victims of abuse or neglect (Texas DFPS, 2011). Of these cases, 67%

were aged 0-13 years and a disproportionate number of ethnic minorities were represented. The incidence of violence has been documented by The Texas Department of Public Safety (TDPS), showing a high amount of family violence and increases in hate crimes for certain racial and ethnic groups and the sexually diverse population. The incidence of family violence according to TDPS was 185,453 in 2013. A 2014 Hate Crime Report of TDPS showed an increase of 23% when compared to the prior year. The larger percentage of hate crime reports were race/ethnic/ancestry (56.1%) in nature according to TPS. The second most commonly reported bias motivation was sexual orientation (27.1%). This calls for the need to address and care for those impacted by trauma to be culturally competent and sensitive to address the needs of the groups at higher risks. When we study violence exposure as a source of trauma, suicide must be included as a violent and traumatic event. Suicide is the second leading cause of death of young people in Texas 15 to 24 years old and the second leading cause of death for children 10 to 14 years old (DSHS, 2016).

Other important children populations in Texas impacted by trauma are displaced and migrant populations. In 2011, Texas became the leading state of residence of refugees admitted to the US and 34% of the refugees were younger than 18 (Martin & Yankay, 2011, Office of Refugee Settlement Data). Since 2011, Texas has been the leading state of resettlement of refugees admitted to the U.S. Refugees, often seeking asylum due to life-threatening persecution or fleeing war-torn countries, are exposed to significant risk-factors for developing PTSD (Lhewa, Charney & Cabral, 2006). More recently in 2014, Texas has experienced the largest surge of unaccompanied minors crossing the U.S. – Mexico Border in the U.S. history with a special increase of number of children entering younger than 13 years of age. Furthermore, an increase number of youth experiencing human trafficking, particularly sexual exploitation, has been documented and investigated by law enforcement and health and human services organizations in Texas. Attending appropriately to the impact of trauma in the lives of children in Texas needs to become a priority and an integral part of their care in the public health system and the community at large. Liberman & Van Horn (2005) explained that during childhood “exposure to interpersonal violence interferes in achieving age appropriate developmental milestones and increases the risk of developing mental illness.”

The impact of exposure to war conflict in Texas is more directly evident in the Military and Veteran Family population living in Texas, including the children and youth of these families. Military Service members and veterans living in central Texas counties have been impacted directly and indirectly by the multiple deployments related to the wars in Iraq and Afghanistan since 2001 (Defense Manpower Data Center, 2014; Westat, 2010). Studies have estimated that around half of military families have experienced one or more deployments (DoD, 2010). This has caused children and youth to be exposed to parental injury, illness, loss, and other hardships. For children of military/veteran families, the rate of abuse and neglect has increased (DoD, 2010). A study from Chandra, et.al (2009) reveals that children from military families have more emotional difficulties

compared to national samples including school, family, and peer related difficulties. Studies done since operations in Afghanistan and Iraq suggest the distress that deployments place on families include: rates of marital conflict, domestic violence, mental health issues in the non-deployed parent, vicarious traumatization, parenting difficulties, and risk of children developing emotional and behavioral problems (Saltzamn, Lester and et. al., 2011).

Before the creation of the TCRFT initiative, the Texas Veteran Commission data of 2011 documented that the largest number of veterans families in the state of Texas were located in the Interstate -35 Highway corridor. Texas had the second largest population of Selected Reserve military service members in the nation and is ranked third in number of Active Duty members in the United States. The 2010 Demographics Profile of Military Communities reports that out of 122,879 Active Duty Members living in Texas, 44.1% have children. From the 55,971 Selected Reserve members in Texas, 43.2% have children. This profile reports that children of military families are predominantly 11 years of age or younger. For Active Duty members, 42.5 % of the children are ages 0 to 5, while 30.7% are 6 to 11, and 22.8% are 12 to 18. For Selected Reserve members, 27.9% of children are 0 to 5 years, 30.1% are 6 to 11, and 30.3% are 12 to 18 years. Overall the percentage of service members with children had increased, as well as the proportion of single personnel and dual military families with children. For the Army and National Guard, the 2012 Texas Military Forces data showed 23,611 spouses and children who are in the families of 21,956 service members. For military children, the probability of being exposed or impacted by trauma is high (Chandra, A., et al., 2009; Milot, Ethier, St-Laurent & Provost, 2010).

The national estimated rate (25%) of children experiencing trauma (SAMHSA, 2011; NCTSN, 2007) can be used to calculate the number of children of military service members in Texas impacted by trauma. Using the number of children documented in the profile of 2010, it was estimated that there were a minimum of 78,357 of children of military families in Active Duty or Selected Reserves in Texas, out of these at least 19,590 children of military families have experienced trauma. With this high number of military children living in Texas and the number of children with histories of trauma, the CMH service delivery system of DSHS had to be able to identify and appropriately treat these children. The selection of the primary pilot sites for direct care services of the TCRFT initiative in 2012 took in consideration the number of veteran families with children living in the serving area that had limited access to local resources that could appropriate screen, assess and address the impact of trauma and their needs.

The selection of the primary pilot sites for direct care services under the TCRFT initiative called “Community Treatment Service” (CTS) Centers under this NCTSI SAMSHA grant, considered multiple requirements. The selected pilot sites must be:

- A Local Mental Health Authority (LMHA) contracted under DSHS that provides community mental health services for children and adolescents

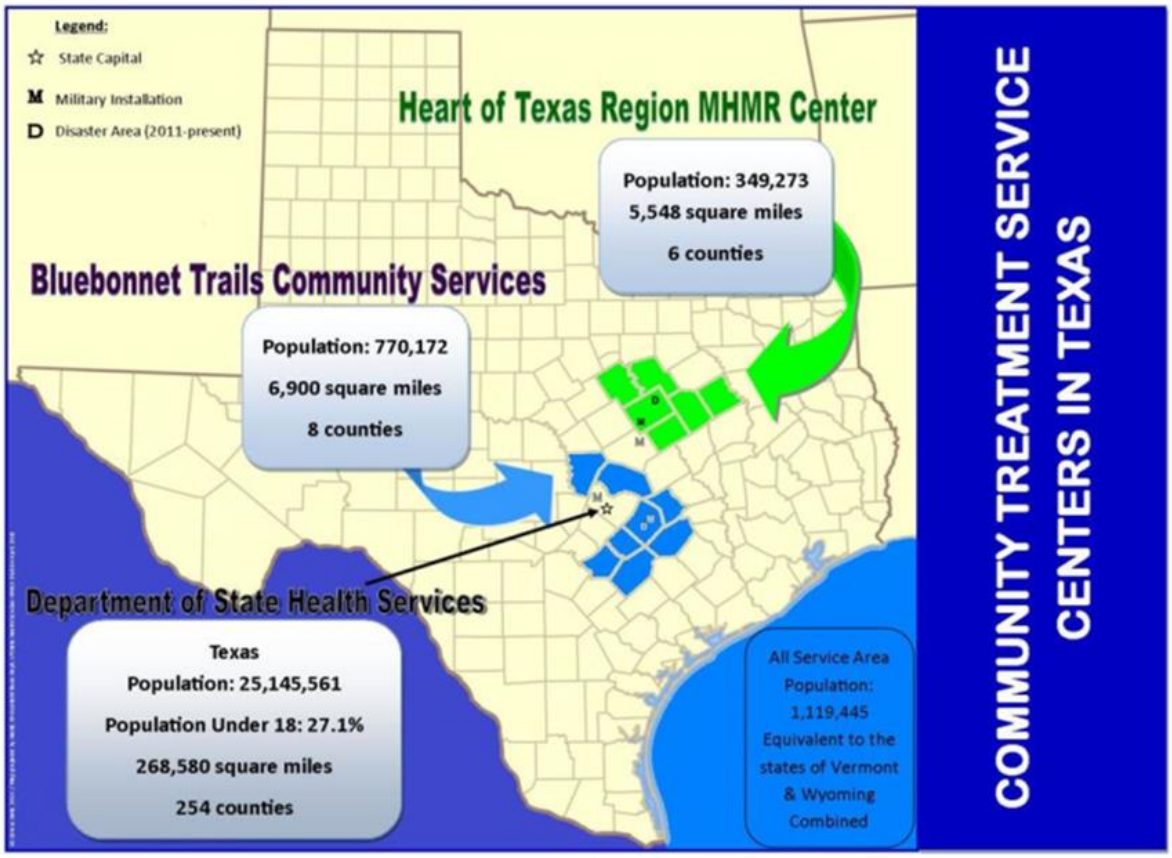
- Located in the I-35 corridor in a county surrounding a military base or military facility (active or reserve facility or any military branch), preferably a large military facility such as Fort Hood, Sam Houston or Camp Mabry/Texas Military Forces. Fort Bliss in El Paso was also considered.
- The licensed mental health providers of the selected LMHA must have the need for training on trauma screenings, trauma assessments and trauma-focused evidence-based practices.
- The service region of the LMHA must include urban and rural counties, and must have limited local resources or no resources that appropriately address the needs of children impacted by trauma with evidence-based practices and must need to address the needs of children of military and veteran families.
- Must meet the SAMHSA grant requirements to provide direct care services
- The LMHA and its leadership must demonstrate readiness, motivation and commitment to contribute to the TCRFT initiative, NCTSN and be an on-going pilot site for trauma informed care transformation and dissemination in Texas under DSHS.

Map 1 shows the selected primary pilot sites of year 1 at the beginning of the TCRFT initiative. Bluebonnet Trails Community Services experienced workforce shortages and organizational restructuring and priorities during year 1 of the initiative that impacted their ability to continue participating in the TCRFT initiative beyond year 1. As a result, Heart of Texas Region MHMR Center became the sole consistent primary pilot site throughout the entire project period.

Heart of Texas Region Mental Health and Mental Retardation Center (HOTRMHMR) - Heart of Texas Region MHMHR Center serves six counties: McLennan, Falls, Freestone, Limestone, Bosque and Hill. These counties cover 5,548 square miles. The total population of this service area in 2010 was 349, 273 with 22.2% aged 3-17 (Center for Health Statistics, 2011). Across these counties, 60-90% were White, 14-24% were Hispanic, 2-25% were African American, 0.6 % were American Indian, 1.0 % were Asian and 2.4% considered themselves other ethnic or race group. The percentage of people living in poverty in these six counties ranges from 15% - 23 % (CHS, 2011). This area includes one Army National Guard Armory and the Waco VA Medical Center. The Waco/McLennan County area has a large concentration of veterans, many of whom have settled in the area due to the Waco VA Medical Center (US Dept. of Veterans Affairs, 2011). Texas Military Forces statistics reveal that 16,425 veterans live throughout the service area of HOTRMHMR and 16,425 live in McLennan County which is located directly north of Ft. Hood. The database manager for OIF/OEF veterans at the VA Benefits Office reports that Central Texas has the second largest concentration of OIF/OEF veterans in the state. McLennan County alone has 2,300 OIF/OEF veterans, of whom 12% are women. The percentage of residents in these counties living in poverty ranges from 15-23%. Heart of Texas Region MHMR Center's direct service sites for children and adolescents is called Klara's Center for Families and was located only in Waco at the beginning of the TCRFT initiative. Direct care services are provided in by Heart of Texas's providers in the office,

home or through the use of telehealth/telemedicine depending on the family's choice or provider's availability in the local area.

Map 1. TCRFT Community Treatment Service Centers (CTS) and pilot sites that provided direct care services in Year 1.



From 2010-2013, DSHS redesigned the Children Mental Health (CMH) service delivery system to focus on a recovery oriented, person/family centered system that uses evidence-based practices [EBPs]. These system improvements foster resilience for the culturally and linguistically diverse population of Texas. The intent of DSHS through the new community mental health service delivery system for children and adolescents is to integrate the strategic initiatives of SAMHSA on trauma and justice, military families, recovery support and data, and outcomes and quality into the redesign of services. Moving away from a diagnosis and disease management model, the service delivery design, Texas Resilience and Recovery launched in September 2013, is based on the principles of systems of care, and intensity service delivery system that takes into account the needs and strengths of the child and family to promote the MHSA Division's vision of "hope,

resilience and recovery for everyone". Many of the existing policies that governed the delivery of CMH services during 2012 in Texas were developed with a diagnostic centered approach. This traditional model did not adequately address the context of the child's personal story, family, culture, or community. Consequently, the trauma histories of many children and youth seeking CMH services have not been screened, acknowledged or treated appropriately throughout the state before the beginning of the TCRFT initiative. In order to increase the competence of the CMH providers, training on EBPs is necessary but the scarce amount of trainers on such practices in Texas challenges the ability to create a competent workforce and foster effective practices.

The gaps and needs identified during the redesign of the service delivery system called for a children and adolescent behavioral health service system with trauma-informed workforce competent, skilled, knowledgeable and sensitive to the needs of individuals and families impacted by trauma. Such behavioral health system would have in place policies, practices, community partnerships, and professional development opportunities for the workforce that ensure the capacity of mental health providers and an organizational culture to foster the resilience and recovery of those impacted by trauma, in particular children and their families. In response to this gap the Texas Children Recovery From Trauma initiative was created and a proposal to SAMHSA was submitted to enhance the existing service delivery system and aim towards a trauma informed care systems transformation. SAMHSA awarded the Category III CTS Center NCTSI Grant from September 30, 2012 to September 29, 2016.

SUMMARY

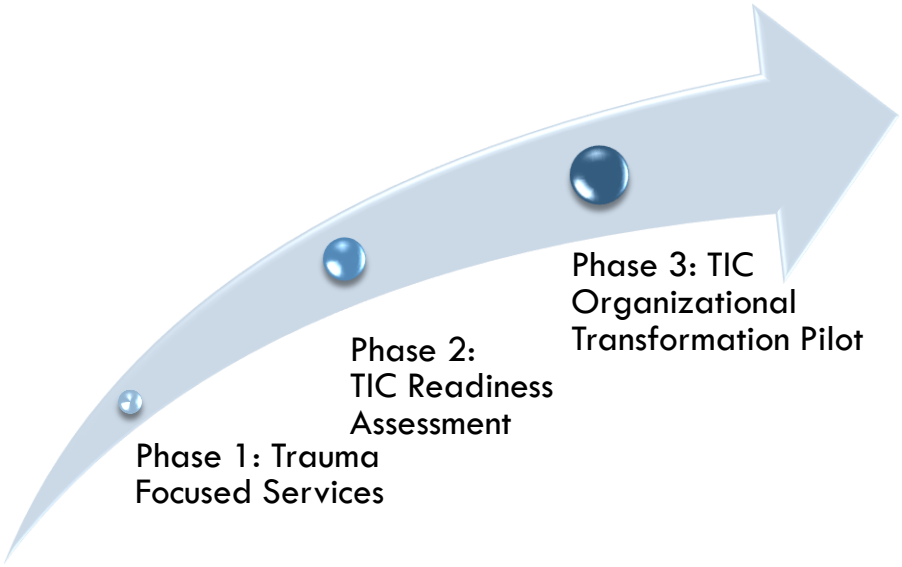
In order to achieve the aim the of the TCRCT initiative to transform community behavioral health services into a trauma informed service delivery system, , four specific goals were created to ensure that the aim of this project could be achieved, measured and evaluated within the project period. This initiative also piloted organizational system transformation establishing sustainable infrastructure elements that would support continuing trauma informed care after the grant period ended. The status of the progress of the goals of this initiative have been reported in quarterly and annual reports submitted to SAMHSA during the course of the grant project period. The aim of this project was set to be achieved through the following goals:

1. Transform the existing children's mental health services in Texas into trauma-informed care services by training the workforce, enhancing policies and practices, and increasing the number of mental health professionals trained in the following trauma-focused treatments: Trauma-Focused Cognitive Behavior Therapy (TF-CBT) and Parent Child Interaction Therapy (PCIT).
2. Increase access to trauma-informed services for the target populations and create partnerships that promote access to trauma-informed treatments.

3. Evaluate the outcomes of the trauma-informed treatments received by children and adolescents using four standardized instruments: Child and Adolescents Needs and Strengths (CANS), University of California in Los Angeles Post Traumatic Stress Disorder Reaction Index (UCLA-PTSD RI), Trauma Symptoms Checklist for Young Children (TSCYC), and the National Outcomes Measure Scale (NOMS) Client-Level Measures for Discretionary Programs Providing Direct Care Services: Service Tool for Child/Adolescent or Caregiver Combined Respondent Version.
4. Integrate trauma screening practices into community mental health organizations and increase the number of children screened for trauma in Texas.

The scope of work of the initiative was structured in three phases of implementation as seen in Figure1.

FIGURE 1. Texas Children Recovery From Trauma Phases of Implementation of Trauma Informed Care (TIC) Transformation



These three phases were completed by the end of the grant. Phase 1, "Trauma Focused Services", consisted of the transformation of children mental health direct care services into trauma-focused services of the primary pilot sites and CTS centers of the TCRFT initiative. An oversight infrastructure of steering/advisory committees were created at the state level and local level during this initial phase. The initial training and implementation of trauma screenings, trauma assessments and trauma-focused evidenced-based practices were held during years 1 and 2 of the project period. During phase 1, the direct care services at the CTS centers were re-structured and a new direct care flow-chart was created to determine eligibility to TCRFT services at Heart of Texas Region MHMR Center and Bluebonnet Trails Community Services. Texas Child and Adolescent Needs and Strengths Assessment was rolled out in January 2013 and incorporated as a pilot in the state's Uniform Assessment for community mental health services.

Evidenced-based trauma focused treatments [Trauma-Focused Cognitive Behavior Therapy (TF-CBT) and Parent Child Interaction Therapy (PCIT)] were rolled out during phase one.

Phase 2, "TIC Readiness Assessment", consisted of trauma-informed readiness assessments on the workforce that were completed in years 2 and 3. Three readiness assessment instruments were utilized to inform this readiness assessment:

- Trauma Informed Care Knowledge Workforce Survey (TIC-KWS) – Developed by the Texas Institute for Excellence in Mental Health of the University of Texas at Austin
- Organizational Self-Assessment (OSA) - Developed by the National Council for Behavioral Health
- Secondary Traumatic Stress Index Organizational Assessment (STSI-OA) – Developed by University of Kentucky Center on Trauma and Children (Sprang, G, Ross, L. & et. al, 2014)

Phase 3, TIC Organizational Transformation, was held during years 3 and 4 of the project period. It consisted of a year and half long learning collaborative and pilot on trauma-informed care organizational transformation for behavioral health services and the creation of elements to sustain trauma informed care. During the fourth year of this grant, the TIC transformation efforts impacted the development of the new Statewide Behavioral Health Strategic Plan. The state's leadership of Behavioral Health Services added trauma informed care as the fourth guiding principle of this strategic plan that targets fiscal years 2017 to 2021. The state's behavioral health strategic plan can be found on the following URL: https://hhs.texas.gov/sites/hhs/files/050216-statewide-behavioral-health-strategic-plan.pdf . An action plan and implementation plan were developed in the last year to support trauma informed care transformation by the Mental Health and Substance Abuse (MHSA) Trauma Informed Care (TIC) Transformation Team [MHSA TIC Team] in collaboration with TIEMH. The Mental Health and Substance Abuse (MHSA) Division created the MHSA "TIC Transformation Team" as the core transformation team that leads TIC transformation and sustainability efforts in behavioral health services in Texas. This TIC Team consisted of leadership, program services administrative staff of all behavioral health services sections and persons with lived experience (youth, family and adult consumer representatives). During the last quarter of the project period the 1st Statewide Trauma Informed Care Summit was held, and the Trauma Informed Network of Texas met for the first time. Further details of the progression and implementation of each of these phases can be found in the Phases of Implementation section of this report and in prior quarterly and annual reports of the TCRFT initiative.

IMPACT AND SUCCESS STORY

State's Impact

TCRFT seeks to improve the life of children/youth and their families through the implementation and provision of trauma-focused treatments and evidence based practices that address childhood traumatic stress. The goal of giving access to appropriate services to our target

population and meeting the target proposed by DSHS for this grant was achieved. The outcomes evaluation of these treatments and details of the number and profile of children served can be found in the evaluation section of this report. The scope of work of the TCRFT initiative was completed and impacted all Local Mental Health Authorities (LMHAs) in Texas through the implementation of the trauma screenings, trauma assessments and the following two-evidence-based practices in the TRR service delivery system in Texas: TF-CBT and PCIT. The following bullet points summarize the success stories and impact at the state level of the TCRFT initiative:

- Increase Access to Trauma-Informed Evidence-based Services – TCRFT provided access and served 1,199 of children and family members during the last four years. The initiative surpassed the target percent of children of military and veteran families served of 10%. 19% of all children and youth served were children of military and veteran families.
- Universal Trauma Screenings – on average more than 20,000 children and youth are screened for trauma throughout the entire TRR service delivery system in Texas every year. The Texas Child and Adolescent Needs and Strengths (CANS) Comprehensive 6-17 and the Texas CANS 3-5 assessments are utilized as the universal assessment of all children and youth entering services. These versions of the CANS include a Trauma Adjustment item indicator that is asked to all children entering services to identify possible trauma exposure or history. This Trauma Adjustment item triggers the completion of a Trauma Screening Module that includes trauma screening for different types of traumatic events and trauma related symptoms. This screening is required by policy and contract to all providers.
- Trauma Assessments – The UCLA Post-Traumatic Reaction Index (for children ages 8 and above) and the Trauma Symptoms Checklist (for children ages 3 to 7) are now utilized by licensed mental health clinicians that provide trauma-focused evidence-based practices such as TF-CBT and PCIT to monitor the symptoms of children exposed to traumatic events that receive trauma-focused EBPs.
- Trauma-Focused Evidence-Based Practices (EBPs) – TF-CBT and PCIT are now included in the service array of counseling modalities under the Texas Resilience and Recovery (TRR) for CMH services. They are detailed in the TRR Utilization Management Guidelines for Child and Adolescents Mental Health Services in Texas. TF-CBT has been implemented as a required EBPs for children and youth impacted by trauma in all LMHAs in Texas. The DSHS Centralized Training Infrastructure coordinates and funds with state funds training on these practices for all mental health providers under DSHS after the project period.
- Increase the Number of Providers Trainers in Trauma-Focused EBPs –
    - 234 behavioral health providers completed training in trauma screening and assessments
    - 343 behavioral health providers completed TF-CBT training
    - On average 35 providers participated in PCIT training each year starting on year 2
    - PCIT Trainers: Five PCIT Level I Organizational Trainers were developed. One PCI Level II Regional Trainer was developed and completed the training. These trainers will help support the sustainability of PCIT training in Texas. At the end of the project period a PCIT Training of Trainers and Training Certification was scheduled for FY 17 to continue enhancing the capacity of mental health providers in Texas

to provide PCIT. At least eight (21 %) of the 38 LMHA had a PCIT therapist candidate in-house at the end of the project period completing competency requirements.

- Training Requirements – All licensed mental health providers of Trauma-Focused EBPs are required to complete TF-CBT and PCIT training according to national standards requiring not only training lecture but clinical consultation and case presentation. All providers of TRR services are required by policy and contract to meet a higher standard of training and competency. By the end of the project period, the TIC Transformation Team had created a subcommittee that was focusing on developing training policies on trauma informed care for all providers of behavioral health services in Texas.
- TIC Organizational Transformation – By the end of the project period sixteen pilot sites had completed a trauma informed care learning collaborative through TIEMH and the National Council for Behavioral Health Services. State funds expanded the number of pilot sites for the organizational transformation from two pilot sites to sixteen pilot sites. This pilot impacted all community behavioral health services in Texas by including: children mental health, adult mental health, substance use treatment and substance abuse prevention providers. In addition, the state central administrative offices of all behavioral health services under DSHS participated as one pilot site. Furthermore, one of the three Tribal Nations in Texas participated in this pilot implemented trauma informed care in their behavioral health, and their health and human services department. This pilot made impact statewide in 85 counties in the state. A TIC framework was created under the guidance of NCBH and TIEMH to guide TIC transformation in the future. The evaluation section of this report details the outcomes of this pilot.
- Partnering with Persons with Lived Experiences (PWLE) – TCRFT incorporated the voice of youth, family and adult consumer representatives in its efforts from year 1. The TCRFT Steering Committees at the state and local level incorporated family representatives and youth voice throughout the four years of the grant. Partnerships were created with Texas Systems of Care, Via Hope, Texas Families Network, PRO International and TIEMH to help provide training, technical assistance and enhance the capacity of TCRFT pilot sites to engage and partner PWLE, and incorporate the voice of persons with lived experience (youth, family and adult consumer representatives) into leadership roles and transformation teams and workgroups that share the power to make decisions regarding trauma-informed care transformation. Multiple trainings and webinars were developed and provided through the project period to expand this key TIC domain that is core to trauma-informed care systems transformation. Special trainings were provided on this TIC Domain to all TIC pilot sites participating in the TIC organizational Transformation Learning Collaborative. All sixteen pilot sites were required to have PWLE as core members of their local TIC Transformation Teams. At least 17 PWLE participated in the TIC Organizational Transformation Learning Collaborative. DSHS incorporated into their MHSA TIC Transformation Team one youth representative, two family representatives (one representing families and the other representing family partner/peer providers) and one adult representative as equal members of the core team that leads the state transformation. Candace Aylor, a family representative of TCRFT, helped lead the development and creation of a “Partnering with PWLE Continuum Model” that could

guide how to develop the voice and partnerships of PWLE. This would help create a plan of action and implement the TIC Domain of Consumer Driven-Care Services. This continuum stemmed from a model of Georgetown University, but expanded on its application and implementation. This training handout can be found in the appendix section of this report. In addition, TCRFT staff and partners collaborated in the development of the Sharing Power in Trauma Informed Care Transformation handout series of the NCTSN Partnering with Youth and Families Collaborative group.

- TIC Action Plan/ Strategic Plan – The Texas Statewide Behavioral Health Strategic Plan defined Trauma Informed Care as the fourth guiding principle of behavioral health services and this strategic plan from 2017 to 2021. The strategic plan is a key sustainability element of trauma informed care beyond the project period that helps supports the efforts that started under the TCRFT initiative. The MHSA TIC Transformation Team created an action plan to continue the TIC organizational transformation and support the strategic plan after the project period ends.
- Community Partnerships:
    - *TCRFT Steering Committee* - The TCRFT Steering Committee that started as a community partnership with the core partners of the TCRFT initiative, community stakeholders, state agencies and consumer representative has been transitioned and incorporated into a state advisory committee. The 84th Texas Legislative Session through Senate Bill 200 consolidated the TCRFT Steering Committee and the Texas Systems of Care Council a new Children and Youth Behavioral Health Advisory Subcommittee under the Texas Behavioral Health Advisory Committee of the Health and Human Services Commission. This advisory committee continues overseeing trauma informed care efforts in Texas beyond the TCRFT initiative and supports the Trauma Informed Network of Texas created by the TCRFT initiative. This serves as an element of sustainability of trauma informed care.
    - *Trauma Informed Network of Texas* -The TCRFT initiative launched the Trauma Informed Network of Texas during the 1st State Trauma Informed Care Summit in August 2016. This group promotes the dissemination, implementation and sustainability of trauma informed community partnership efforts in Texas that prevents, address and treats the need. Throughout the four years multiple partnerships were created and reported during the quarterly reports and annual reports in the last year. The evaluation section of the report summarizes these community partnerships as part of the outcomes.
    - *Texas CANS 2.0 / Trauma Screenings Across Child-Serving Systems* - The 84th Texas Legislature required the Department of Family Protective Services (DFPS) - Child Protective Services (CPS) to add a new comprehensive psychosocial assessment and trauma screening for all children entering foster care services. As a state inter-agency collaboration between DSHS and DFPS, TCRFT led the development of this new CANS version. TCRFT identified as a lesson learned by the end of the 2nd year that the trauma screening practice of the Texas CANS 6-17 version had to be improved since only a single question about trauma exposure the screening for trauma exposure. This new Texas CANS version improves the trauma screening

and suicide prevention screening, as well as creating a CANS version that could utilized across child-serving systems. This version incorporate the best practice trauma screening of the NCTSN CANS Trauma version, in which a trauma comprehensive trauma screening history is asked to all children instead of a single question that triggers the screening. In addition, the new Texas CANS incorporates the Columbia Suicide Screening Rating Scale (CSSR-S), an EBP for suicide risk assessment to effectively screen for suicide risk and help guide safety planning and treatment for suicidal ideations. This new Texas CANS version, known as Texas CANS 2.0 was implemented in September 1, 2016 by Child Protective Services for children entering in foster care for the first time and is in place statewide in the child welfare system in Texas for that population by the end of the grant period.

- *Children of Military Forum* – TCRFT's Leadership participated in SAMHSA"s Veteran Military Families Implementation Academy and contributed to the creation of a strategic plan to address the needs of children of military and veteran families in Texas. TCRFT collaborates in an inter-agency Veterans Collaborative Group of the Health and Human Services Commission of Texas. In 2014 TCRFT brought SAMHSA's leadership of the Implementation Policy Academy to facilitate the first Children's Military Forum to help identify gaps and needs of children of military and veteran families in Texas. Four recommendations were made to the Texas Legislature through the Texas Veteran Commission as a result of this Forum that was held on May 2014 in San Antonio, Texas. The Texas 84th Legislative Session incorporated the recommendations of this forum and legislative report and passed Senate Bill 19 to develop prevention programs targeting veterans/military families and their children preventing abuse and neglect.
- *Survey of Trauma Informed Care in Child Welfare* - During the 3rd year of the grant, TCRFT staff (TIEMH/UT-Austin) 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.
- *Other important community partnerships*:
  - *Central Texas Coalition on Trauma Informed Care* – TCRFT participated in the development of this coalition and partnered in their development and planning of their first Central Texas Trauma Informed Care Conference. Dr Ginny Sprang, an NCTSN Partner of the University of Kentucky was brought as a closing keynote speaker for the conference.
  - *Manor Independent School District* – Trauma Informed Care Transformation – TCRFT provided consultation and training on trauma informed care systems transformation to this school district in central

Texas, and provided training to all their counselors, and social workers on trauma informed care.

- *Williamson County Juvenile Justice Services* – TCRFT opened training opportunities on trauma-focused EBPs to the licensed mental health providers of this county during the first year and facilitated access to the THINK Trauma Toolkit that was later implemented by this organization. TCRFT staff facilitated the development of a youth brochure. The Youth of their Leadership Academy living in detention facilities re-designed the TCRFT Brochure and created the "Never-ending Brochure" designed by youth and targeted for youth as an interactive informational brochure that could also be used as a psychoeducation activity in TF-CBT sessions.
- *Addressing the Needs of Unaccompanied Minors* – Since the Summer of 2014, TCRFT collaborated in multiple efforts to help address the needs of unaccompanied minors entering the U.S. In particular, the TCRFT Project Director provided training to the following organizations: Young Center for Immigrant Children's Rights, SAMHSA Podcast 2014, Children's

- National Partnership – The active participation in collaborative efforts of NCTSN through multiple national collaborative groups, such as Partnering with Youth and Families, Secondary Traumatic Stress, Policy, Military Families, Complex Trauma and Culture, allowed TCRFT to have an impact at the national level in the creation and dissemination of best practices that address childhood traumatic stress. TCRFT's partnerships with multiple NCTSN partners led to the successful implementation of TF-CBT and PCIT as well as contribute data to NCTSN to enhance the understanding of children impacted by trauma and evidence-based practices. TCRFT contributed to the development of NCTSN products such as the Sharing Power handouts or the dissemination of the NCTSN Core Curriculum of Childhood Trauma (CCCT) in Texas by developing two CCCT Facilitators that provided training in Texas to mental health providers. The following NCTSN Partners contributed to the success of the TCRFT initiative:
  - SCAN Inc. (NCTSN Affiliated Member): Dr. Susana Rivera, a TF-CBT Master Trainer and Culturally Modified TF-CBT Trainer and Clinical Consultant.
  - Allegheny General Hospital-Singer Research institute, Center for Traumatic Stress in Children and Adolescents (NCTSN Category II Partner): Dr Judith Cohen, national developer of TF-CBT, TF-CBT Master Trainer and Principal Investigator.
  - University of Oklahoma (NCTSN Category II Partner): Dr Beverly Funderberk, master trainer of PCIT and Principal Investigator
  - Children's Institute Inc. (NCTSN Category III Partner): Dr Leslie Ross, NCTSN Steering Committee Member, Co-Chair of NCTSN STS Collaborative Group, STS expert, co-author of the STSI-OA tool
  - University of Kentucky, Child and Adolescent Trauma Treatment Institute (NCTSN Category III Partner): Dr Ginny Sprang, Co-Chair of NCTSN STS Collaborative Group, STS expert, co-author of the STSI-OA tool
  - Aliviane Inc. (Category III Partner): Program Directors (Dante Jimenez and Carolina Gonzalez), Members of TCRFT Steering Committee

- NCCTS (Category I Partner): CCCT Master Trainers and CCCT Task Force, Dr. Melissa Brymer (Disaster & Terrorism Director), Dr Greg Leskin (Military Families Collaborative Group, Chris Foreman (Partnering with Youth and Families), Chris Siegfried (NCTSN Program Liaison), Trauma Informed Care Summit, The Road To Recovery Toolkit for Trauma and IDD Training of Trainers.

Figure 2 shows a visual representation of the impact of this initiative that stems at the level of the individual (child/youth) and family, and expands through the implementation of trauma-focused EBPs to the therapy level, and ripples to the organizational level through trauma informed care organizational transformation efforts at the local (community level) and upwards to the state level. The multiple partnerships of TCRFT and active participation in NCTSN expand the impact to the national level.

FIGURE 2. Impact of the Texas Children Recovering From Trauma Initiative

Community Success Story

The success of the TCRFT initiative was consistently evident in the community of the service area of Heart of Texas Region MHMR Center (HOTRMHMR). The leadership of HOTRMHMR was instrumental and key in creating outstanding successful community partnerships and internal organizational transformation to support the implementation of trauma informed care at the

organizational and community level. This community was impacted by TCRFT in multiple ways. The trauma informed care transformation at HOTRMHMR has become a successful example for the state of Texas. The Local Advisory Committee of TCRFT at HOTRMHMR created very successful trauma-informed community partnerships that led to sustainable efforts that address trauma.

Community Partnership to Address Disaster Response and Critical Incidents in Schools -
In the area of disasters response and critical incident management that impact children and youth, this Local Advisory Committee created a community partnership effort focused on preparedness and emergency response to support schools after critical incidents. This included local school districts, the local community mental health center (HOTRMHMR), Child Protective Services, child advocates such as NAMI, local county and city representatives, law enforcement and juvenile justice services. After the fertilizer plant explosion in West, Texas that made national news in the spring of 2014, the community under the leadership of HOTRMHMR was prepared to immediately address this emergency response community effort that helped the West Independent School District respond to the aftermath of this explosion in a smooth and effective manner. Immediate crisis services were provided to the schools that were physically impacted and a short and long-term response plan was created that included the provision of Psychological First Aid, Skills for Psychological Recovery and individual or group counseling for the students that needed it. TCRFT staff of DSHS provided technical assistance and support in coordination with the National Center for Child Traumatic Stress to develop the short and long-term plan to the leadership at HOTRMHMR and the local school districts that had to move and transport hundreds of children every day as a result of the physical destruction of multiple schools in the area and many children losing their homes. HOTRMHMR staff coordinated and led these efforts for more than a year.

Community Partnership to Address the Needs of Veteran Families –
With the leadership of HOTRMHMR the community of McLennan County in Waco, Texas created a local Veteran One Source center that provides integral care services (medical, behavioral health and human services to veterans and military families and their children). This effort incorporated local government and non-profit agencies partnership, as well as the local Veterans Administration, veteran organizations, veteran families and other community stakeholders to address the gaps of services of veterans in their local area, including addressing the needs of the children of military and veteran families. A therapist of HOTRMHMR was assigned to serve children at this location, at their home or at the children's mental health clinic, Klara's Center for Families depending of the choice of the family. The local TCRFT Advisory Committee at HOTRMHMR was instrumental in making sure that this community collaboration and partnership was created and that children and youth had access to the behavioral health services as needed.

Trauma Informed Care Organizational Transformation - HOTRMHMR also participated in the TCRFT TIC Organizational Transformation Pilot during phase 3 of this project. This year and a half

learning collaborative, focused on creating TIC organizational transformation. HOTRMHMR created a "Culture Transformation Team", this team with the buy-in from the HOTRMHMR executive leadership led the organizational transformation efforts at HOTRMHMR across all their service divisions including: children mental health, adult mental health, crisis services, early childhood intervention services and services for individuals with intellectual and developmental disabilities (IDD). HOTRMHMR prioritized three TIC Domains of Implementation to establish three goals during the learning collaborative. These were: (1) Trauma Informed Responsive and Knowledgeable Workforce, (2) Creating a Safe and Secure Environments, and (3) Community Partnerships. The outcomes of these goals for year 4 during the TIC Organizational Learning Collaborative for HOTRMHMR are as follow:

(1) *Trauma Informed Responsive and Knowledgeable Workforce* – During the last year of the project period, all staff from administrative/office staff, maintenance, human resources, and direct care staff all the way to the executive director received TIC Transformation "training". 392 employees of the 450 employees across all service divisions of HOTRMHR completed the four hour TIC training developed by their Culture Transformation Team by the end of the project period. This TIC Transformation training consisted of a four hour- TIC training on the concepts of trauma-informed care (trauma, trauma-informed care, how to engage with consumers and co-workers in a trauma-informed manner, secondary traumatic stress & self-care, and ASK suicide prevention). TIC training was added to the New Employee Orientation for all upcoming new employees at HOTRMHMR.

(2) *Creating a Safe and Secure Environment*- The children mental health clinic, Klara's Center for Families, completed a safe environment scan and redesigned their spaces and hallways in a cost-effective manner. They created a comfort room that could be shared by staff and youth and families in services to create a private safe and supportive space were individuals, families and staff can rest.

(3) *Partnering with Youth and Families / Consumer Driven-Care and Services* – HOTRMHMR efforts also focused on partnering with youth and families in order to create consumer-driven care and services. HOTRMHMR did a focus group with family members of youth in services to identify needs to partner with family members and parents. Family Representatives and Adult Representative participate as core members of the TIC transformation team at HOTRMHRM that make decisions in the planning of the TIC transformation. Physical space was given in the offices of HOTRMHMR to family representatives that participate in the Local Advisory Committee and the TIC Transformation Team to perform any duties as needed. They travel expenses were also supported by HOTRMHMR.

(4) *Community Partnership, and TIC Sustainability*- HOTRMHMR focused its efforts on community partnership from the first year of the initiative. The TIC Culture Transformation Team created a sustainability plan for TIC after the project period.

This sustainability plan included enhancing community partnerships with local school districts and applying for external funds to address the needs of transitioning age youth impacted by trauma in school districts and involved in juvenile justice services. On September 2016, HOTRMHMR was awarded as a result of these sustainability efforts a SAMSHA Systems of Care grant that will focus on addressing the service gaps of transitioning age youth impacted by trauma. Trauma-informed therapists will be placed in school districts to provide trauma-informed services inside the high schools in HOTRMHMR service area.

TCRFT PHASES OF IMPLEMENTATION

Phase 1: Trauma Focused Services

Trauma Focused Services are defined under TCRFT as a system, practice or program designed to treat and address the actual impact or sequelae of traumatic events. It primarily focuses on impacting direct care staff only and protocols and procedures related to direct care services. During phase 1, evidence-based screening, assessment and treatment practices were implemented within the service delivery system to provide care that is consistent with the values of trauma informed care. Direct care services were provided to the target population throughout the length of this initiative at HOTRMHMR as the National Child Traumatic Stress Network (NCTSN) Community Treatment Service (CTS) Center for the TCRFT initiative. The target population of direct care services were children ages 3 to 17 who have been exposed or have witnessed traumatic events, and the children of military/veteran families.

In Year 1, TCRFT had two primary pilot sites or CTS centers that provided direct care services; HOTRMHMR and Bluebonnet Trails Community Center as described in the original proposal submitted and approved to SAMHSA. Trauma screenings were implemented by the fourth month as required by SAMHSA. TCRFT used the Trauma Screening Module of the Child and Adolescent Needs and Strengths (CANS) assessment to screen all children and youth. The Texas CANS Comprehensive 6-17 was implemented as the uniform assessment for all children and youth entering services.

A new eligibility procedure was created to ensure that all children are screened and assessed with the CANS as indicated in Figure 3. Clients consented for services at Intake. Once children were screened and assessed with the CANS, eligible children and youth consented to participate in TCRFT initiative and completed additional trauma assessments including the National Outcomes Measures Scale (NOMS), the UCLA PTSD Reaction Index or the Trauma Symptoms Checklist for Young Children (TSCYC) depending on the child's age. Children 8 years of age and above had the UCLA PTSD Reaction Index, children ages 3 to 7 had the TSCYC trauma assessment completed by their trained therapist. Children and youth were also screened with the CANS for

military transitions impacting their lives. Those who screened positive with a score of 1 or above in the CANS military transitions item were also eligible for TCRFT services. Trauma focused evidence-based therapies (TF-CBT and PCIT) were incorporated into the service array of community mental health services and available to all children screening having trauma history and indicators of impact of trauma. Children and families consented to share their data and complete the NOMS with the TCRFT initiative. If the child or Legal Authorized Representative didn't want to participate in the TCRFT initiative but wanted to receive the services, trauma-focused treatments were provided to those who needed them, but those clients and their data were not incorporated in the TCRFT initiative data and didn't count as client's served. Figure 3 features the direct care services eligibility and consent for services flow chart.

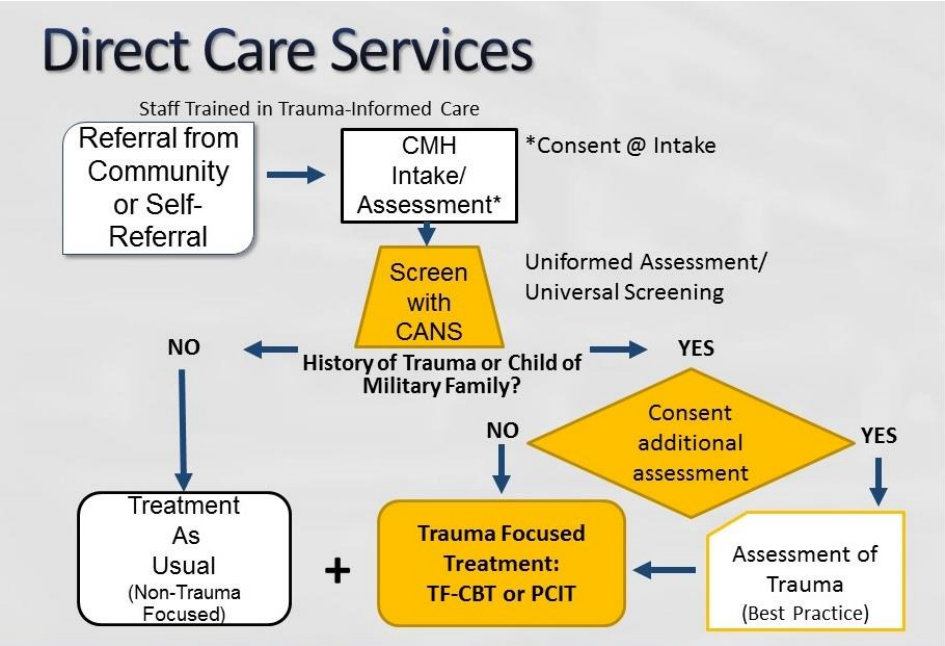


Figure 3. TCRFT Direct Care Services Flow Chart at Heart of Texas Region MHMR Center

During the 1st year, providers received training and clinical consultation supervision to ensure their competence and meet national training requirements standards for TF-CBT. Training requirements for TF-CBT were added in policy for children mental health services in Texas. The provider's contract include the same training requirements. These training requirements support the sustainability of trauma-focused treatments evidence-based practices of TCRFT after the grant is over.

During the 2nd year of the TCRFT initiative, a three year Parent Child Interaction Therapy (PCIT) Training of Trainer Cohort was created to develop PCIT Certified therapists and PCIT Level I Organizational Trainers and PCIT Level II Regional Trainers in Texas. A cohort of PCIT Trainers in Texas will help sustain PCIT training after the grant period. Sixteen PCIT Trainer Candidates were selected amongst a pool of applicants that completed an application with letters of support from

their executive leaders/managers to participate in this training and support their role as trainers of PCIT in Texas. Twelve of these PCIT Trainer Candidates started the PCIT Therapist Certification Level and four therapists started the PCIT Level I Trainer training. By the end of the project period five providers had become PCIT Level I Trainers and one had become PCIT Level II Regional Trainer in Texas. Ten PCIT Trainer Candidates dropped from the intense training of trainer's cohort. During year 4 of the project the 3rd phase of the PCIT Trainer Cohort was planned. Four new Level I Trainer candidates were scheduled to start training at the end of the project, while four new community mental health centers were registered to have their child therapists complete the one year PCIT Therapist's Certification.

Although the initial implementation of the trauma-focused EBPs occurred during the first two years of the grant period, trainings continued throughout the entire project and the outcomes of these were reported in quarterly reports. A summary of training evaluation on trauma-focused EBPs and treatment outcomes for trauma-focused EBPs are included in the evaluation section of this report. At the end of year two, trauma screenings were in placed in all local mental health authorities in Texas and had been incorporated in the policies and procedures of TRR community mental health services in Texas.

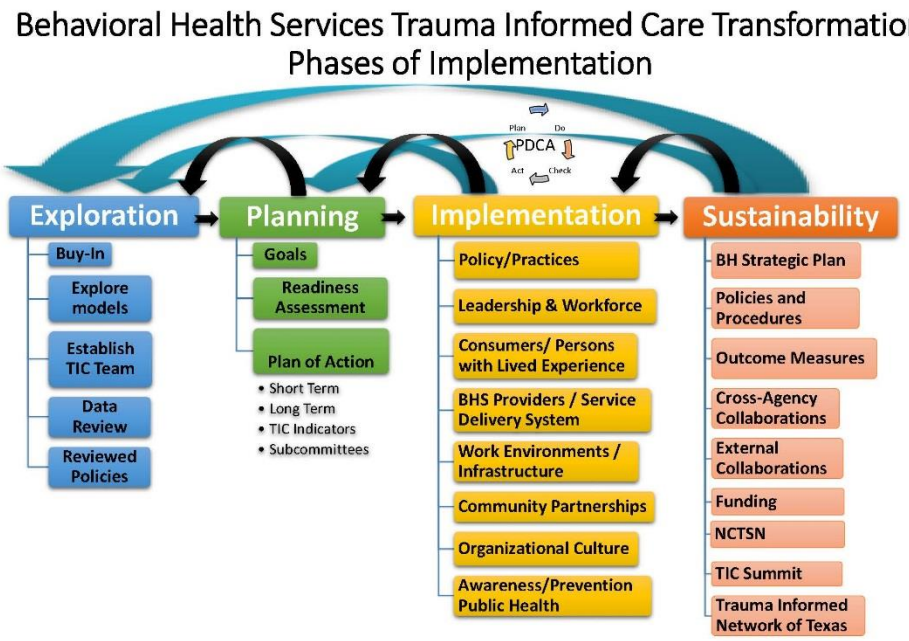
Between years 3 and 4, DSHS through the TCRFT initiative developed a new updated version of the CANS that could be used by community mental health services providers and children entering foster care services of the child welfare system.

Phase 2: Trauma Informed Care Readiness Assessment

To guide and inform the planning of the trauma informed care organizational transformation pilot a readiness assessment phase was started at the end of year 2. A Trauma Informed Care Workforce Survey was developed by TCRFT staff partners of TIEMH/Univ. of Texas at Austin and approved by DSHS. The survey was completed by members of the workforce. This specific survey focused on informing the level of knowledge and priorities of the workforce in regards to trauma informed care. This Trauma Informed Care Workforce Survey was conducted across all local mental health authorities and state office sites in Texas during the month of September 2014. This is part of the readiness assessment of the Trauma Informed Care Transformation. The survey was accessed by 1,529 respondents, with 4% of respondents representing Central Office of the Department of State Health Services, 78% representing staff at local mental health authorities (LMHA), and 15% indicating they were employed at other organizations. Other organizations were affiliated with the LMHAs, but could include early childhood programs, programs for individuals with intellectual or developmental disabilities, substance abuse programs, and affiliated hospital programs. The findings of this survey can be found on the evaluation section of this report.

During this phase implementation science was utilized to develop an implementation model that could guide the creation of an implementation plan TIC Organizational transformation efforts of the TIC pilot sites. The implementation model for organizational/systems transformation had four stages: (1) Exploration, (2) Planning, (3) Implementation and (4) Sustainability. This model was included in the TIC Organizational Transformation Training provided by the National Council for Behavioral Health during the TIC Learning Collaborative in year 3. The final implementation plan scheme of the Behavioral Health Services Transformation Organizational Transformation can be seen in the figure below.

Figure 4. BHS TIC Transformation Phases of Implementation



During this phase TCRFT Steering Committee explored TIC models and reviewed existing TIC readiness assessments and TIC toolkits that could be used to create a TIC framework for Texas. The TCRFT initiative incorporated the SAMSHA TIC framework (principles) and its definitions of trauma and trauma informed care from SAMHSA's TIP 57 and the SAMHSA's TIC Conceptual Framework to be used to guide the TIC transformation. In order to create common language across pilot sites certain core concepts were defined and included in the TIC Organizational Training. The trauma concepts definitions are describe in the background section at the beginning of this report. Trauma Informed Care is defined according to SAMHSA's definition; "a system or program that is knowledgeable and sensitive to the impact of trauma in the individual/families' lives and/or the vulnerabilities of survivors of traumatic events". Trauma Informed Care focuses on all the workforce. The services of a trauma informed organization are delivered in a way that prioritizes safe and avoid re-traumatization of all (clients and staff). It

acknowledges and recognizes that any individual in the workforce may have his or her own trauma history, and the nature of their work in a behavioral health organization exposes the workforce to traumatic events that could impact their personal and professional functioning, performance and well-being. As a result a trauma informed organization thrives to prevent and address the vicarious impact of trauma exposure in the workforce.

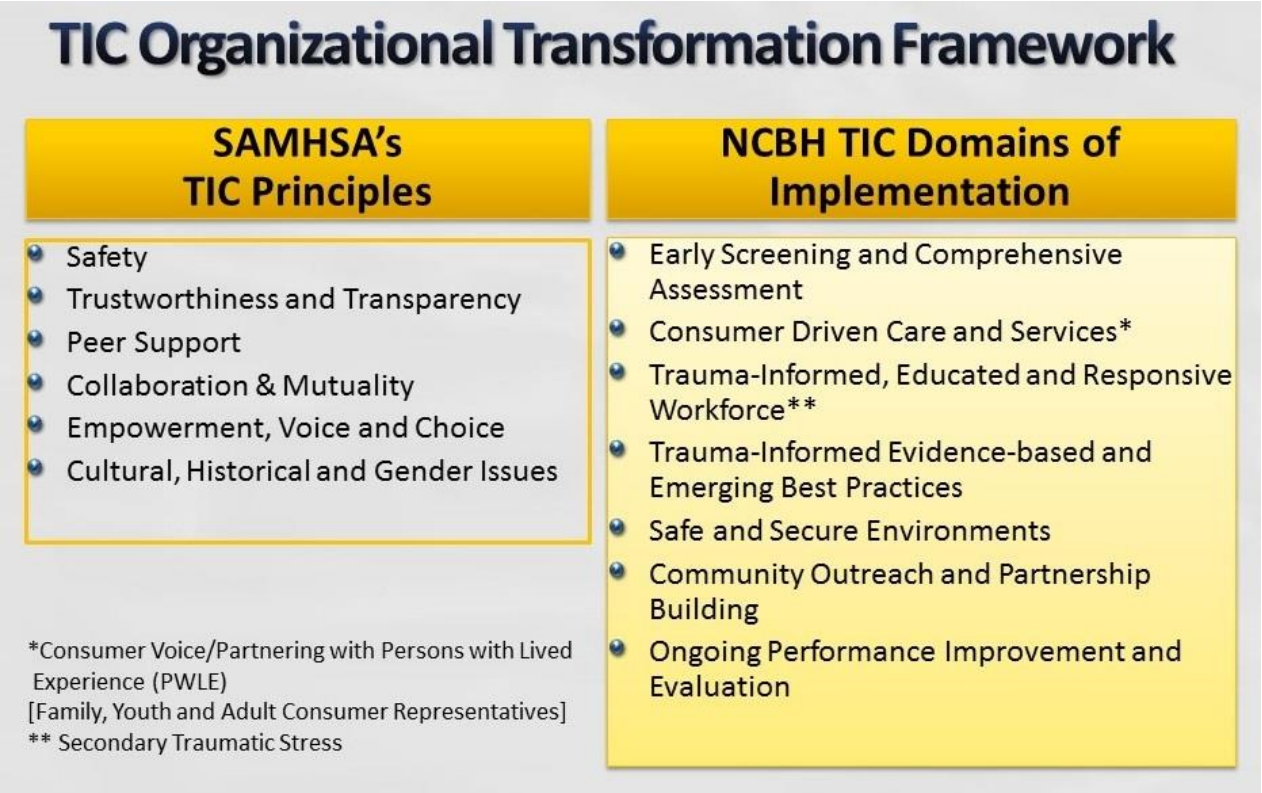
During this phase TCRFT Steering Committee explored TIC models and reviewed existing TIC readiness assessments and TIC toolkits that could be used to create a TIC framework for Texas. The TCRFT initiative incorporated the TIC Domains of Implementation of the National Council for Behavioral Health (NCBH) with the SAMSHA's TIC framework (principles) and its definitions of trauma and trauma informed care from SAMHSA's TIP 57 and the SAMHSA's TIC Conceptual Framework to be used to guide the TIC transformation. This resulted in the TIC Organizational Transformation Framework utilized by the DSHS TIC Organizational Transformation Pilot as seen in the figure below.

Trauma Informed Care

"A SYSTEM OR PROGRAM THAT IS KNOWLEDGEABLE AND SENSTIVE TO THE IMPACT OF TRAUMA IN THE INDIVUAL/FAMILIES'SLIVES AND/OR THE VULNERABILITIES OF SURVIVORS OF TRAUMATIC EVENTS". "IT ACKNOWLEDGES AND RECOGNIZES THAT ANY INDIVIDUAL IN THE WORKFORCE MAY HAVE HIS OR HER OWN TRAUMA HISTORY , AND THE NATURE OF THEIR WORK IN A BEHAIOVRAL HEALTH ORGANIZATION EXPOSES THEM WORKFORCE TO TRAUMATIC EVENTS THAT COULD IMPACT THEIR PERSONAL AND PROFESSIONAL FUNCTIONING.

This Trauma Informed Care Organizational Transformation Framework (Figure 5) incorporates Consumer Voice and Partnering with Persons with Lived Experience (Youth, Adults and Family Representatives) under the Consumer Driven Care and Services TIC Domain. It also prioritizes preventing and addressing secondary traumatic stress in the workforce through the Trauma-Informed, Educated and Responsive Workforce TIC Domain.

Figure 5. Trauma Informed Care Organizational Transformation Framework



In Year 3, the TIC Organizational Transformation Learning Collaborative included another readiness assessment that was completed by every pilot site to inform the local organizational transformation. This readiness assessment consisted of the completion of the Organizational Self-Assessment (OSA) readiness assessment of the National Council for Behavioral Health and the Secondary Traumatic Stress Index-Organizational Assessment of the University of Kentucky (An NCTSN Partner). These readiness assessment would help guide each of the sixteen pilot sites on the local TIC Organizational Transformation. The OSA scales would help measure and guide the elements of implementation of trauma informed care according to a TIC Seven Domains Framework of the NCBH that parallels and enhances SAMHSA's TIC Approach and definitions. The STSI-OA would help pilot sites measure and guide organizational transformation that can prevent and address secondary traumatic stress in the workforce. Findings of these readiness assessments were included in prior quarterly reports. The OSA findings included the three TIC Domain of implementation goals that each pilot site prioritized to work during the TIC Organizational Transformation Learning Collaborative.

Phase 3: Trauma Informed Care Organizational Transformation Pilot

A TIC organizational transformation pilot and learning collaborative was started on the 3rd year and ended in year 4. The original scope of work of the proposal of TCRFT targeted transformation of children community mental health services only included two pilot sites HOTRMHMR and DSHS. Under the guidance and planning of the TCRFT Steering Committee and the approval of the DSHS MHSA Executive Leadership the scope of the pilot was expanded as to impact all community behavioral health services under DSHS that impact children and families including; community mental health services, substance abuse treatment services, substance abuse prevention services and tribal nations in Texas. DSHS utilized state funding ($16,000) to expand the number of pilot sites from two, to sixteen as described in the table below:

Table 1. Trauma Informed Care Organizational Transformation Pilot Sites

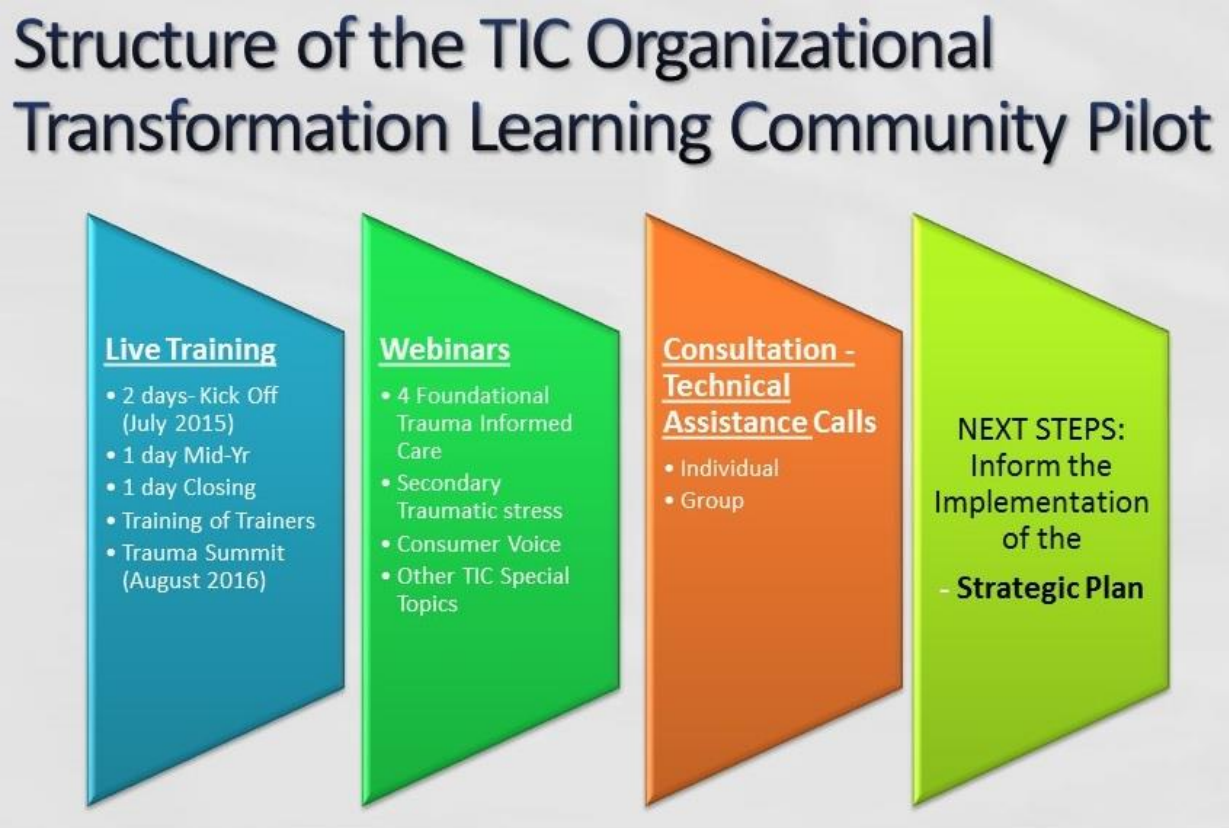
Name of Pilot Site	Type of Organization			
	LMHA	SAP	SAT	Tribal Nation or State Government
Aliviane Inc.		X	X	
Burke Center	X			
Center for Health Care Services	X			
Central Plains Center	X			
Department of State Health Services (MHSA)	-	-	-	X
DePelchin Children's Center		X		
East Texas Council on Alcoholism & Drug Abuse		X		
Family Service Association of San Antonio		X		
Heart of Texas Region MHMR Center	X			
Hill Country MHDD Center	X		X	
MHMR of Tarrant County	X			
MHMRA of Harris County	X		X	
Pecan Valley Center	X	X	X	
Rainbow Days Inc.		X		
YWCA of Greater Austin		X		
Ysleta del Sur Pueblo		X	X	X
LMHA = Local Mental Health Authority, SAP = Substance Abuse Prevention, SAT= Substance Abuse Treatment				

The sixteen pilot sites impact 86 counties throughout Texas as seen in Map 2.

Map 2. TIC Organizational Transformation Learning Collaborative Pilot Sites

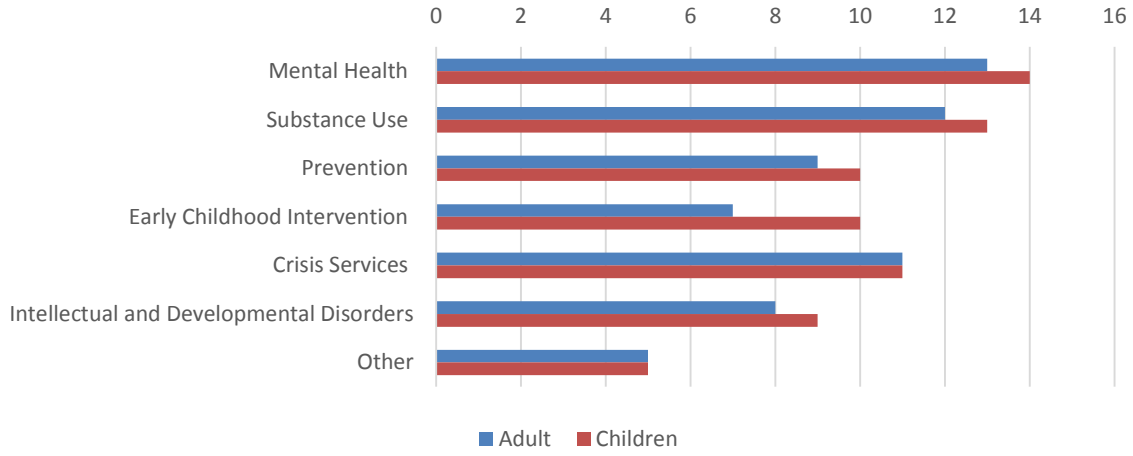
The structure of the TIC Organizational Transformation Learning Collaborative can be seen in the Figure 6.

Figure 6.



Multiple surveys were conducted throughout the learning collaborative to measure the progress of the TIC Organizational Transformation. Findings of the progress of the TIC Organizational Transformation are summarized and discussed in the evaluation report section of the report. At the beginning of the TIC Organizational Learning Collaborative the TIC Teams completed OSA, STSI-OA and a survey. Respondents were asked to report the service areas that the TIC teams' work will impact. As seen in Figure 6 below, the majority reported that children and adults receiving mental health care and substance use treatment would be impacted. On the whole, the work will address services equally for children and adults and across a wide array of service types.

Figure 7. Service areas impacted as part of the TIC Learning Collaborative

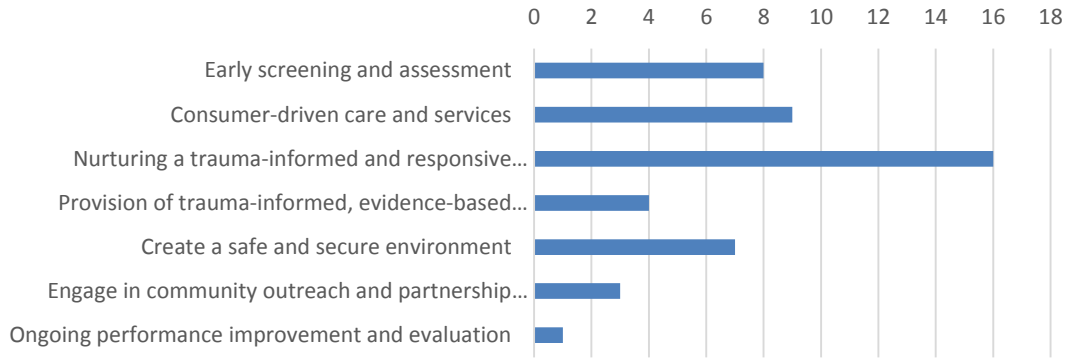


Pilot Sites reported on the three goal areas that their teams have decided to address in the TIC Learning Collaborative. The most common goals selected were:

- Nurturing a trauma-informed and responsive workforce (N=16);
- Consumer-driven care and services (N=9); and
- Early screening and assessment (N=8).

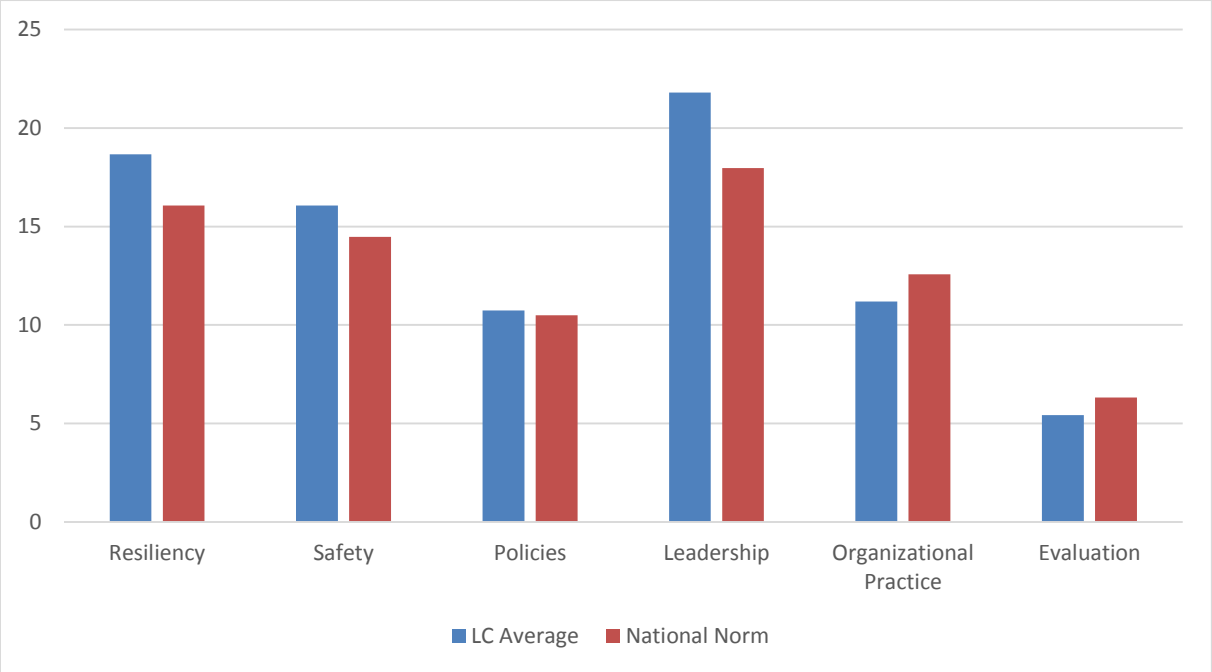
Only one organization opted to examine quality improvement processes.

Figure 8. Goals selected by teams for TIC transformation



The STSI-OA showed the following baseline at the beginning of the TIC Organizational Transformation Learning Collaborative. The TIC Teams Leads at each pilot site responded to a number of items reflecting their organization's current level of support for reducing the impact of secondary traumatic stress within the workforce. In some sites, staff within the organization were surveyed for a broader sample. Sites were provided with site specific results in comparison to national norms, but average scores across all of the TIC LC sites are provided in Figure 9.

Figure 9. Mean Scores on the Secondary Traumatic Stress Organizational Assessment



GOALS: Overview of achievements and challenges

All objectives of the TCRFT initiative were accomplished. TCRFT was about to achieve the aim of piloting trauma informed care organizational transformation and created the foundations to transform the community behavioral health services in Texas into a trauma-informed care system. The evaluation section below will summarize and describe the achievements and outcomes related to the objectives of the TCRFT initiative. The challenges faced by the TCRFT initiative were discussed in all the prior quarterly reports during the past four years. Nevertheless they can be summarized by year in the following manner:

Challenges Year 1

- Workforce shortages and organizational restructuring to new project priorities at Bluebonnet Trails Community Services (one of the original pilot sites) impacted their ability to provide services and continue participating in the TCRFT initiative.
    - Plan of Correction - The initiative created a plan of correction to ensure targets were met and scope of work of the initiative would not change. Through the approval of SAMHSA, the types of providers and clients served were expanded to include the clients of the external community providers (non-HOTRMHMR) receiving training and completing clinical consultations under the TCRFT initiative.

TIEMH of the University of Texas at Austin became the organization that determined eligibility and enrolled clients in the TCRFT initiative for these external providers. HOTRMHMR expanded the number of providers by including clinicians with temporary clinical licenses under clinical supervision by an approved board clinical supervisor that worked at HOTRMHMR.

- Lesson Learned – Competitive priorities that result of organizational restructuring that changes the priorities of program services impact direct care services. Leadership Buy-In is key in the successful completion of trauma informed care organizational and systems transformation.

Challenges in Year 2

- The National Center for Trauma Informed Care dropped the TCRFT technical assistance due to their changes in financial support. This delayed the TIC Readiness Assessment and the planning of the TIC Organizational Transformation Pilot.
  - Plan of Correction – The TCRFT Steering Committee in partnership with Texas Systems of Care and TIEMH explored and interviewed other national organizations that could serve as master trainers and experts on trauma informed care. Proposals were reviewed by the TCRFT Steering Committee.
  - Lesson Learned – An oversight committee of a systems transformation initiative is key in effectively problem solve major set-backs that may impact the scope of work. Incorporate input from local experts on trauma-informed care and systems transformation to develop a cost-effective Plan B. Grass-roots efforts and community partnerships guide systems transformation faster.

Challenges in Year 3

- State Legislature may impact the progress of systems transformation through the sunset of state agencies and consolidation of program services. Senate Bill 200 mandated the transition of the MHSA Division from DSHS to the Health and Human Services Commission. This bill eliminated most advisory committees and steering committees of children and adolescent services in Texas. It mandated the consolidation of the TCRFT Steering Committee with the Texas Systems of Care Council into a new Children and Youth Advisory Subcommittee. This legislative mandate impacted the contract procedures and procurement procedures of the MHSA Division. It delayed the completion of contracts and procurements that delayed the PCIT Trainer of Trainer's Cohort and the beginning of the TIC Organizational Transformation Learning Collaborative. Furthermore, this consolidation with HHSC required the creation of a new strategic plan for behavioral health services in Texas and put a stop on the development of competitive strategic planning of behavioral health services.

Challenges in Year 4

- The consolidation of DSHS into HHSC and the transition of the MHSA Division where the TCRFT initiative resides to HHSC continued in the last year of the grant project. The transition of the MHSA Division into a new Behavioral Health Services Program Services Section under HHSC became effective on September 1, 2016. The transition from DSHS to HHSC continued impacting the contracting and procurement procedures and delayed certain contracts and purchases such as the payment of training rooms to hold the PCIT Training of Trainer during the last quarter. It also limited the access to budget accounts during certain periods of time when the financial operating procedures of the agency were been reviewed and transitioned from DSHS to HHSC. This impacted the TCRFT's initiative ability to use unused balance funds at the end of the project in an effective manner. This delayed the scheduled of the Trauma Informed Care Summit and the 1st meeting of the Trauma Informed Network of Texas to the month of August 2016 and limited the number of contracted speakers. It also delayed the amendments of the contract of TIEMH/Univ. of Texas at Austin that provided funds for the TIC Summit. Furthermore, the transition to HHSC impacted the ability of TIEMH to access the state clinical data of the CANS after the end of the project.

TCRFT EVALUATION REPORT

Overview of the Evaluation

In the Texas Children Recovering from Trauma (TCRFT) initiative, the Department of State Health Services and its partners set out to accomplish the following key goals:

1. Transform the existing public children's mental health service system into trauma-informed care services by:
   - Training the workforce on trauma-informed, evidence-based practices (EBPs);
   - Enhancing policies and practices that promote trauma-informed care services;
   - Increasing the number of mental health professionals in Texas trained to use trauma screening tools;
   - Provide the following trauma-informed practices and treatments:
     - Trauma-Informed Care (TIC)
     - Trauma-Focused Cognitive Behavior Therapy (TF-CBT)
     - Parent Child Interaction Therapy (PCIT);
   - Increase access to trauma-informed services for the target population.
2. Create partnerships that promote access and linkage of children and adolescents to trauma-informed treatments.
3. Evaluate the outcomes of trauma-informed treatment received using the following instruments:

- Child and Adolescent Needs and Strengths Assessment (CANS)
- UCLA-Post Traumatic Stress Disorder Reaction Index (UCLA-PTSD Index)
- Trauma Symptoms Checklist for Young Children (TSCYC)
- National Outcomes Measures (NOMs)

4. Increase child functioning, child and caregiver strengths and decrease the needs and risk behaviors, and PTSD symptoms of children and adolescents receiving trauma-focused treatments.
5. Integrate trauma screening practices into community mental health organizations and increase the number of children screened for trauma in Texas.

The aim of the evaluation is to examine the extent to which these goals were achieved and the impact on Texas agencies, providers, children and families. The evaluation aims to identify lessons that have been learned over the course of the initiative and barriers and challenges that remain. Evaluation information has been shared with the project team throughout the course of the project to monitor progress and the quality of care. This information has been used to identify the need to obtain additional training, increase oversight of activities, or problem solve the removal of barriers.

The evaluation report is organized into five sections. The first section provides an overview of the cross-site evaluation of infrastructure and service goals, using measurements required by SAMHSA. The next three sections summarize the local evaluation, describing changes observed at the provider-level, at the child and family level, and at the organization and state level. The final section summarizes lessons learned from the evaluation and recommendations to support subsequent efforts to address the needs of children who have been exposed to traumatic events and their children.

Cross-site Evaluation Infrastructure Measures

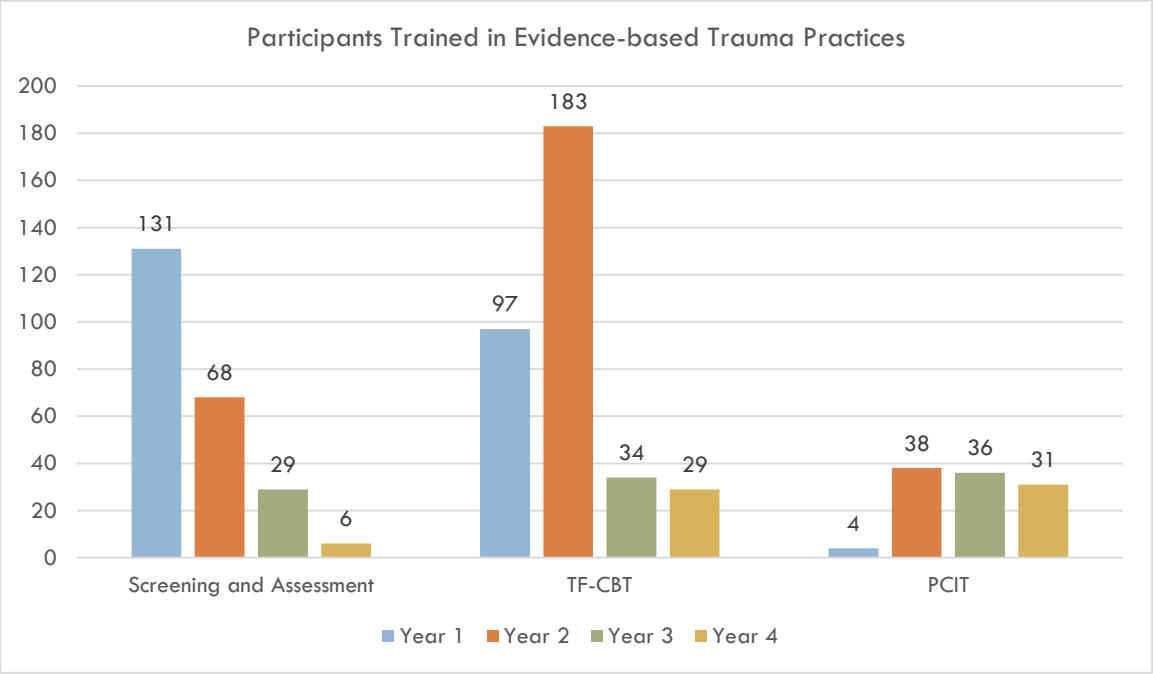
Cross-site evaluation measures were put in place by SAMHSA to monitor many of the project goals that crossed all of the grantees. These measures are used to examine the accomplishment of goals in the following domains: (a) workforce development; (b) partnerships and collaboration; (c) accountability through participation of families or youth; (d) children served by evidence-based treatments; (e) children screened for mental health concerns; and (f) individuals receiving training in mental health promotion. The following section summarizes the results across each of these areas.

(a) Workforce Development

Strengthening of the workforce to provide trauma-informed, high quality behavioral health services was a large focus of the TCRFT initiative. The primary aims of the project were to provide training in evidence-based trauma screening and assessment tools, which included the Child and

Adolescent Needs and Strengths (CANS) assessment, the UCLA PTSD Reaction Index (UCLA) and the Trauma Symptom Checklist for Young children (TSCYC), and trauma-focused treatments, which consisted of Trauma-Focused Cognitive Behavioral Therapy (TF-CBT) and Parent Child Interaction Therapy (PCIT). The number of providers trained over the grant period in these evidence-based tools are presented in Figure 10.

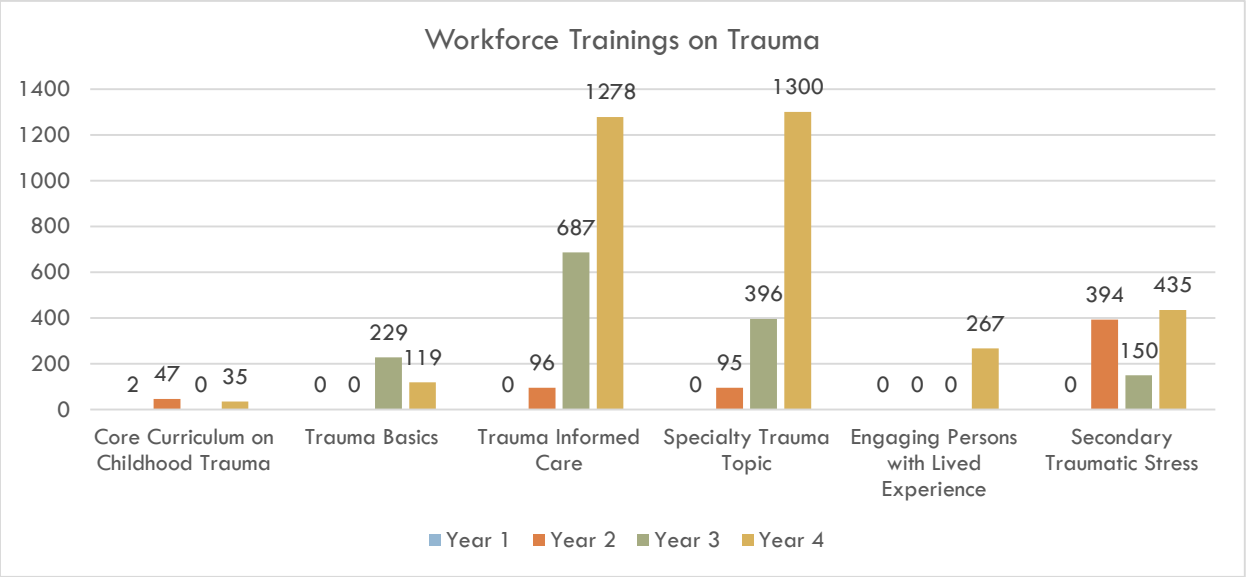
Figure 10. Cumulative Number of Participants in the TCRFT Evidence-based Practice Trainings



The initial two years of the grant focused on the implementation of evidence-based screening and assessment practices, with 234 behavioral health providers trained over all four years, and TF-CBT, with 343 behavioral health providers trained. PCIT was initiated with providers from the local service area attending trainings through a NCTSN learning collaborative, with state roll-out beginning in Year 2. The focus of the PCIT roll out was to develop state infrastructure for local and regional trainers. Therefore, trainings primarily focused on a cohort of providers who were progressing towards different certifications.

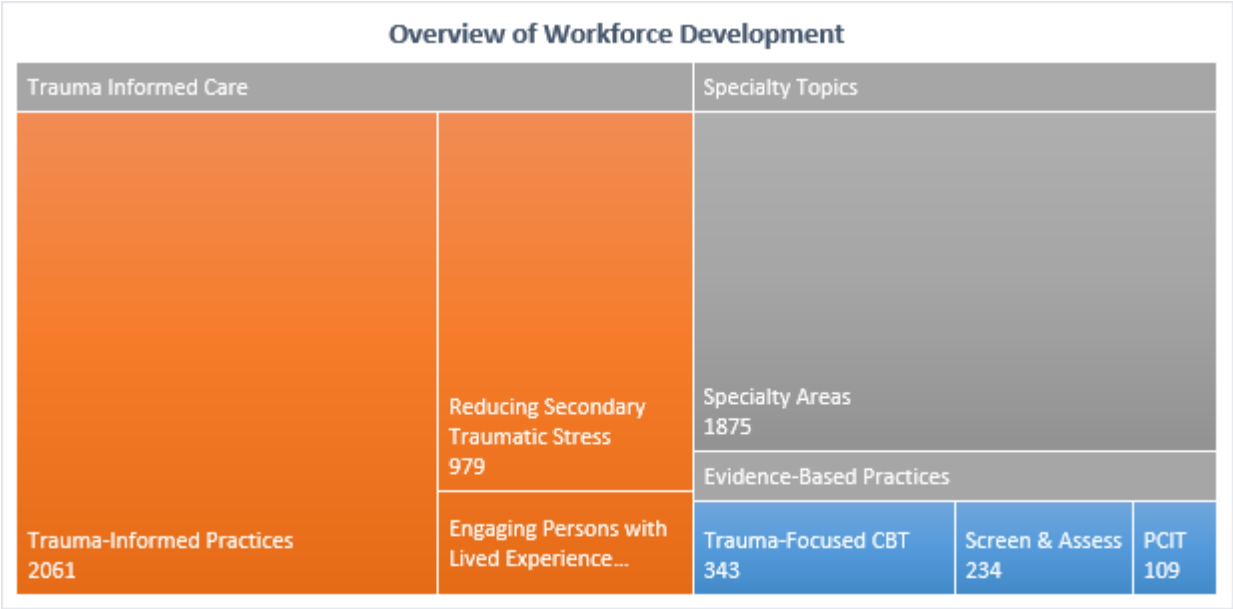
A second workforce development goal of the initiative was to train the broader workforce on the impact of trauma on children, trauma-informed approaches to care, and additional specialty topics in trauma-informed care. Particular emphasis was placed on trainings focused on engaging people with lived experience into trauma-informed care transformation activities and addressing secondary traumatic stress within the workforce. One NCTSN curriculum that was used to provide additional training to the clinical workforce was the Core Curriculum on Childhood Trauma, which two members of the TCRFT team became certified to deliver. The total number of individuals trained across the grant period on these topics is summarized in Figure 11.

Figure 11. Number of Individuals Trained on Trauma Topics by Grant Year



Many of the workforce trainings targeted the goal of transforming mental health organizations to be trauma-informed. Further evaluation of this effort is described in subsequent sections. Workforce trainings in Year 3 primarily focused on 16 organizations participating in an intensive learning collaborative and trainings in Year 4 were expanded to include the broader child-serving workforce from across the state. A summary depiction of all training efforts across the course of the initiative is provided in Figure 12. Space within the figure represents the relative number of individuals trained in that topic area.

Figure 12. Representation of Workforce Members Trained by Content Area



(b) Partnerships/Collaboration

The TCRFT initiative set out to create a number of different partnerships and increase that collaboration and sharing of resources at both state and local levels. Collaboration was achieved through a variety of formal committees and planning groups, formal agreements, shared resources and collaborative events. Table 2 displays the number of organizations (a total of 220 collaborations) that collaborated, coordinated, and/or shared resources as a result of this grant. The state-level steering committee for the TCRFT initiative was a primary partnership, including 12 organizations as well as parent representatives. Each of the local sites also developed community steering committees, with eight organizations participating in Heart of Texas and 15 in the Bluebonnet Trails site (participating in initial years). Other key accomplishments include the opening of a Veteran's One Stop location in Waco, including services to children of veterans, which represented shared resources across multiple agencies. Additionally, in the final year of the grant, a collaborative Trauma Informed Care Summit was held which launched an ongoing partnership through the Trauma Informed Care Network, a statewide network of organizations and individuals interested in advancing trauma-informed approaches in the state.

Table 2. Number of Organizations Collaborating/Coordinating/Sharing Resources during the Grant Year

Category	Sub-category	No. of Organizations	Note
Committee	State-level Steering Committee	12	· The organizations include the state and community mental health authorities, an advocacy group, a state university, a training and technical assistance organization, and the state child welfare agency.
	Community-level Steering Committee	23	· 8 organizations in the Heart of Texas region and 15 organizations in the Bluebonnet community region participated in the committees.
	Other committees	47	· Parent Child Interaction Therapy Planning Committee (7) · Military Family Subcommittee (3) · Committee on Refugee Mental Health Needs (4)

			· Heart of Texas Human Trafficking Coalition Subcommittee (7) · Ending Family and Youth Homelessness Strategy Committee (8) · Trauma Summit Planning Committees (18)
Collaboration	Collaborative	19	· Heart of Texas System of Care (9) · Trauma Informed Care Collaborative (3) · Collaboration on Youth Service Project (2) · Collaboration on Veteran and Military Families Implementation Policy Academy (5)
	In Agreement/ Signed Contract	25	· Parent Child Interaction Therapy Roll-Out (3) · Trauma Informed Care Collaboration (3) · Trauma Informed Care Transformation (16)
	Support & Participation	55	· Parent Child Interaction Therapy Train-the-Trainer Development (15) · Military Children and Families Forum (15) · Conduct of Trauma Informed Care Surveys (9) · Documenting Trauma Informed Care Initiatives (2) · Trauma Screening for Child Welfare (2) · Voices Against Substance Abuse Coalition (9)

			· Supporting Leadership Development (3)
	Outreach	14	· the Veterans One Stop (2) · the Heart of Texas Homeless Coalition (2) · the Hill Country Youth Substance Abuse Coalition (2) · the Military Families Event (8)
	Coordinated activities & events	19	· Back to School Event Planning (4) · Cross Discipline Trauma Conference of Central Texas on March 30-31 (5) · Trauma Informed Care Conference (2) · Trauma and IDD Toolkit Training (3) · Texas Trauma Informed Care Summit (5)
Resource Sharing	Training Space/Equipment, Staff, & Educational Resource	6	· Training facility space and equipment (1) · Opening of Veterans One Stop Shop in Waco (3) · Educational Resources for Individuals Interacting with Unaccompanied Minors (2)
Total		**220**	-

(c) Accountability

One key goal of the TCRFT initiative was to ensure that family members of children who had experienced difficulties adjusting to trauma and youth or young people with these experiences were involved in planning, overseeing, and evaluating the activities. Table 3 identifies the different workgroups or councils associated with TCRFT and the percentage of members who were family members or young people with lived experience.

Table 3. Average Number and Percentage of Consumer and Family Members on Work Group/Advisory Group/Council

Group	2013	2014	2015	2016
State Steering Committee	2 (11.0%)	3 (13.4%)	4 (20.0%)	4 (22.3%)
Subcommittee for Family Representation	5.5 (85.7%)	4 (91.7%)	4 (66.7%)	4 (66.7%)
Youth Advisory Service Project	4 (100%)	-	-	-
Subcommittee for Back to School Event	-	4 (50%)	-	-
Local Youth Voice Committee	-	-	2 (66.7%)	2 (66.7%)
Local Family Voice Committee	-	-	5 (83.3%)	5 (83.3%)
Implementation Teams within Learning Collaborative Participants	-	-	17 (13.1%)	17 (13.1%)
Trauma Summit Planning Committee	-	-	-	6 (31.6%)

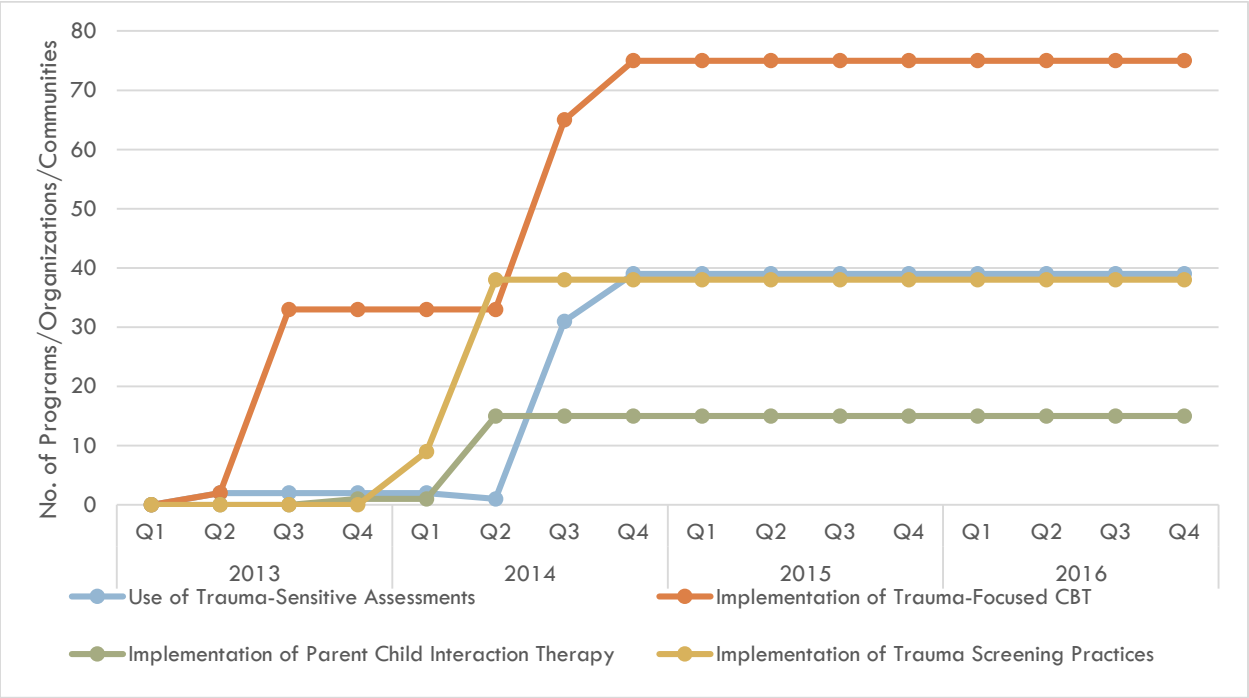
Table 3 shows that youth and family members have been engaged in different state and local-level committees, work groups, and advisory groups to represent consumers and their families. In initial years of the project, the involvement of youth and families primarily focused on state and local steering committees. This partnership was strengthened when specific committees were developed to enhance youth and family voice in the third year of the grant. When additional organizations were invited to participate in the Trauma Informed Care Learning Collaborative, youth and family involvement was identified as a key selection criteria and a partnership with Texas System of Care supported travel for family and youth representatives to attend face-to-face training activities. Many participating organizations included consumers, family members, and/or youth on their implementation teams.

(d) Implementation of Evidence-Based Trauma Practices

Another goal of the TCRFT initiative was to expand the number of organizations providing evidence-based screening, assessment, and trauma treatments, namely TF-CBT and PCIT. In addition to the workforce trained in these practices, the number or organizations in which these practices were embedded was measured. Figure 13 displays the number of organizations that implemented specific mental health-related practices/activities that are consistent with the goals of the grant. Since 2013, 38 organizations received training and began utilizing the CANS to screen for trauma experiences and other behavioral health and family needs at the participating

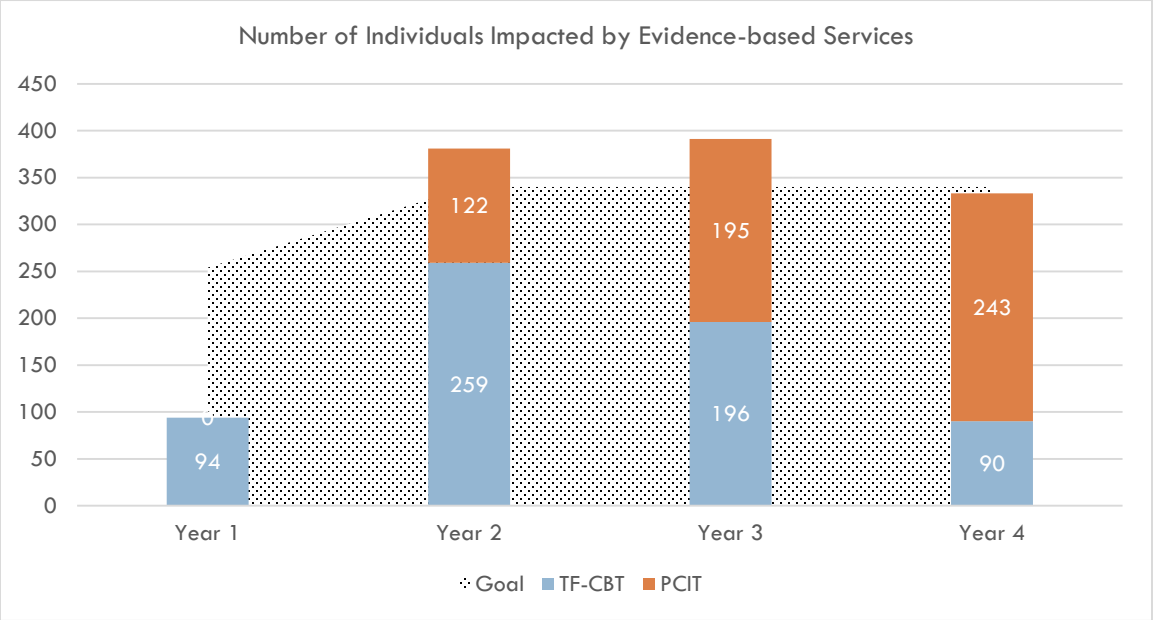
service sites. Thirty-nine organizations implemented trauma-sensitive assessment protocols for children, youth, and families who experienced traumatic events. By the end of the grant year, 75 organizations had implemented TF-CBT to serve consumers with trauma experiences and 15 organizations had implemented PCIT. These practices were embedded primarily in mental health clinics, but participating organizations also included child advocacy centers, domestic violence shelters, sexual assault crisis facilities, substance abuse providers, juvenile justice agencies, and organizations serving the foster care population.

Figure 13. Cumulative Number of Organizations that Implemented Specific Mental Health-Related Practices Consistent with the TCRFT Goals: 2013 Q1 to 2016 Q4



The TCRFT evaluation also tracked the number of children and family members impacted by TF-CBT and PCIT across the timeframe of the project. Goals were set for each year of the initiative and this accomplishment is depicted in Figure 14.

Figure 14. Annual Number of Individuals Impacted by Evidence-Based Mental Health-Related Services

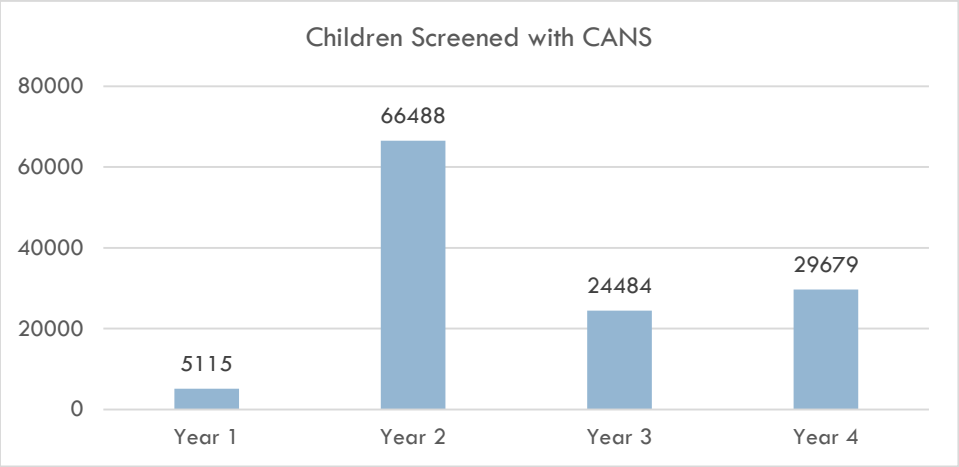


In Year 1, the initiative failed to meet the initial goal of 254 individuals served. In subsequent years, however, the initiative served a greater number of individuals than proposed and came very close to meeting the goal in the final year, when recruitment slowed down for project close-up activities. Overall, a total of 639 children and family members participated in TF-CBT and 560 children and family members received PCIT during the grant year, for a total of 1,199 individuals impacted by evidence-based services.

(e) Children screened for exposure to trauma and other mental health concerns

All public mental health clinics were trained in the use of the Child and Adolescent Needs and Strengths (CANS) measure and began screening children. The CANS was piloted in Year 1 of the grant and then implemented statewide in Years 2-4. The number of children screened each year is presented in Figure 6. Elevations in Year 2 were due to a subsequent change in the way the data was reported, eliminating any subsequent screenings for the same child within a grant year. Children reported in quarters 3 and 4 of Year 2 and all subsequent quarters represented unique children screened that year.

Figure 15. Children Screened



(f) Mental health promotion or prevention

A number of individuals were impacted through the TCRFT initiative by receiving information or training on promoting mental health and preventing the negative impacts of trauma. Outreach efforts focused primarily at the local service site in central Texas, where project staff made presentations to local groups, participated in health and school fairs, and shared information at local events. Similarly, information was shared at state conferences and events to promote resiliency following trauma and at events, such as Children's Mental Health Awareness Day. The mental health promotion and prevention activities are summarized in Table 4. Overall, a total of 4,477 individuals at 24 different events were impacted by these activities

Table 4. Number of Events and Recipients of Presentation/Training on Mental Health Promotion and Prevention: 2013-2016

Item	No. of Events	No. of Individuals	Events Name
2013	1	400	· Booth at Behavioral Health Conference
2014	10	1,717	· Booth at the Williamson County School Mental Health Conference · Training at the Mental Health Forum (Austin, TX), NAMI Waco Lunch and Learn, Waco Independent School District Back 2 School Event, Waco Veterans Administration Summit, Speak Your Mind

			Texas Community Conversation, Historical Trauma and Trauma Informed Care Initiatives · Mental Health Promotion through Children's Mental Health Awareness Day Event and a Youth Creativity Contest · Presentation to the Texas School Safety Center Board
2015	7	876	· Booth at Waco Mental Health Expo, Elementary School Resource Fair, and Health Resource Fair · Brochures on Veterans One Stop Outreach Event · Presentation at the Waco Mental Health Expo and Parent Conference Trauma Presentation · News coverage on trauma and military families,
2016	6	1,848	· Presentation at a Luncheon for the Waco area National Alliance on Mental Illness (NAMI) · Brochures on Trauma Informed Care conference, Heart of Texas Children's Mental Health Awareness Day, Texas Trauma Informed Care Summit, Waco Back to School Event, · Training on Understanding How Trauma Defines Behavior for parents
Total	24	4,477	-

(f) Finance

An additional possible activity within the grant was the development of financing policies that supported the efforts. While TCRFT leadership did not propose any financial policy changes, one change was made that allowed for shared funding to support provider training in PCIT, which led to an additional $45,000 to support PCIT training infrastructure.

Evaluation of Provider-Level Changes

Provider Attitudes Towards Evidence-based Practices

Prior to trainings in TF-CBT and PCIT, participants completed the Evidenced-Based Practice Attitude Scale (EBPAS), which measures the extent to which individuals are likely to implement evidence-based practices. Table 5 presents the average provider scores for the Total Score and four subscales in comparison to national norms of mental health providers.

Table 5. Provider Attitudes towards Evidence-based Practices

EBPAS Domain	TF-CBT Providers (mean)	PCIT Providers (mean)	National Norm (mean)
EBPAS Total Score	2.44	2.54	2.33
Appeal	3.18	3.54	2.91
Requirements	2.77	2.80	2.41
Openness	2.98	3.28	2.76
Divergence	.93	.52	1.25

Note: Scores range from 0 to 4. For Total Score, Appeal, Requirements, and Openness, higher scores reflect a greater tendency to adopt EBPs. For Divergence, higher scores reflect a lesser tendency to adopt EBPs.

Overall, both groups of providers had more positive attitudes towards the adoption of evidence-based practice than found in national normative samples. The PCIT trainees reported being more

influenced by the appeal of a practice than the TF-CBT trainees and reported greater openness to trying new therapy strategies and techniques. Both groups reported similar levels to which a requirement or mandate would influence their decision to implement an evidence-based practice. Overall, these providers seemed to have attitudes that supported their implementation of TF-CBT and PCIT.

Impact of Training

Immediately following trainings in evidence-based practices, participants completed the Inventory of Training and Technical Assistance (IOTTA), which assesses the quality of the training and the perceived importance and impact on the individual's work. Results of these surveys are summarized in Table 6 by training type.

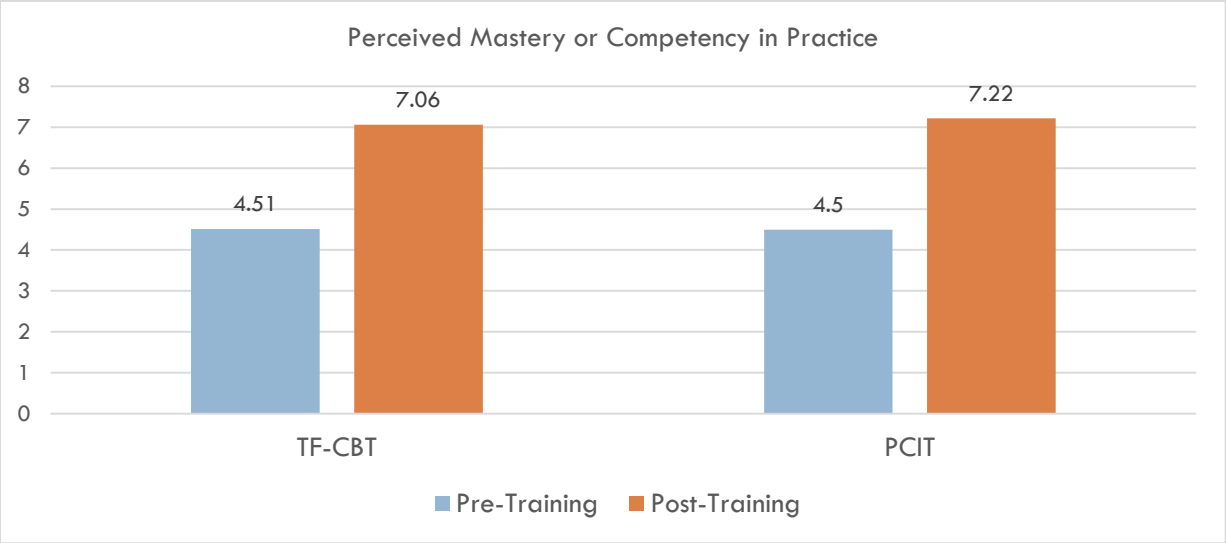
Table 6: Evaluation of Training

Item	TF-CBT Mean	TF-CBT Standard Deviation	PCIT Mean	PCIT Standard Deviation
Importance of training goals	8.00	1.96	8.66	1.34
Trainer credibility	9.29	1.05	9.63	0.88
Training organization	8.47	1.41	8.56	1.53
Training interest	8.38	1.65	8.41	1.79
Overall impact on work	8.34	1.60	9.00	0.99
Impact on assessment & service planning	8.22	1.64	8.78	1.20

Note: Items range from 0 to 10, with 10 representing highest/greatest level of the criteria.

Participant reports on their initial level of competence in the evidence-based practice and their perceived competence at the end of the workshop are presented in Figure 7.

Figure 7. Changes in Perceived Mastery in the Evidence-based Practice Following Training



Participating providers were surveyed six months following the training events to evaluate the extent to which they had implemented the evidence-based practice and the factors that could be impacting the extent or success of implementation. Overall, 74.6% of the TF-CBT training participants reported that they participated in the coaching/supervision calls that occurred following the workshop training. All respondents to the PCIT survey reported that they participated in the coaching calls; however, five of the original trainees did not respond to the follow-up survey and may have represented the proportion that was no longer actively involved. Perceptions of the importance of coaching calls are summarized in Table 7.

Table 7. Trainee Perceptions of Coaching/Supervision Calls

Item	TF-CBT % Agree	TF-CBT % Strongly Agree	PCIT % Agree	PCIT % Strongly Agree
I am very satisfied with the content of the coaching calls.	52.1%	39.6%	66.7%	33.3%
I feel I am more competent at providing TF-CBT/PCIT as a result of the coaching calls.	54.2%	39.6%	72.7%	27.3%
I actively participated in the coaching calls.	43.8%	39.6%	58.3%	33.3%

I frequently thought about not calling in for the coaching calls.	12.8%	4.3%	0%	8.3%
I would have liked the calls to be more frequent or last for a longer period of time.	16.7%	0%	16.7%	8.3%

Respondents also indicated the extent to which they are utilizing the practices within their organization. Only 9.7% of TF-CBT trainees and 8.3% of PCIT trainees indicated that they are not using the model with any clients. Most respondents (48.5% of TF-CBT and of 33.3% of PCIT) indicated that they had used the model a little, meaning with one or two clients or tried some components). Another 26.5% of TF-CBT participants and 33.3% of PCIT participants indicated that they have used the model with three to five clients and only 7.4% of TF-CBT and 25% of PCIT providers indicated they have used it a lot, with six to ten clients. No trainees indicated that they have used the model extensively, with more than ten clients.

Fidelity to EBPs

Adherence to the components of TF-CBT and PCIT was measured through provider session checklists. Session forms were submitted for most youth served; however, providers did not report individual sessions for 19.7% of children. The majority of youth (n=237; 62.5%) received TF-CBT and a smaller number (n=142, 37.5%) received PCIT. For youth who have been discharged from care, the average number of TF-CBT sessions is 9.4 (*sd*=8.0) and the average number of PCIT sessions is 7.3 (*sd*=7.4). Table 8 presents information about the total number of sessions completed by youth discharged from care. Retention was slightly greater in TF-CBT than PCIT, with 33.5% completing at least 10 TF-CBT sessions and 25.1% attending at least 10 PCIT sessions.

Table 8. Number of Sessions Received for Youth in Evidence-based Care

Number of Sessions	TF-CBT N=236	PCIT N=124
1 Session	36 (15.3%)	15 (12.1%)
2 – 5 sessions	64 (27.1%)	56 (45.2%)
6 – 10 sessions	36 (15.3%)	14 (11.3%)
11 – 15 sessions	32 (13.6%)	10 (8.1%)
16 – 20 sessions	25 (10.6%)	11 (8.9%)

More than 20 sessions	22 (9.3%)	10 (8.1%)

Adherence to Trauma Focused Cognitive Behavioral Therapy. Two-hundred and thirty-six youth who were served had documentation of TF-CBT sessions, resulting in a total of 2,053 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 were moderately adherent with the assignment of homework, with homework assigned at 62.1% of sessions. When homework was assigned, 33.7% of youth or parents completed the assignment fully and another 39.1% partially completed it. Therapists included caregivers in the treatment session for 41.0% of the documented session, suggesting that parents or other caregivers were frequently included in the treatment, but not at the frequency recommended by the TF-CBT model.

Information on adherence to the TF-CBT model was collected through a therapist checklist of core treatment elements. The results are presented in Table 9. Analyses are focused on only those 211 youths 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 9. Frequency of TF-CBT Components Conducted During Treatment Sessions – Discharged Youth

TF-CBT Core Component	Number N=211	Percent
Psychoeducation	196	92.9%
Parenting Skills	106	50.2%
Relaxation	138	65.4%
Affective Regulation	154	73.0%
Cognitive Coping	119	56.4%
Trauma Narrative	72	34.2%
In Vivo Desensitization	31	14.7%
Conjoint Sessions	43	20.4%
Safety Planning	50	23.7%

Skill Development	84	39.8%

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 50.2% 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. One hundred and forty-two youth served had documentation of receiving PCIT sessions. A total of 1,009 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 86.6% of the time (excluding initial appointments), so this component of the treatment structure was adhered to. Although a minority of parents (30.7%) completed the homework all seven days of the week, 60.2% completed the assignment three or more days of the week. Only 9.1% of the time did parents fail to complete any of the homework assignment.

Information on adherence to the PCIT model was collected through a therapist checklist of specific session tasks. The results are presented in Table 10. Analyses are focused on only those 124 children discharged from care. 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 does not reflect the quality of the intervention.

Table 10. Frequency of PCIT Core Components Conducted During Treatment Sessions

Core Component	Number N=124	Percent
Therapy Orientation Session	104	83.9%
CDI Teaching Session	96	77.4%
First CDI Coaching Session	81	65.3%
Second CDI Coaching Session	68	54.8%

Third CDI Coaching Session	51	41.1%
Fourth or Later CDI Coaching Session	48	38.7%
PDI Teaching Session	37	29.8%
First PDI Coaching Session	37	29.8%
Second PDI Coaching Session	30	24.2%
Third PDI Coaching Session	23	18.6%
Fourth PDI Coaching Session	19	15.3%
Fifth PDI Coaching Session	14	11.3%
Sixth PDI Coaching Session	11	8.9%
Seventh or Later PDI Coaching Session	9	7.3%
Graduation Session	19	15.3%

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. Nineteen children and families (15.3%) have reached the graduation session.

Child and Family Level Evaluation

Characteristics of Youth Served

A total of 472 children were reported served through submission of the National Outcomes Measure (NOMS). Demographics of the youth served are presented in Table 11. Results are presented separately for the Heart of Texas service site, as the primary partner in service delivery.

Table 11. Demographics of Youth Served

	Heart of Texas	Other Sites	Total
	n=236	n=234	n=472
Gender – Female	103 (43.6%)	105 (44.9%)	208 (44.3%)
Gender - Male	132 (55.9%)	62 (54.7%)	260 (55.3%)
Transgender	1 (0.4%)	0 (0%)	1 (0.2%)
Ethnicity – Hispanic	71 (30.1%)	78 (33.3%)	149 (31.7%)
Race – African American	84 (36.2%)	42 (17.9%)	126 (27.1%)
Race – Asian	0 (0%)	1 (0.4%)	1 (0.2%)
Race – Native Hawaiian	2 (0.9%)	3 (1.3%)	8 (1.1%)
Race – Alaska Native	1 (0.4%)	2 (0.9%)	3 (0.7%)
Race – White	137 (59.1%)	177 (75.6%)	314 (67.5%)
Race – American Indian	19 (8.2%)	9 (3.8%)	28 (6.0%)
	Mean (SD)	Mean (SD)	Mean (SD)
Age of Child	10.9 (4.5)	8.3 (4.4)	9.6 (4.9)

The race and ethnicity of the youth served show some differences when compared to the estimated demographics of the population of children in Texas. 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 (27.1%), while 12% of the Texas children are African American. The non-Hispanic White alone served group (35.0%) is similar to the population in Texas (33%). The youth identifying as Native American

(6.0%) are small, but larger than the Texas population (<.5%). A total of 85 (18.0%) of the children served had families with military involvement, a key goal of recruitment in the grant.

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*=3.0; sd=1.7; range 0 to 8), while the youth reported an average of 3.5 different trauma types (*sd*=2.2; range 0 to 10). Table 12 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. Several types of traumatic experiences were more likely to be reported by youth than parents, including being in a natural disaster, physical abuse in the home, physical assault or threat in the community, witnessing community violence, and the traumatic death of a loved one.

Table 12. Trauma Experiences by Respondent Type

Trauma Types	Parent Report	Youth Report
	N (%) (n=185)	N (%) (n=201)
Being in a big earthquake that badly damaged the building the child was in.	1 (0.5%)	4 (2.0%)
Being in another kind of disaster, like a fire, tornado, flood, or hurricane.	25 (13.5%)	43 (21.4%)
Being in a bad accident, like a very serious car accident.	34 (18.6%)	39 (19.3%)
Being in a place where a war was going on around your child.	2 (1.1%)	5 (2.5%)
Being hit, punched, or kicked very hard at home.	49 (26.9%)	68 (34.2%)
Seeing a family member being hit, punched or kicked very hard at home.	90 (49.2%)	89 (45.2%)
Being beaten up, shot at or threatened to be hurt badly in your town.	47 (26.4%)	75 (37.3%)
Seeing someone in your town being beaten up, shot at or killed.	41 (22.9%)	66 (32.8%)

Seeing a dead body in your town (not at funeral).	17 (9.2%)	21 (10.5%)
Having an adult or someone much older touch the child's private sexual body parts when your child did not want them to.	58 (32.4%)	68 (34.0%)
Hearing about the violent death or serious injury of a loved one.	70 (38.5%)	103 (51.5%)
Having painful and scary medical treatment in a hospital when your child was very sick or badly injured.	33 (18.1%)	46 (22.8%)
Other situation that was really scary, dangerous or violent.	89 (49.2%)	84 (43.3%)

Note. Respondents can indicate more than one trauma type.

Several measures of baseline functioning are also available to describe the population of youth served. As indicated previously, the majority of youth completed the UCLA PTSD Reaction Index, which is based on the *DSM IV*, 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 31.5 (*sd*=12.7), while children and adolescents reported average symptom scores of 33.2 (*sd*=15.1). 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 49.1 (*sd*=12.8), which translates into an age and gender-adjusted T-score of 75.6. A T-score within this range suggests that, on average, youth scored higher on traumatic stress than 96% of the normative population (see Table 13).

Table 13. Trauma Symptom Severity at Enrollment

	Mean	Standard Deviation	Percent above Clinical Cut-off >24 / >38
UCLA Parent Symptom Total (n=146)	31.5	12.7	66.4% / 30.8%
UCLA Child/Youth Symptom Total (n= 193)	33.2	15.1	72.0% / 38.3%
			T-Score Cutoff >65T / >70T

TSCYC PTS Raw Score (n=131)	49.1	12.8	
TSCYC PTS T-Score (n=131)	75.6	19.8	63.4% / 55.7%

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=374, 85.8%). Only five youth were reported to have "poor" overall health (1.2%), with 51 (11.7%) 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 14. Youth were generally reported to be functioning well. However, the majority of respondents did indicate difficulty with coping (64.5%). Additionally, a substantial number (37.3%) identified being unsatisfied with their family life.

Table 14. Youth Functioning

Item	Strongly Disagree/ Disagree	Undecided	Strongly Agree/ Agree
I am [my child is] handling daily life. (n=435)	106 (24.4%)	60 (13.8%)	269 (61.8%)
I get [my child gets] along with family members. (n=433)	129 (29.8%)	55 (12.7%)	249 (57.5%)
I get [my child gets] along with friends and other people. (n=433)	102 (23.6%)	64 (14.8%)	267 (61.7%)
I am [my child is] doing well in school and/or work. (n=410)	134 (32.7%)	56 (13.7%)	220 (53.7%)
I am [my child is] able to cope when things go wrong. (n=434)	280 (64.5%)	68 (15.7%)	86 (19.8%)
I am satisfied with our family life right now. (n=429)	160 (37.3%)	63 (14.7%)	206 (48.0%)

Nineteen youth or families reported being homeless (4.4%) at some time during the month before entry into the program. The majority of participating youth (87.4%) had no out-of-home days during the past month, with thirty youth (6.9%) reporting between one and ten days outside the home and twenty-five (5.7%) reporting more than 10 days outside the home.

Psychiatric hospital stays were the most common reason for an out-of-home stay with 31 youth reporting a hospital stay. Thirteen youth reported a stay in a detention center.

Outcomes for Children and Youth Involved in Care

State Administrative Information. Providers at the Heart of Texas Region MHMR also completed the Child and Adolescent Needs and Strengths assessment (CANS) as a component of existing agency processes. Children served through the TCRFT project were matched with the administrative data available from DSHS, which contained the CANS scores. The baseline CANS score was identified as the score that was closest to the child's entry into TCRFT and a follow-up CANS was selected that was closest to six months following the baseline. There were 255 youth served in TCRFT by Heart of Texas and 242 could be matched with administrative data. Youth who received at least one follow-up CANS assessment after entry into the project were included in the sample, regardless of the length of time they received treatment. A follow-up assessment was chosen closest to the six-month reassessment point. However, if a child ended care prior to the six-month assessment, their CANS data was still used. This represents an "intent-to-treat" sample.

Table 15. Improvement on Child and Adolescent Strengths and Needs

CANS Domain	CANS ITEM	% with identified need at baseline n=197	% improved at 180 days (of those with identified need)
Child Risk Behaviors	Risk of Suicide	9.6%	89.5%
	Risk of Runaway	3.0%	50.0%
Child Behavioral and Emotional Needs	Impulsivity-Hyperactivity	42.6%	16.7%
	Depression	16.2%	43.8%
	Anxiety	36.0%	32.4%
	Oppositionality	31.0%	29.5%
	Conduct Problems	11.7%	26.1%
	Anger Control	47.2%	37.6%
	Adjustment to Trauma	41.6%	28.0%

Life Functioning	Family Functioning	29.9%	32.2%
	School Functioning	29.9%	32.2%
	Social Functioning	20.8%	24.4%
Child Strengths	Child Involvement in Community Life	48.2%	15.8%
	Child's Relationship Permanence	39.1%	15.6%
	Child's Affect Regulation	25.4%	28.0%
Caregiver Strengths and Needs	Caregiver Knowledge	7.1%	35.7%
	Caregiver Mental Health	10.7%	23.8%
	Family Stress	31.5%	32.3%

The most common mental health problems identified at program entry was Anger Control, Adjustment to Trauma, and Impulsivity or Hyperactivity. Many youth did not have strong involvement in their community and had limited relationship permanence, both potential resilience factors. Almost a third of caregivers expressed significant family stress related to the child's mental health challenges. While the majority of children did not demonstrate severe risk factors, such as suicidal or runaway risk, the majority of those that did had decreased risk at 6 months. The greatest percentage of children showing improved emotional or behavioral problems on the CANS were those with depression symptoms, anger control, and anxiety symptoms. Almost one-third of the children with difficulties in family and school functioning were identified as improved following treatment. Caregivers saw the greatest improvements in their knowledge and family stress.

Evaluation Outcome Measures. Within the local evaluation study, outcomes of children and youth were measured through several methods. For most children involved in trauma treatment, parents and youth were asked to complete the UCLA PTSD Index at program entry, every 3 months, and at discharge. For young children, the Trauma Symptom Checklist for the Young Child (TSCYC) was completed by caregivers using the same scheduled. In addition, therapists completed a Clinical Global Improvement rating at each visit. The following table illustrates the results of these outcome assessments across all children served in the program.

Table 16. Outcomes of Children Receiving Trauma Care

Item	Mean Baseline Scores	Mean Follow-up Scores	Dependent t-test
UCLA PTSD Reaction Index – Parent Report (n=38)	31.2	20.3	t=5.76, p<.0001
UCLA PTSD Reaction Index – Youth Report (n=66)	35.2	23.0	t=7.68, p<.0001
TSCYC PTSD T Score (n=28)	74.0	63.1	t=3.92, p=.0006
TSCYC Anger T Score (n=28)	71.7	58.2	t=5.82, p<.0001
TSCYC Anxiety T Score (n=28)	69.2	61.5	t=2.10, p=.0456
TSCYC Dissociation T Score (n=28)	61.7	55.7	t=2.42, p=.0227

Clinical Global Impression Scale	Significantly Worse	A Little Worse	No Significant Change	A Little Better	Significantly Better
TF-CBT Participants (n=189)	2 (1.1%)	14 (7.4%)	54 (28.6%)	77 (40.7%)	42 (22.2%)
PCIT Participants (n= 95)	0 (0%)	4 (4.2%)	31 (32.6%)	24 (25.3%)	32 (33.7%)

Results demonstrate that the majority of children and youth are improving in care across a number of symptom areas. Both parents and youth report significant improvement on the UCLA PTSD rating scale. The change on the TSCYC represents a change of 11 points on the PTSDT-score, meaning an average change of more than one standard deviation. Provider ratings using the Clinical Global Impression Scale (CGI) suggest the majority of children have shown some improvement in care. This is similar across both TF-CBT and PCIT. The additional value of this rating is that it captures children and youth who do not remain in care through the second assessment point. This sample, described as “intent to treat,” reflects the impact of care on all youth receiving more than one treatment session. It is considered a conservative estimate of treatment outcome. Examinations of differential outcomes by race (Black vs. Anglo) and ethnicity (Hispanic vs. Anglo, non-Hispanic) found no significant differences.

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 17 provides the results of the 181 families with a completed survey. Results were overwhelmingly positive, with the vast majority of respondents indicating satisfaction with all items. One or two respondents occasionally indicated that they were unsatisfied or undecided if they were satisfied on specific items.

Table 17. Perception of Care

Item	Strongly Disagree/ Disagree	Undecided	Strongly Agree/ Agree
Staff here treat me with respect.	3 (1.7%)	1 (0.6%)	177 (97.8%)
Staff reflected my family's religious/spiritual beliefs.	2 (1.1%)	3 (1.7%)	175 (96.7%)
Staff spoke to me in a way that I understand.	2 (1.1%)	0 (0%)	179 (98.9%)
Staff was sensitive to my cultural/ethnic background.	3 (1.7%)	3 (1.7%)	175 (96.7%)
I helped choose my [my child's] services.	2 (1.1%)	3 (1.7%)	176 (97.2%)
I helped choose my [my child's] treatment goals.	1 (0.6%)	2 (1.1%)	178 (98.3%)
I participated in my [my child's] treatment.	1 (0.6%)	4 (2.2%)	176 (97.2%)
Overall, I am satisfied with the services I [my child] received.	1 (0.6%)	4 (2.2%)	176 (97.2%)
The people helping me [my child] stuck with me [us] no matter what.	2 (1.1%)	2 (1.1%)	176 (97.2%)
I felt I had my [my child had] someone to talk to when I [he/she] was troubled.	2 (1.1%)	1 (0.6%)	178 (98.3%)
The services I [my child and/or family] received were right for me [us].	3 (1.7%)	6 (3.3%)	172 (95.0%)
I [my family] got the help I [we] wanted [for my child].	2 (1.1%)	5 (2.8%)	174 (96.1%)

I [my family] got as much help as I [we] wanted [for my child].	1 (0.6%)	5 (2.8%)	175 (96.7%)

State Level Evaluation

Survey of Readiness for Trauma-Informed Care in Public Mental Health

To understand the readiness of the public mental health workforce for trauma-informed care, a survey was conducted across all local mental health authorities and state office sites in Texas at the beginning of the second grant year. The survey was accessed by 1,529 respondents, with 4% of respondents representing Central Office of the Department of State Health Services, 78% representing staff at local mental health authorities (LMHA), and 15% indicating they were employed at other organizations. Other organizations were affiliated with the LMHAs, but could include early childhood programs, programs for individuals with intellectual or developmental disabilities, substance abuse programs, and affiliated hospital programs.

Within these settings, respondents were asked to identify the programmatic areas in which he/she works. Table 18 summarizes the responses for these programmatic areas. The majority of respondents (61%) indicated they work in community mental health, with an additional 18% indicating working in intellectual and developmental disabilities. Representation also included substance abuse treatment, prevention, early childhood intervention, and physical health care. A proportion of respondents indicated "other" programmatic areas (11%); however, many of the responses suggest that they are serving in roles that impact several programmatic areas (e.g., billing, contract management, and administration). Other programmatic areas also included staff focused on special populations, such as the court system or foster children.

Table 18. Programmatic Focus of Respondents' Role

Programmatic Focus Areas	Number	*Percentage
Community Mental Health	933	61%
Intellectual and Developmental Disorders	271	18%
Substance Abuse Treatment	156	10%
Substance Abuse Prevention	127	8%
Hospitals and Facilities	120	8%
Early Childhood Intervention	98	6%

Physical Health Care	46	3%
Other	164	11%

*Respondents were allowed to choose multiple answers and percentages are greater than 100%.

The sample was generally representative of the various responsibilities of staff working in the public system. One hundred and one respondents (7%) identified themselves as an administrator or program director, 15% as a program manager or supervisor, 46% as a direct service provider, and 24% as administrative or support staff. Three percent indicated "other" roles, such as information technology, building maintenance, or policy support.

Table 19. Organizational Role of Respondents

	Number	Percentage
Administrator or Program Director (Upper Management)	101	7%
Program Manager or Supervisor (Middle Management)	233	15%
Service Provider	708	46%
Administrative or Support Staff	363	24%
Other	49	3%

Within their role in their agency, 200 (30%) individuals indicated that their work impacts primarily children and families, 535 (35%) respondents indicated their work impacts adults only and 41% (619) indicated their activities focus on both adult and child/family populations. Respondents were also asked to estimate the percentage of individuals that their work impacts who have experienced traumatic events in their lifetime. This question provides information on both respondents' work experiences, as well as their awareness of the prevalence of traumatic experiences. One quarter of respondents (*n*=392) reported that almost all the individuals they serve have experienced traumatic events. Another 27% (*n*=418) reported that almost half the individuals they serve have experienced trauma. An additional 23% (*n*=347) indicated that only a few of the individuals they work with have experienced trauma, and 7% (*n*=100) were unsure if they work with traumatized individuals. Twelve percent (*n*=181) indicated they have not worked with traumatized individuals at all.

Training & Skills**.** A number of questions related to training, skills and supervision of trauma-focused intervention were presented only to those respondents who identified as "Service

Providers." This includes not only behavioral health clinicians, but also nurses, physicians, peer support specialists, service coordinators, case managers, etc. Over half of providers (*n*=358; 62%) felt they had received the training necessary to identify and assess those individuals who have experienced traumatic events. Interestingly, a greater number (*n*=422; 73%) of providers felt they have the necessary skills to do identify and assess individuals with trauma symptoms, perhaps in spite of the perceived lack of training. About 20% (*n*=113) of the providers gave a "neutral" response to the question of training, indicating they were unsure whether they had the training necessary to identify and assess traumatic events in their clients. A similar number (*n*=108; 19%) reported a definite lack of training needed to identify and assess individuals who have experienced traumatic events. Approximately 13% (*n*=73) reported to not have the skills necessary for identification and assessment.

Similarly, only about half (*n*=310; 53%) of providers felt they have received the training necessary to engage and provide effective treatment to individuals who have experienced traumatic events. However, slightly more (*n*=364; 63%) felt they actually have these skills. Almost a quarter (*n*=133; 23%) of providers indicated they did not receive such training and the same percentage were simply unsure. Only 16% (*n*=93) of providers felt they did not have the skills to engage and treat traumatized individuals. However, 21% (*n*=123) reported they were unsure if they had these skills.

Rating of Strategies to Enhance Trauma-Informed Care. Respondents were asked to rate the organizational changes they believe would be most important if an organization was planning to make changes to improve the experience of children, youth and adults who have experienced trauma. They were asked to separately rank changes to the organization and changes to the services offered. They ranked each strategy on a 1-10 scale with 1 being the most impactful and 10 being the least impactful. Tables 20 and 21 summarize the mean ranking within each category. Training was ranked as the most important change respondents felt would contribute towards creating a trauma-informed organization. These results are consistent with the results indicating that many providers feel they have not received the necessary training to both identify and assess individuals who have experienced traumatic events, as well as engage and provide effective treatment to such individuals.

Table 20. Perceptions of Impact of Organizational Strategies for Trauma-Informed Care

Organizational Change Strategy	Mean Rank	Standard Deviation
Training for staff	2.37	1.66
Training for leadership	3.08	1.85
Creating implementation team	3.28	1.76

Developing written policy for Trauma-Informed Care	3.52	1.87
Programs to reduce secondary stress for staff	4.44	2.84
Creating a welcoming environment	5.36	20.51
Establishing policies for restraint	5.36	2.70

Note: Rankings range from 1 to 10, with 1 being the most impactful strategy.

Respondents were also asked to rate the service changes they believe would be most important if an organization was planning to make changes to improve the experience of children, youth and adults who have experienced trauma. Screening for trauma experiences was ranked as the most important service change that would reflect a trauma-informed organization, followed by the implementation of trauma assessments. Implementing peer services was ranked lowest in importance.

Table 21. Perceptions of Impact of Service Changes for Trauma-Informed Care

Service Change	Mean Rank	Standard Deviation
Screening for trauma experiences	2.53	1.96
Trauma assessments	2.94	1.79
Implementing trauma-focused treatments	3.15	1.67
Providing trauma education to consumers	3.93	2.15
Implementing strategies to improve resilience	4.62	1.93
Establishing strong continuity of care practices	4.27	2.06
Implementing peer services	4.86	1.96

Current Readiness for Trauma-Informed Care. Respondents were also asked to rate the extent to which key organizational and services activities that support trauma-informed care have been implemented within their work setting. Respondents rated implementation of each strategy on a Likert scale of 1 to 10, with one indicating that the activity had not been implemented at all and ten indicating the activity has been fully implemented and sustained over time.

As shown in the table below, most strategies received average ratings reflective of moderate implementation. Large standard deviations suggest that answers varied greatly across respondents. Activities that reflect the lowest implementation ratings are programs to reduce secondary stress, the creation of a change team focused on trauma-informed approaches and written policies for trauma-informed care. The activities that respondents rate as the greatest degree of current implementation are written policies on restraint, strong continuity of care practices, and accessible peer services.

Table 22. Respondent Ratings of Implementation of Trauma-Informed Strategies

Trauma-informed Activities	Mean Rating	Standard Deviation
Programs to reduce secondary stress	4.72	2.85
Creating a change team focused on trauma-informed approaches	4.74	2.70
Written policy for trauma-informed care	4.78	2.86
Consistent education of consumers on trauma and its impact	5.01	2.78
Standardized assessments for trauma symptoms	5.21	2.78
Training for leadership in trauma-informed values and culture	5.22	2.65
Training for staff in trauma-informed care approaches	5.25	2.62
Standardized screening for traumatic experiences	5.25	2.74
Availability of trauma-focused treatments	5.28	2.66
Welcoming waiting area and other spaces	5.71	2.81
Training on skills and strategies to improve resilience	5.73	2.70
Accessible peer services	5.87	2.83
Strong continuity of care practices	5.97	2.64
Written policies on restraint	6.51	2.94

Note: Ratings range from 1 to 10, with 10 being fully implemented and sustained.

Evaluation of the Texas Trauma-Informed Care Learning Collaborative

Overview of the Learning Collaborative

In the third and fourth year of the grant, TCRFT sponsored 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 was facilitated by the National Council for Behavioral Health, with additional support provided through the TCRFT initiative and partner organizations with Texas System of Care and NCTSN. Sixteen organizations were selected for participation, including the state behavioral health authority, for the year-long initiative. Each of the organizations identified implementation teams, including parents, youth, and adults with lived experience. Implementation teams attended three face-to-face training and networking events over the course of the year. They also participated in monthly learning collaborative calls with National Council coaches and had access to webinars and other resources on trauma-informed care.

Overview of the Evaluation

The evaluation of the trauma-informed care transformation focused on understanding the impact of the different implementation support activities on the changes that were made at each participating organization. Since each organization selected the domains in which they would focus their efforts and each identified unique strategies for improving their systems, the evaluation examined the process by which organizations made changes and the factors that supported or impeded their progress. Due to the early nature of the transformation activities, the evaluation did not focus on the impact of the changes on consumer outcomes, but rather it focused on developing an understanding of what factors contributed to successful implementation of chosen strategies. The following evaluation questions were posed:

1. What core aspects of TIC do agencies prioritize? What strategies do they undertake? What barriers are encountered? How are these barriers addressed?
2. Do TIC teams perceive changes in organizational implementation of TIC strategies following participation in the Learning Collaborative?
3. How successful were agencies in advancing the organization based on the prioritized components?
4. What factors appear to contribute to the success of organizations in the implementation of trauma-informed practices?

Several data collection tools were developed to address evaluation questions. Specifically, surveys to measure implementation and factors affecting implementation were developed for administration three times throughout the year. The surveys were designed to be reported by the team lead or a consensus of the team at each site. Data from the Organizational Self-Assessment (OSA), a measure of trauma-informed care readiness, was gathered by the National Council and shared with the TIEMH evaluation team. An analysis pre-post OSA scores was conducted to assess change over time as reported by implementation teams. Qualitative analysis was also undertaken using text responses on qualitative survey questions, notes during coaching calls, and presentations by organizational teams at the final meeting of the learning collaborative to identify themes represented across organizations.

Participant Feedback on Trauma-Informed Care Learning Collaborative

At each in-person meeting, respondents were asked a variety of questions regarding their experience with the training and planning event. Table 23 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. Participants particularly noted excitement and positive expectations at the initial meeting and feeling positive about the work accomplished and the role of the learning collaborative in supporting this work at the final meeting.

Table 23. Participant Perceptions of the Trauma Informed Care Kick-Off Event

Kick-Off Meeting	Strongly Agree	Agree	Disagree	Strongly Disagree
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%
I am leaving this meeting feeling energized to adopt TIC.	60.9%	33.3%	5.7%	0%

Mid-Year Meeting	Strongly Agree	Agree	Disagree	Strongly Disagree
I feel confident that my team is making progress toward becoming more trauma-informed.	46.0%	52.4%	0%	1.6%
I heard/learned new approaches I can use within my team from hearing from other teams.	41.3%	54.0%	3.2%	1.6%
I am feeling positive about the work my team has done so far.	47.6%	46.0%	4.8%	1.6%
The day was well organized.	20.3%	72.9%	3.4%	3.4%
Final Meeting	**Strongly Agree**	**Agree**	**Disagree**	**Strongly Disagree**
I am feeling positive about the work my team is doing and confident that we will continue our work beyond the learning community.	65.2%	34.8%	0%	0%
The learning community has helped our organization focus our efforts to becoming trauma-informed.	63.0%	37.0%	0%	0%
The support my team received from the National Council staff was helpful in keeping our organization focused.	50%	45.7%	6.5%	0%
The day was well organized.	32.6%	60.9%	6.5%	0%

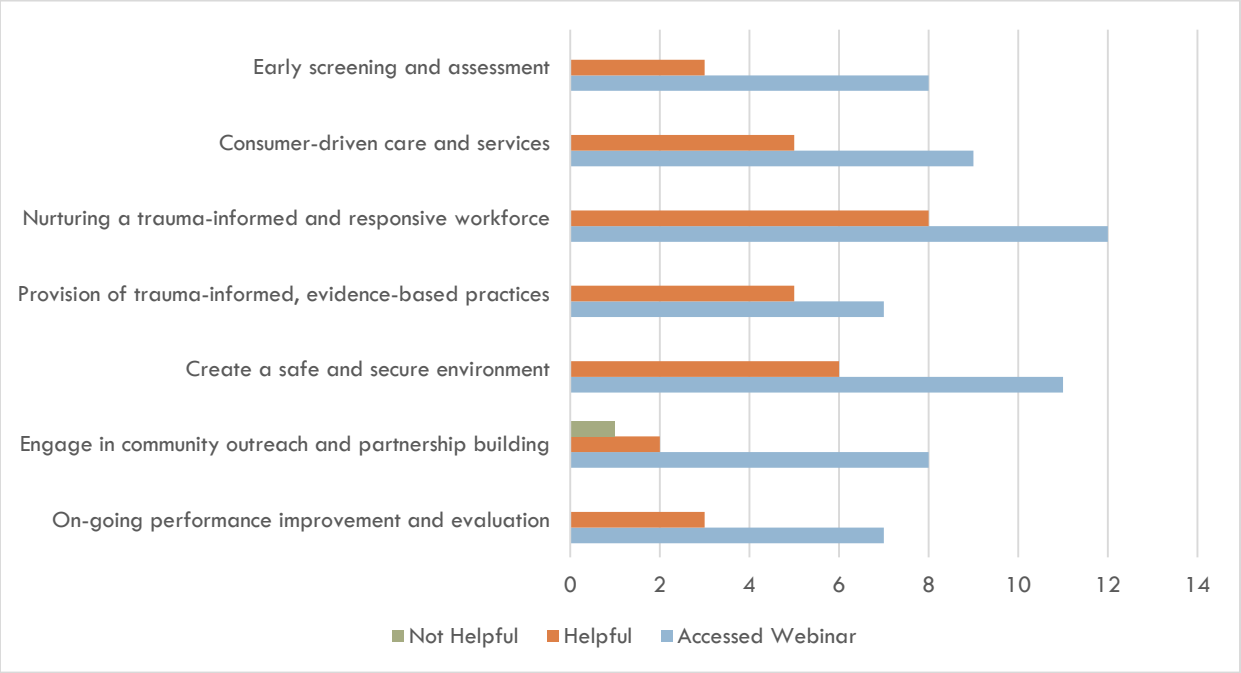
Participant Feedback on Resources

Survey respondents were asked whether they have accessed resources related to their team's transformation goals on the National Council website, and if so, whether the resource(s) was/were helpful. The most accessed resources related to *Nurturing a trauma-informed and responsive workforce* and *Create a safe and secure environment*. Of those who accessed resources, most found the resources helpful. A small number did not find the resources helpful.

Although the most commonly selected goals were *Nurturing a trauma-informed and responsive workforce*; *Consumer-driven care and services* and *Early screening and assessment*, almost all contacts reported accessing the resources related *Create a safe and secure environment*. Resources that were reported by the most respondents as helpful resources were those related to *Nurturing a trauma-informed and responsive workforce* and *Create a safe and secure environment.*

Respondents were also asked to report whether they had accessed National Council *webinars*. The most accessed webinar was related to the goal of *Nurturing a trauma-informed and responsive workforce,* followed by the goal of *Creating a safe and secure environment*. Each of these was reported to be helpful by more than half of respondents. The other goals were all accessed by about half of respondents, and were perceived as helpful with the exception of the webinar on *Engage in community outreach and partnership building* reported by one respondent, and had the lowest reported level of helpfulness among all goals. In addition, 14 respondents reported utilizing resources from the NCTSN in their transformation work.

Figure 16: Perceptions and Use of National Council Webinars by Domain



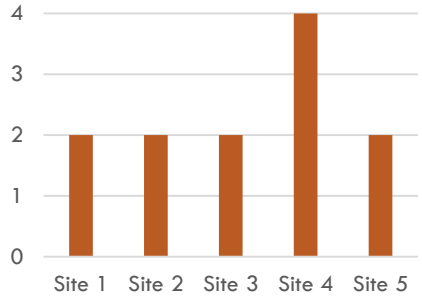
Progress on Trauma-Informed Care Domains

Team leads were asked to report on the progress that their team has made on each of the learning collaborative domains they had selected as well as to highlight the greatest accomplishment for the year.

Domain 1: Early Screening and Assessment. Early screening and assessment was chosen by 5 organizations (35.7%). The majority of organizations reported "moderate" progress on their efforts to implement trauma-informed early screening and assessments and one reported fully accomplishment of their goals. The following accomplishments were reported by participating sites:

- Our intake staff are using the CANS and ANSA and focusing on screening for trauma at program entry;
- One program implemented a new trauma assessment and is conducting a pilot program to work out the flow of trauma-focused services;
- One site realized internal programs were using many different tools and worked to choose two tools that could be used across all program areas;
- We began using the ACE for youth and the PCL-5 to screen and assess for trauma and better inform care planning and service delivery;
- One site is revising their intake interview to be more sensitive to trauma and change questions that may be triggering; they also have added more trauma types to their psychosocial intake assessment.

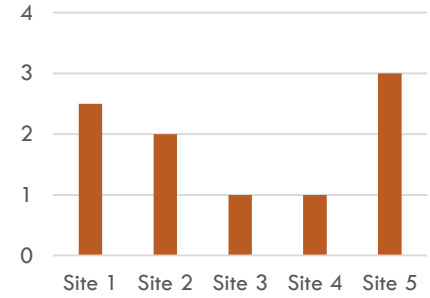
Figure 17. Progress on Domain 1 0=No progress, 2=Moderate progress, 4=Goals accomplished



Domain 2: Consumer-driven Care and Services. Consumer- driven care and services was selected by 5 organizations (35.7%). Two sites reported "a small amount" of progress, with others reporting "moderate" to "a great deal" of progress. The following accomplishments were reported by participating sites:

- Several sites reported having one or more persons with lived experience on their implementation team.
- One site reported gathering input from current consumers via surveys and focus groups.
- One site began a peer workforce initiative to recruit and retain peer support providers through employed or voluntary positions. This site has a subcommittee working with existing peers to examine recruitment, training, and certification efforts for peer workforce.
- One site stated they have peers on their workforce.
- One site reported that they have added a new client satisfaction survey with multiple access portals.

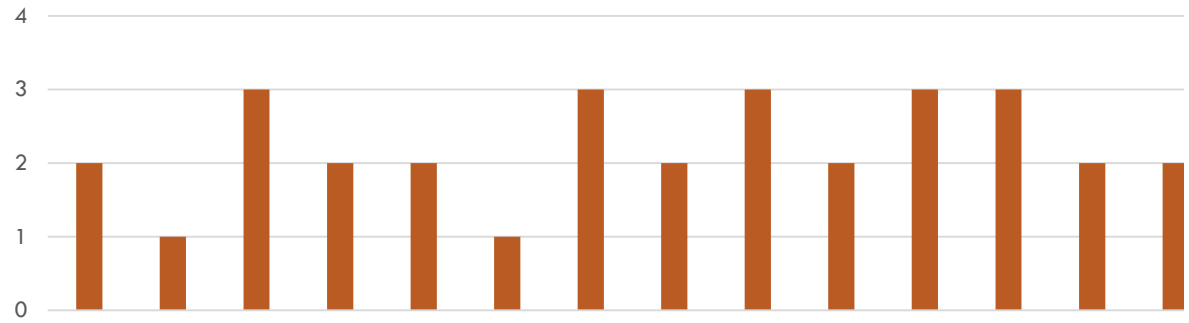
Figure 18. Progress on Domain 2 0=No progress, 2=Moderate progress, 4=Goals accomplished



Domain 3: Trauma-Informed Workforce. All participating sites addressed Domain 3, *Nurturing a Trauma-Informed and Responsive Workforce* (100%). Two sites reported "a small amount" of progress. The majority of sites reported either "moderate" progress (50%) or "a great deal" of progress (35.7%). Many of the sites reported developing a training for staff focused on the prevalence and impact of trauma, including one site that reported training 1,100 employees in the basics of trauma and another that has trained 50% of their 2,000 employees. Some sites had developed training during the course of the project and were getting ready to roll it out in the coming months. Additional accomplishments reported by participating sites included:

- One site reported conducting constant surveillance of customer service.
- One site reported incorporating self-care tips on mailers and other internal documents that staff see, read, and act on frequently. Several other sites have begun sending out weekly TIC tips to staff, frequently focused on self-care.
- One site reported that leadership implemented strategies to gather staff input into clinical and administrative policies that directly impact their work experience.
- One site experienced a significant restructuring during the course of the learning collaborative and worked to implement trauma-informed practices when transitioning clients and staff.
- Two sites described restructuring job descriptions and performance evaluations to include trauma-informed expectations of staff.
- One site has instigated a monthly staff training on trauma informed care and trained staff in Mental Health First Aide.
- One organization has focused on training leadership throughout the organization and piloted a training on trauma informed care transformation.
- One site is working to add a trauma-informed customer service training to be embedded in new employee orientation.
- One site reported that team members have been asked several times to lead the response following a staff crisis, as the agency is coming to understand the effects of vicarious trauma and secondary exposure to trauma.
- One site has added the use of the Professional Quality of Life (ProQOL) to clinical supervision and is exploring adding an employee assistance program.

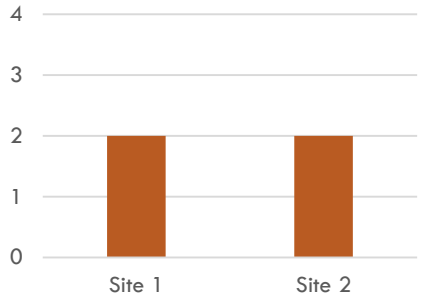
Figure 19. Progress on Domain 3
0=No progress, 2=Moderate progress, 4=Goals accomplished



Domain 4: Evidence-based and Emerging Practices.

Evidence-based and Emerging Practices was chosen by two of the participating sites (14.3%). Both sites indicated that they were able to make "moderate" progress over the course of the year, however, it was not clear that specific progress was made through incorporating additional trauma practices. The following accomplishments were reported by participating sites:

Figure 20. Progress on Domain 4
0=No progress, 2=Moderate progress, 4=Goals accomplished

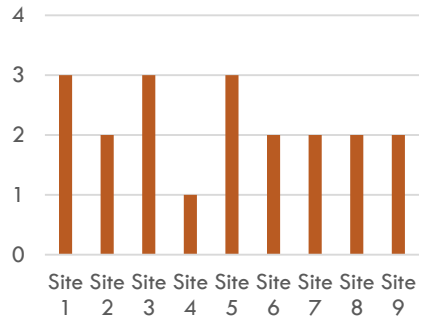


- One site reported having an impact on the intake process by adding trauma therapists to the pool of intake workers and decreasing wait time.
- One site reported routinely using evidence based therapies, including CPT, CBT, TF-CBT or EMDR.
- One site reported that the substance abuse prevention program they use is an evidence-based practice.

Domain 5: Safe and Secure Environment. Nine of the fourteen sites (64.3%) chose to focus on creating safe and secure environments. The majority of sites reported "moderate" progress toward their goals (55.6%), with an additional 33.3% reporting "a great deal" of progress. The following accomplishments were reported by participating sites:

- One site conducted a recent client survey on feeling safe within the treatment facility demonstrating 92% felt safe.
- One agency reported working on the design of a new mental health clinic, designed with a more open lobby, improved signage, and a calmer, less clinical feel.
- Another site improved the arrangement of their lobbies to make them more open and welcoming.
- One site changed some of the wording and appearance of signs to make them less abrupt (and/or harsh) sounding. Another posted a non-discrimination statement to alleviate concerns about discrimination around sexual orientation.

Figure 21. Progress on Domain 5
0=No progress, 2=Moderate progress, 4=Goals accomplished

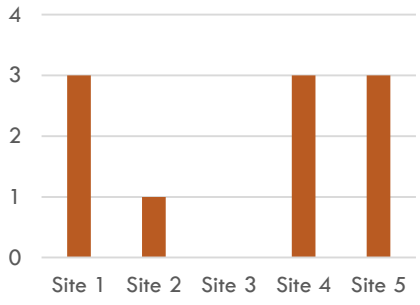


- One site reported providing physical safety training for all staff and rearranged the location of staff to decrease the anxiety of a staff member who was secluded.
- One site reported implementing client safety and comfort measures in the waiting room, such as providing bottled water and snacks and another reported arranging chairs so no one has to sit with backs to the door.
- All doors in to office locked except front door, buzzer entry to where staff are located.
- One team was approved by the building committee to participate in decisions related to refurbishing existing facilities, including choices of paint color, flooring and lighting.

Domain 6: Engage in Community Outreach and Partnership. Five organizations (64.3%) selected community outreach and partnership as a focus of the learning collaborative. Three of the five organizations reported "a great deal" of progress on their goals, with one site reporting "a small amount" of progress and another no progress. The following accomplishments were reported by participating sites:

- One organization informed and educated faith based leaders and community gatekeepers on trauma-informed care and trauma-informed communities.
- This organization also engaged a faith based leader (also a parent of an individual in services) to participate in the learning collaborative.
- One organization reported providing trauma-informed care to organizations in region prior to the learning collaborative and throughout it.

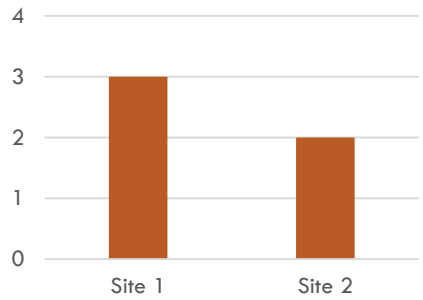
Figure 22. Progress on Domain 6
0=No progress, 2=Moderate progress, 4=Goals accomplished



- One agency partnered with a county-wide program to bring information related to trauma to a larger audience, through outreach and education.
- On agency partnered with the Metro Dallas Homeless Alliance in North Texas to bring a trauma expert to the community for a leadership training.
- One organization hosted two 6-hour workshops in the community on trauma-informed care, training more than 70 individuals.

Domain 7: On-going Performance Improvement and Evaluation. Only two agencies (14.3%) chose to focus on performance improvement and evaluation. One reported "a great deal" of progress on their goals and another reported "moderate" progress. The following accomplishments were reported by participating sites:

Figure 23. Progress on Domain 7 0=No progress, 2=Moderate progress, 4=Goals accomplished

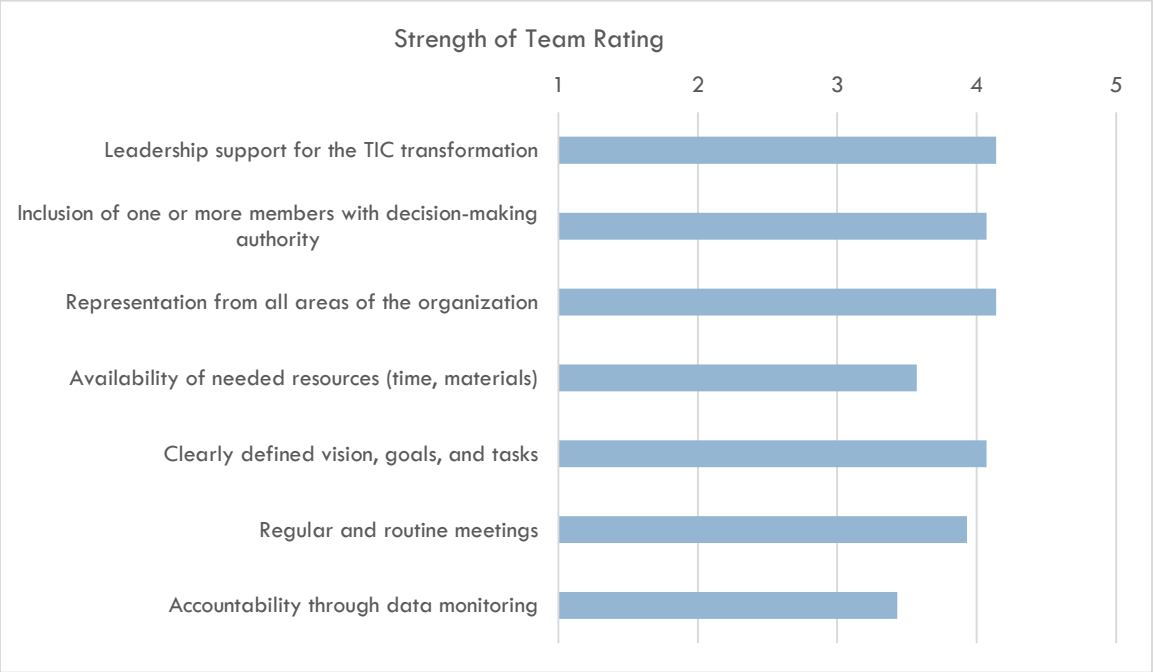


- One site has implemented a knowledge test for staff related to trauma-informed care concepts. They have conducted the pre-test and are preparing to conduct the post-test to evaluate the impact of trainings.
- One site has noted that informal feedback from staff after training sessions has dramatically improved, as well as the level of participation and comfort of the staff.
- One site stated that they have conducted the Organizational Self-Assessment (OSA) tool, the Project Management Tool (PMT) and client feedback surveys during the learning collaborative.

Impact of Implementation Strength on Progress

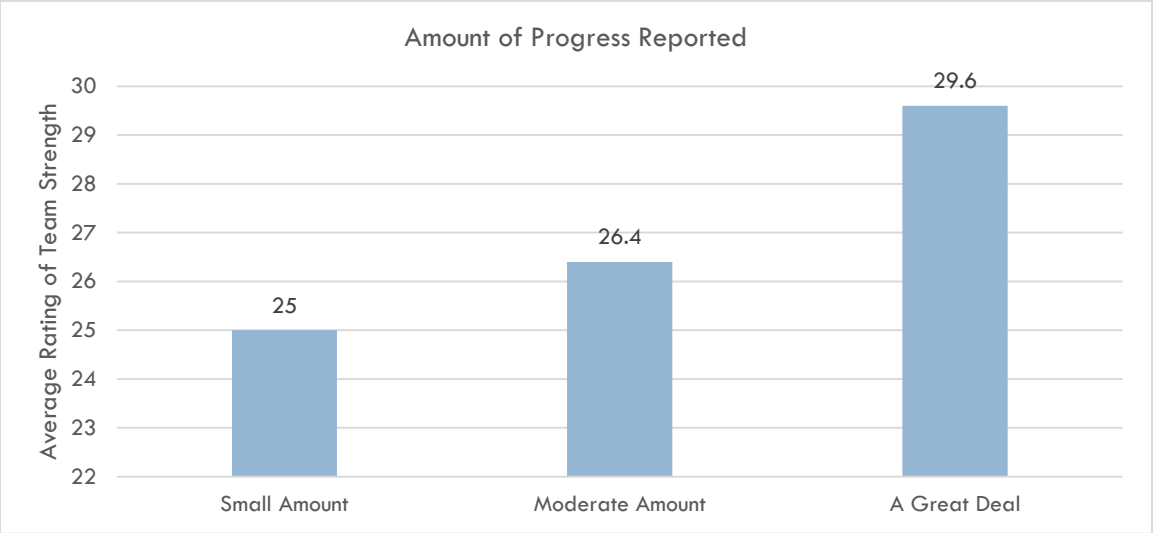
In order to understand the factors that may impact progress within the learning collaborative, teams (or team leads) were asked to report the strength of various aspects of their teams, including the level of leadership support, representation of decision makers on team, availability of resources, defined goals, regular meetings and accountability. In general, team strength did not significantly change over the course of the year-long learning collaborative, and teams reported moderate to high strengths on all scale items. Having available resources, such as time and materials, and ensuring accountability through data monitoring were the lowest scored items. Ratings on team strength from the final survey are reported in Figure 24.

Figure 24: Average Team Strength



Ratings across all elements of team strengths were combined to create a summary measure for each organization. Participating organizations were split into three groups, those who reported small progress (average change score of 1 across domains), moderate progress (average score of 1.5-2.4 across domains, and a great deal of progress (average score of 2.5-3). To examine the possible relationship between the strength of the implementation team and the progress that was accomplished during the learning collaborative, average ratings of team strength is examined across the three levels of progress. Results are shown in Figure 25. Organizations who reported a significant amount of progress over the course of the year tended to report greater strengths on the rating of their implementation team.

Figure 25. Average Strength of Implementation for Small, Moderate, and Great Progress



Qualitative Themes from Trauma Informed Care Learning Collaborative

Evaluation staff observed and took notes during learning collaborative coaching calls and during mid-year and end-of-year presentations. Each participating site was also asked to present on accomplishments, barriers, and lessons learned at the final meeting of the learning collaborative. The following themes were identified through an analysis of the final presentations and through review of notes obtained during coaching calls with sites throughout the year. Themes are presented by domain.

Early Screening & Comprehensive Assessment of Trauma. To address the domain of Early Screening and Assessment of Trauma, organizations reported that it was critical to make sure that staff were trained early and had a core understanding of trauma-informed care. For example, many organizations focusing on this domain incorporated trauma-informed language and expectations into job applications and made efforts to incorporate trauma-specific training into staff orientation. This core training set the stage for creating greater uniformity across divisions in terms of the consistent use of trauma assessments and systematic administration. Specifically, organizations aimed to systematize the delivery of the following assessment tools and screeners: Patient Health Questionnaire 9 (PHQ-9), Generalized Anxiety Disorder 7 (GAD-7), PTSD Symptom Scale Interview 5 (PSSI-5), and the Columbia Suicide Severity Rating Scale (CSSR-S).

Some organizations noted difficulty with modifying intake and assessment instruments to reflect trauma-specific information, as well as increased intake time and additional effort by staff to tailor each tool. However, potential solutions to these challenges included the addition of intake

staff to address the need for more time during assessment as well as the belief that the assessment process would be smoother once the instruments were modified and trauma-specific questions were an ongoing part of the assessment process.

Consumer-Driven Care (Lived Experience) & Services. An important component of ensuring that program implementation honored a consumer-driven model of care was through adding individuals to the implementation team that had lived experience. Pecan Valley Center cited this practice as a contributing factor to their successful implementation of trauma-informed, consumer-driven care. Additionally, they recommended a system that creates a source of client feedback about services. Their center participated in the creation of client feedback survey regarding trauma-related services. Beyond the establishment of a system enabling client feedback, ensuring that this system would be available across different modalities (i.e. online, paper-based formats, phone hotlines) was reported as a useful consideration.

Another avenue for gathering client input to ensure the provision of client-centered care was to create a client advisory committee. Ysleta del Sur Pueblo indicated that a large portion of their success in this domain was due to "using ideas from persons with lived experiences" in a workgroup that was established with the intention of ensuring that client interests were well represented and at the forefront of care delivery strategies.

Trauma-Informed, Educated & Responsive Workforce. A primary theme identified as a positive contributing factor to implementation was that of creating a cultural transformation within the organization that produced long-term change rather than making changes following a training that were not maintained. A holistic shift in approach and mentality reportedly led to a more sustainable structure that promoted lasting uptake of trauma-informed approaches. In that vein, internal structures that included workgroups through which tasks could be delegated was a key factor associated with successful progress over time. Implementation teams found that planning out simple and manageable goals around implementation and choosing goals that were most feasible was an effective strategy. Conversely, difficulties in implementation came into play when staff tried to "take everything on at once" which led to the inability to incorporate any identified needed changes.

Establishing internal workgroups that met frequently also served the purpose of building leadership buy-in and support that served to shift the workforce towards a trauma-informed culture of care. One site indicated that they held "quarterly meetings with TIC and Trauma Champions who (would) then report out to (the) executive leadership team for (the) implementation of changes." Establishing a system of internal input around project implementation created a collaborative process of communication between program staff and leadership that supported success. In this vein, it created a sense of support around the project,

as input for better implementation practices were coming from an established internal structure. According to Christina Marshall, a clinical practitioner at the Center for Healthcare Services, "… we want to ensure that the members of the team stay a consistent representation of the majority of divisional or programs from around the organization."

Internal workgroups could then establish clear goals in terms of changing human resources activities to be trauma informed. Several of the organizations, for example, made changes to job descriptions, job advertisements, and annual evaluation forms to ensure that trauma-informed knowledge and skills was a clear expectation for the workforce. Others focused on enhancing employee orientations and on-the-job training to ensure that the workforce had the necessary knowledge, skills and competencies for a trauma-informed system.

The main barrier cited by most organizations was insufficient resources. As Evelyn Locklin, Harris Center Program Director and Trauma Informed Care Core Implementation Team Lead, noted, "The lack of time and resources is all too common a theme in our field." Organizations that identified this barrier brainstormed primarily around partnering with outside centers in order to pool resources to establish a workforce that was more readily educated around trauma-informed care. Jessica Demasi, Director of Training for DePelchin Children's Center, said that her organization would plan to "partner with other organizations (in order to) solicit more funding." The Harris Center indicated a similar line of thinking around taking a collective approach to strengthen local resources.

Another common barrier was communication breakdowns that could occur across multiple sites within the same organization or really large organizations with very large numbers of staff to engage. Organizations found success when information was standardized and made more readily available across all components of the system, such as through a unique web-based portal or through standardization of training modules. Organizations also found it helpful for staff to better understand their role in trauma-informed care and the relevance of these approaches to their practice when the broader community was engaged. Creating a larger, community-wide context for trauma-informed care was recommended to promote a culture of trauma informed practices and allow organizations to feel connected to a larger movement.

Informed Evidence Based and Emerging Best Practices. Organizations' ideas around establishing and sustaining evidence-based practices commonly indicated the need to be connected to best practice sites or to have examples of best practices available as a basis for comparison. Many sites indicated that they had made efforts to actively reassess their present practices and to explore modalities that were more consistent with the research with the intention of incorporating them into their organization's system of care. A common approach was to create a center of accessible information around evidence-based practices available to all staff within the

organization. The Trauma Informed Care Team at MHMR of Tarrant County said that they "researched best practices and created a library of information for all to access." Establishing a frequently updated system to house and make available research around best practices was also cited as a helpful construct to address the main barrier in changing current practices to more readily reflect research recommendations for care provision. Several organizations indicated that they lacked access to examples of different trauma interventions and that they needed more examples of work being done that reflected the incorporation of best practices.

Safe and Secure Environments. The primary method of ensuring safe and secure environments cited by those focusing on this domain was that of frequently reassessing and modifying center environments to meet standards of trauma-informed care. Modifications such as creating a "decompression space" for staff to collect their thoughts and regulate emotional reactions was a common addition to care environments. Similarly, creating language that warned against trigger words or that was more sensitive to those who had undergone trauma were also referenced. According to Marisol Acosta, Project Director and Program Specialist at the Mental Health and Substance Abuse Division within DSHS, "Environmental Scans will be used to help in the move of staff to new buildings in the HHSC transition to implement the use of concrete strategies."

Community Outreach and Partnership Building. Some implementation teams expanded their efforts to raise awareness and engage partners in the community. For example, MHMR of Tarrant County reported that "as a part of the Mental Health Connection Trauma Committee, we are developing a community campaign utilizing ACES to educate the community on the effects of trauma as it relates to physical health." Darlene Dotson, Coalition Program Manager and TIC Coordinator at the East Texas Council on Alcoholism and Drug Abuse also spoke to how her organization made a broader external impact. She reflected, "A Member of the TIC Implementation Team- our Regional Evaluator - started using his TIC knowledge as he made presentations about data to various groups in our contracted area. This included presentations to college classrooms, public school teachers and most recently to a conference of School Resource and Police Officers."

The main challenge indicated with regard to community engagement was that it could be difficult to obtain buy-in from key individuals external to the organization. Telawna Kirbie, Assistant Director at the Klaras Center for Families in the Heart of Texas Region MHMR said that her organization planned to enact a solution in which they would "begin looking at ways to provide trauma-informed training to our community partners" as well as "integrating ongoing awareness of TIC through the agency newsletter." Tools such as social media were also cited as being potential outlets for reaching community members on a larger scale.

Ongoing Performance Improvement and Evaluation. Leadership support was identified as a key factor in ensuring that performance improvement and continuous evaluation was integrated into organizational procedures. In addition to the formation of workgroups dedicated to the implementation of trauma-informed approaches, the creation of a "champion role" was a commonly employed tactic to ensure a focus on performance improvement and evaluation. According to Telawna Kirbie, "It would be ideal to have someone on staff dedicated to sustaining TIC and provide ongoing support, training, education, implementation as well as additional support for addressing secondary traumatic stress in the workplace." Larger organizations, particularly those with multiple locations, cited a lack of effective communication as an implementation barrier to ongoing performance improvement and evaluation. Specifically, these sites had difficulty translating systematic changes and practices across the large numbers of employees who were distributed across several geographic areas.

The Texas Trauma Informed Care Summit

Texas wrapped up the four-year initiative with a four-day Trauma-Informed Care Summit in August 2016. The Summit consisted of two days of preconference workshops, including a training in TF-CBT and the Core Competencies for Childhood Trauma. The preconference activities also included the final meeting of the Trauma Informed Care Learning Collaborative. Preconference events were followed by a two-day conference, consisting of keynote speeches and breakout sessions. More than 335 individuals attended the event. For this report, 1,610 participant evaluation forms were summarized across 20 breakout sessions. While ratings have been calculated for each presentation separately to assess quality for subsequent training events, a summary of scores across all Summit presentations is included in this report (See Table 24).

Overall, participants reported that the presenters were very knowledgeable, well-prepared and organized. Participants also reported that the information was useful to their work and met their expectations, although ratings were slightly lower for these questions.

Table 24. Participant Feedback on Breakout Sessions

	Mean	*Standard Deviation*
The presenter(s) was knowledgeable on the topic.	1.55	1.17
The presenter was well-prepared and organized.	1.61	1.17
I learned new information from the presentation.	1.81	1.19

I will use information that I learned right away in my work.	1.90	1.20
Overall, the session met my expectations.	1.82	1.22

* Note. The scale ranges from 1 (strongly agree) to 5 (strongly disagree).

SUSTAINABILITY

From year one, TCRFT implemented the scope of work with a long-term vision of trauma informed care sustainability. As a result, the following elements of sustainability are in place at the end of the project period:

- Trauma Focused Evidence-Based Practices are required in the Texas Resilience and Recovery service delivery system for children and adolescent mental health services:
  - Trauma Focused EBPs protocols and procedures are supported by policies and contract requirements.
  - Trauma screenings are incorporated as universal screening as part of the uniform assessment of all children and youth entering community mental health services.
  - TF-CBT and PCIT are part of the TRR service array for available counseling treatment modalities for children, youth and their families.
  - Providers are hold accountable to a higher standard of training and competency as required by state policy.
  - State Trainers were develop to provide training on the following: Texas CANS (trauma screenings and comprehensive assessment), PCIT, Core Curriculum on Childhood Trauma and Trauma Informed Care.
  - The state's Centralized Training Infrastructure of Evidence-based Practices supports through state funding the provision of CANS Superuser training, TF-CBT and PCIT.
  - On-going NCTSN partnerships with other NCTSN Partners and Members support training and technical assistance on EBPs , TIC and Secondary Traumatic Stress.
- Trauma Informed Care Organizational Transformation:
  - A TIC Organizational Transformation Pilot included all community behavioral health service types. The information gathered through this pilot has helped the MHSA TIC Transformation Team create an implementation plan that continues TIC transformation after the end of the project period.
  - An MHSA TIC Transformation Team that consists of representatives of community behavioral health services section, executive leadership and persons with lived experienced meet continues meeting at least once a month working on the implementation of TIC transformation.

- A BHS Plan of Action and Implementation Plan for FY 17 has been created focusing on three TIC Domains of Implementation. Three subcommittees have been created to support the implementation of these domains: (1) TIC Training, (2) Creating Safe and Secure Environments, (3) Partnering with Persons with Lived Experience.
- The Statewide Behavioral Health Strategic Plan of HHSC from 2017 to 2021 defines trauma informed care as the 4th guiding principles for the strategic plan for all behavioral health services in Texas.

- Community Partnerships:
  - Children and Youth Behavioral Health Advisory Subcommittee- continues overseeing the TCRFT initiative after the project period and trauma informed care transformation in collaboration with Texas Systems of Care initiative.
  - Texas Systems of Care Initiative and the Texas Institute for Excellence in Mental Health of the University of Texas at Austin- Technical assistance and training on trauma informed care and partnering with persons with lived experience is coordinated through this on-going partnership.
  - Trauma Informed Network of Texas was created at the end of the project period to continue fostering community partnerships that help disseminate trauma informed care and sustain efforts that help prevent, identify and address the impact of trauma in communities throughout Texas.
  - HHSC Veterans Interagency Collaborative Group – TCRFT staff participate in this state interagency workgroup focusing on addressing the need of children of military and veteran families in Texas.
  - NCTSN Affiliate Members – TCRFT initiative and HHSC continues to be an active participant and collaborative member of the National Child Traumatic Stress Network of SAMHSA through the following NCTSN Collaborative Groups: Military Families, VA Subcommittee, STS Collaborative Group, Partnering with Youth and Families, Culture, Translation Subcommittee, Complex Trauma, Community Violence and Policy. Current partnerships with NCTSN Partner members continue to support the following practices and trainings in Texas through the TCRFT initiative:
    - Military TF-CBT Training through Allegheny (Category II Partner) and SCAN Inc. (Category III Partner).
    - Core Curriculum on Childhood Trauma – NCTSN Facilitators Group
    - TARGET through University of Connecticut (Category II Partner)
    - STS Training and Technical Assistance, and the use of the STSI-OA – University of Kentucky (Category II Partner)

Final Summary and Recommendations

Overall, TCRFT was able to accomplish all of the broad goals set out for the initiative. DSHS, as the state mental health authority, was able to establish a broad priority for the system to strengthen the practices that impact individuals who have experienced trauma. This leadership resulted in changes that occurred across the state and local organizations and impacted mental health providers, children, and families. A summary of findings, key lessons learned through the evaluation of this initiative, and recommendations are provided below.

Summary of Findings:

- Significant impacts were made in the development of the workforce to be better prepared to provide trauma-informed services. The majority of trainings focused on trauma-informed care and trauma-specific specialty topics, but a significant number of providers were trained in trauma screening and assessment, Trauma-Focused-CBT, and PCIT.
- Strong collaborations were developed around shared goals for improving the systems that serve children who have experienced trauma. Collaborations with mental health organizations, substance abuse organizations, and family leaders were the strongest.
- Providers were very open to implementing evidence-based practices and valued the training that they received. The majority of providers participated in coaching calls following the workshop training and used the treatment model with children in their practice setting. Most providers utilized the model with just a few children as they implemented, rather than specializing in that treatment approach.
- Many families did not complete the full course of treatment, with the average attending only seven or eight sessions. Retention in TF-CBT was slightly higher than PCIT.
- Providers were adherent to most aspects of the treatment model, including the provision of homework and the teaching of key skills. Providers were less compliant with the inclusion of parents within the TF-CBT treatment and the provision of parenting skills sessions.
- Children showed significant improvement on all outcome measures, including self-reports from children, reports from parents, and reports from providers. Children and parents also reported satisfaction with the services received.
- Creating a strong implementation team was a critical factor in organizational changes to support trauma-informed care. Representation from across different divisions and the inclusion of champions on the team were also critical.
- Organizations tended to begin their organizational change by building buy-in from leadership and providing training to the workforce. On-going communication to raise awareness of trauma-informed care was also a successful strategy.
- Organizations were able to achieve moderate progress, on average, across two or three domains of trauma-informed care, but planned to continue working to achieve additional transformational goals.

Lessons Learned:

- Providers working within the public mental health system have greater access to trainings on evidence-based practices. Expanding these opportunities to other child-serving providers within the community significantly increases the impact of the training and serves to build collaborations and partnerships. Almost half of the youth served through TCRFT were served by providers who were given the opportunity for training, but received no direct support to incentivize implementation.
- Most providers will use a variety of treatment approaches in their work and may have challenges to practicing with an intensity that builds competency quickly. Organizations should consider allowing providers to focus their treatment on a targeted intervention during the time they are receiving coaching support (e.g., more than half of their caseload), so that key skills and competencies can be built and become "usual care."
- Most children and families within the public mental health system will not complete the majority of planned sessions within the evidence-based models. However, most are experiencing significant improvement in symptoms, which may be the impetus for families to end care. Providers should strive to build discussion of key components of the care into early treatment sessions, allowing for at least some exposure to these concepts. For example, children receiving TF-CBT can participate in early exposure activities during skills building components to gain a sense of mastery over the traumatic content, even if they do not participate in the trauma narrative.
- Implementation teams that are focused on organizational change will accomplish the most when they have strong leadership support, a diverse, enthusiastic set of members, and readily available resources to make desired changes. Implementation teams that had to create all of their successes "from scratch" struggled to keep team members engaged and overcome the limited time that members had available.

Recommendations for the Future:

- The TCRFT made significant impacts at the organizational, workforce, and child and family levels with modest funding. The state should consider utilizing a modest amount of discretional funding (e.g., block grant) to continue to support the implementation of trauma-focused treatment approaches and trauma-informed practices within the service system.
- Texas should continue to examine strategies to embed evidence-based screenings for trauma within agency practices. Despite success in implementing the CANS, many youth who had clear elevations on trauma assessments were not identified on the CANS Adjustment to Trauma item as having a treatment need. Embedding a strong trauma scale within the CANS process will likely increase the appropriate identification of children.
- Texas should consider financial mechanisms for incentivizing the use of high-quality, high-fidelity evidence-based treatment approaches, such as the use of higher reimbursement rates for counseling provided by a certified TF-CBT or PCIT provider.
- Opportunities for communities or regions of the state to share resources and build competency in trauma-informed approaches should be supported, as this is likely to

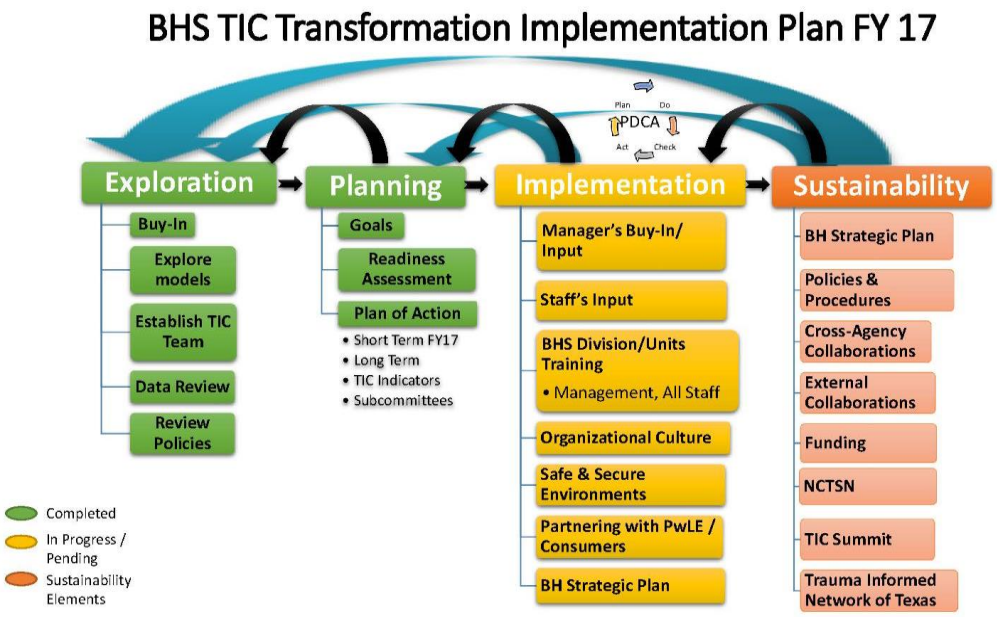
maintain the buy-in of key champions across the state, and create efficiencies in transformational efforts.

- The state should continue to proactively incentivize and support the inclusion of individuals with lived experience as participants in program planning, oversight, and quality improvement initiatives. Many organizations identified this as a key factor in their ability to identify and change practices that were likely unhelpful for individuals with trauma histories.

The Final Fiscal Report was submitted to SAMHSA by DSHS on December 29, 2016.

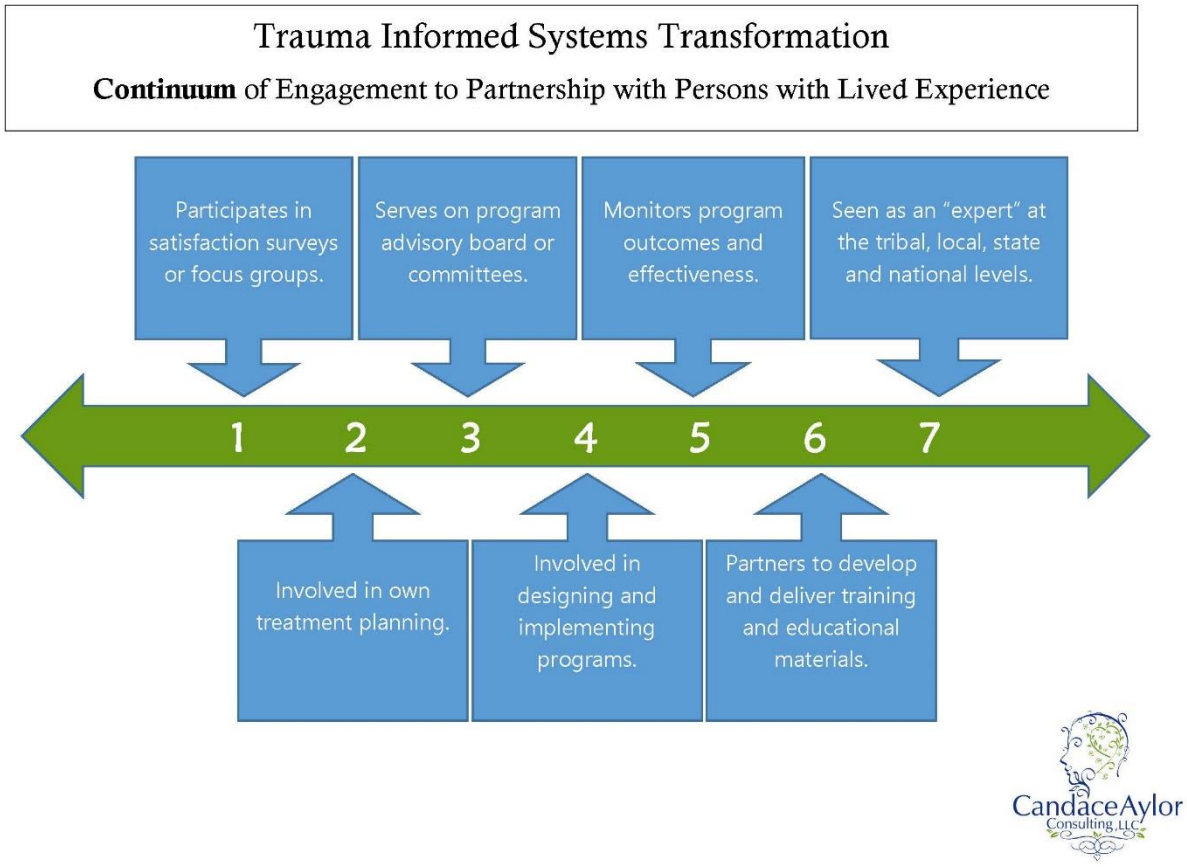
APPENDIX A.

Behavioral Health Services Trauma Informed Care Implementation Plan for FY 17



APPENDIX B.

Partnering with Persons with Lived Experiences Continuum



Credit: Alan Rabideau & Shannon CrossBear, Family Consultants Four Directions Training 2014

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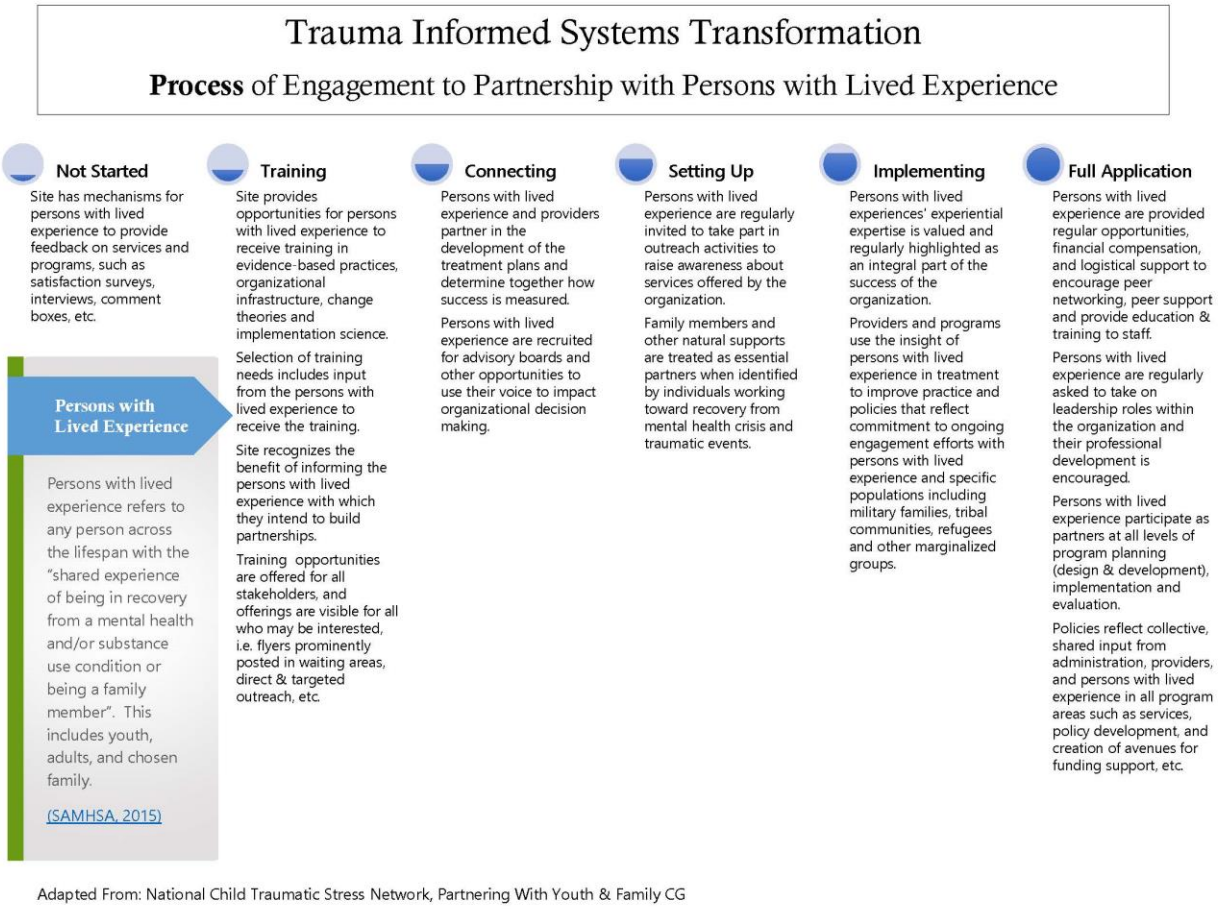

Adapted From: National Child Traumatic Stress Network, Partnering With Youth & Family CG

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