Texas Children Recovering from Trauma

Final Evaluation Report

Texas Institute for Excellence in Mental Health

Advancing Resilience and Recovery in Systems of Care

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Texas Institute for Excellence in Mental Health

Advancing Resilience and Recovery in Systems of Care

Overview of Project

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

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.

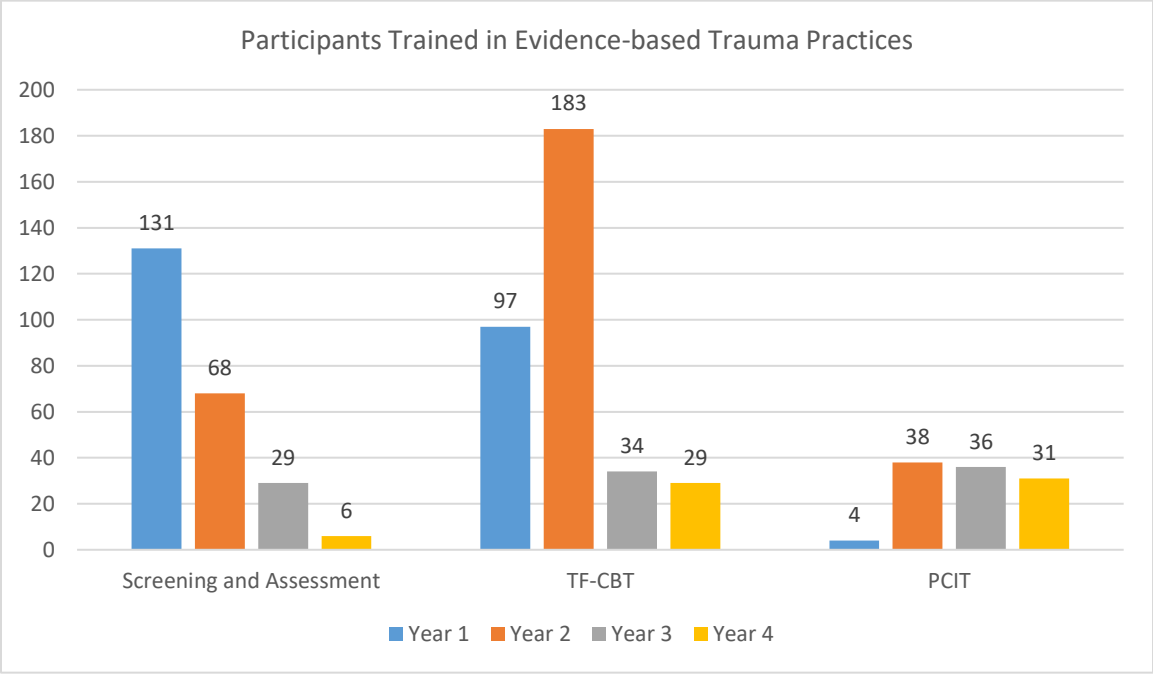
Cross-site Evaluation Infrastructure Measures

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 1.

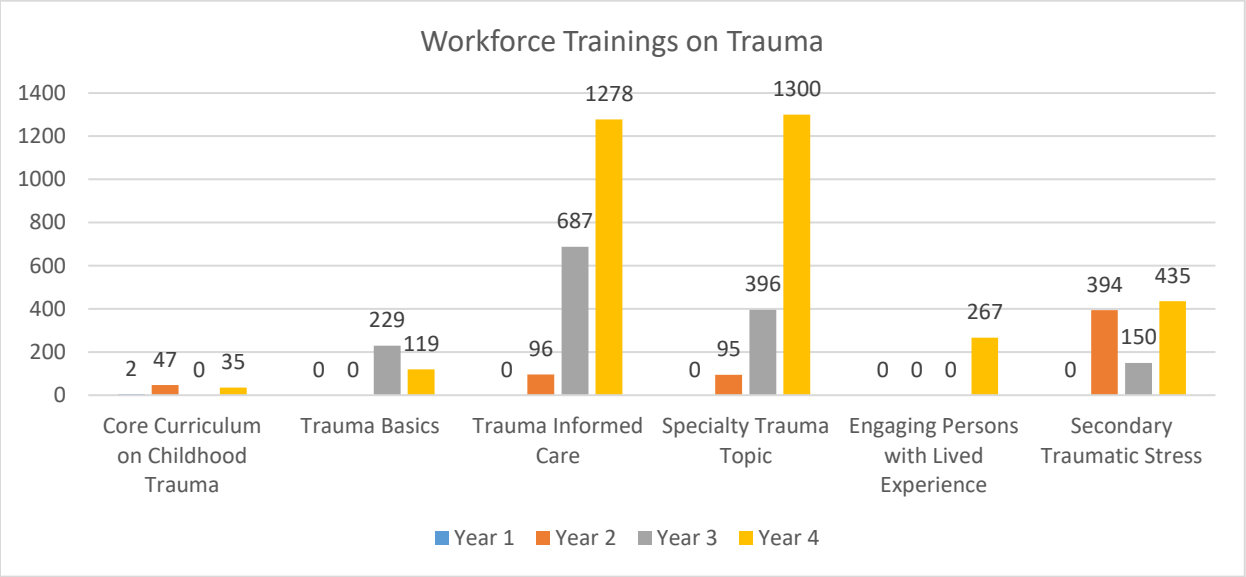
Figure 1. Cumulative Number of Participants in the TCRFT Evidence-based Practice Trainings



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.

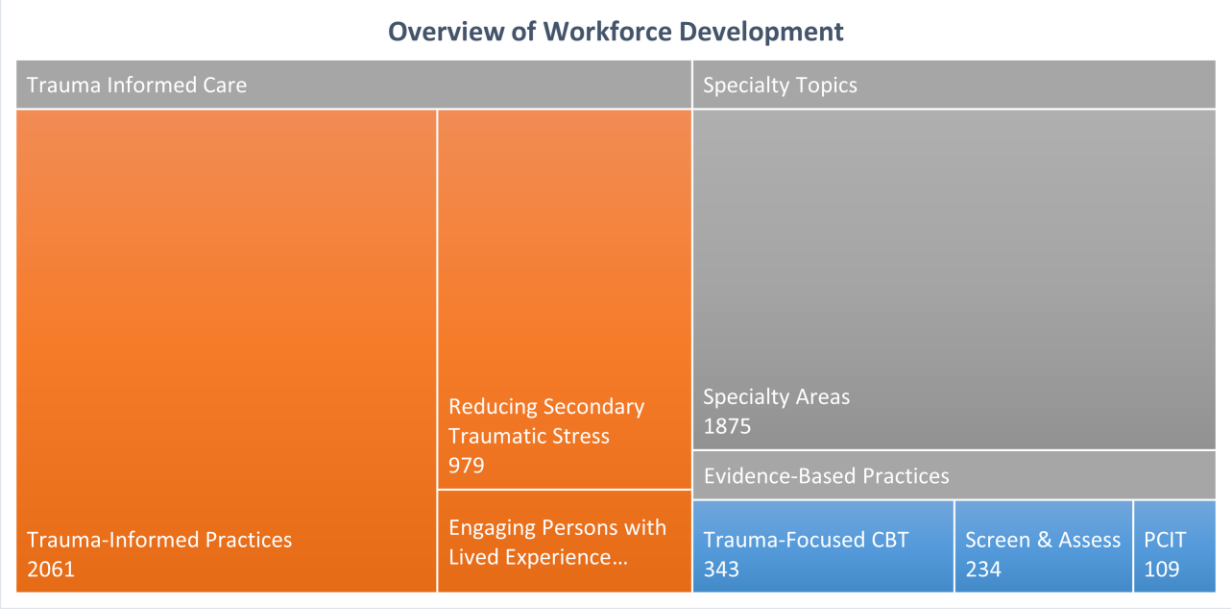
A second workforce development goal of the initiative was to train the broader workforce on the impact of trauma on children, trauma-informed approaches to care, and additional specialty topics in trauma-informed care. Particular emphasis was placed on trainings focused on engaging people with lived 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 2.

Figure 2. 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 3. Space within the figure represents the relative number of individuals trained in that topic area.

Figure 3. 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 1 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 1. 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 2 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 2. Average Number and Percentage of Consumer and Family Members on Work Group/Advisory Group/Council

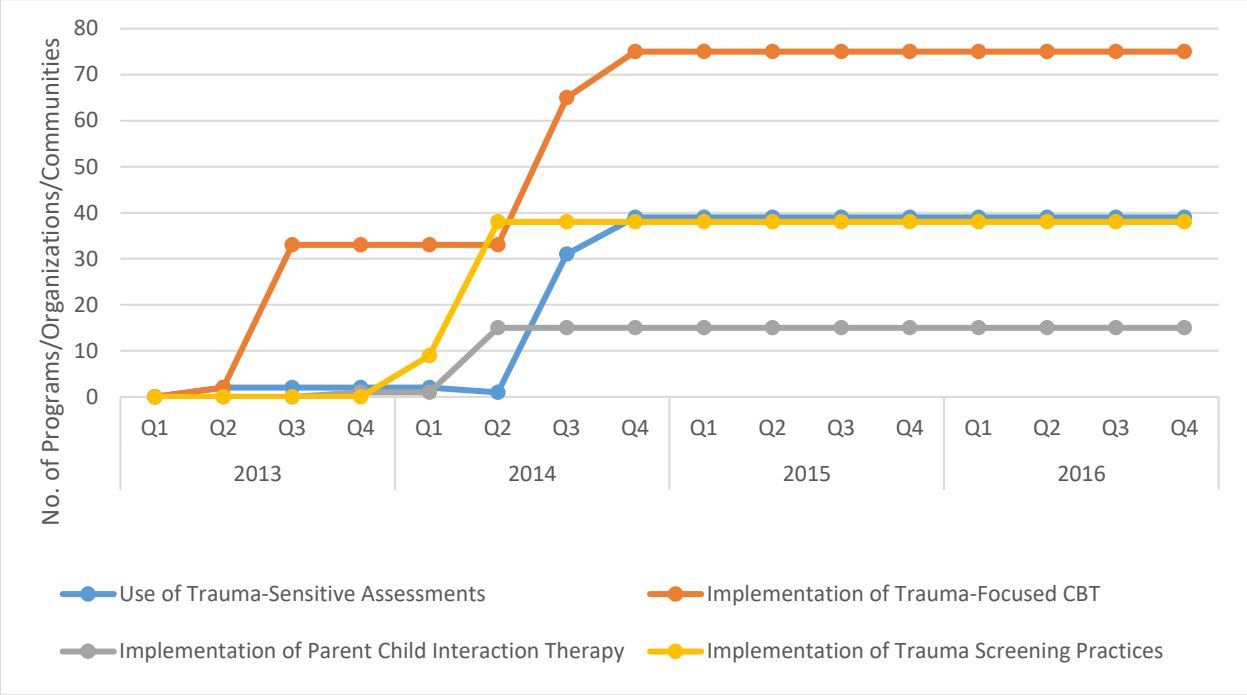
Group	2013	2014	2015	2016
State Steering Committee	2 (11.0%)	3 (13.4%)	4 (20.0%)	4 (22.3%)
Subcommittee for Family Representation	5.5 (85.7%)	4 (91.7%)	4 (66.7%)	4 (66.7%)
Youth Advisory Service Project	4 (100%)	-	-	-
Subcommittee for Back to School Event	-	4 (50%)	-	-
Local Youth Voice Committee	-	-	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 2 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

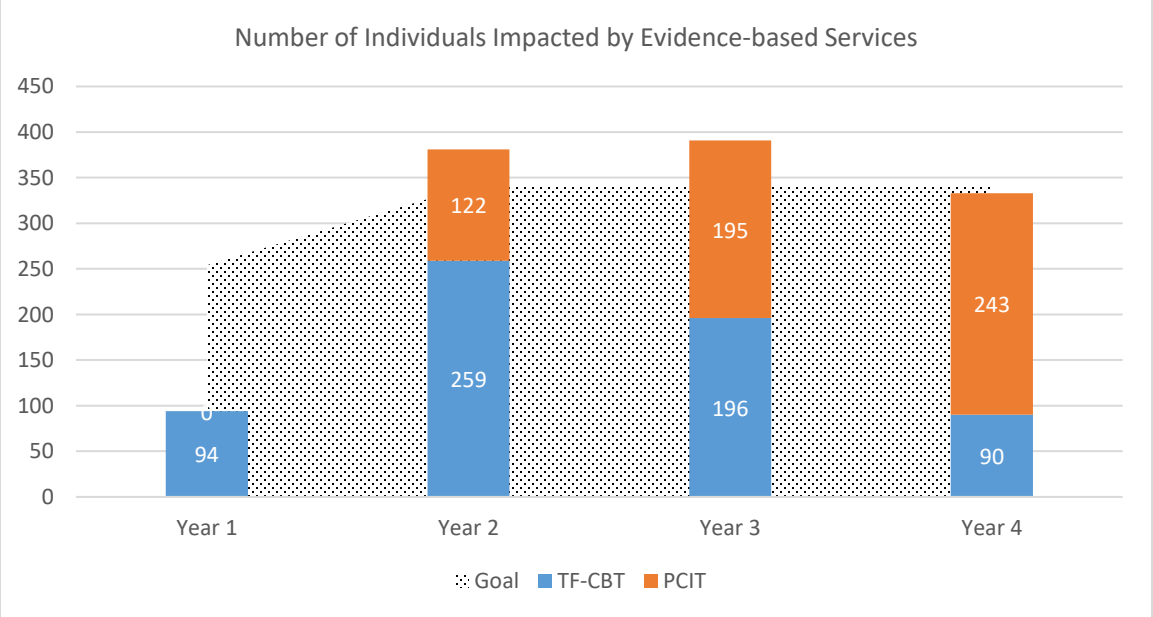
Another goal of the TCRFT initiative was to expand the number of organizations providing evidence-based screening, assessment, and trauma treatments, namely TF-CBT and PCIT. In addition to the workforce trained in these practices, the number or organizations in which these practices were embedded was measured. Figure 4 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 4. 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 5.

Figure 5. Annual Number of Individuals Impacted by Evidence-Based Mental Health-Related Services

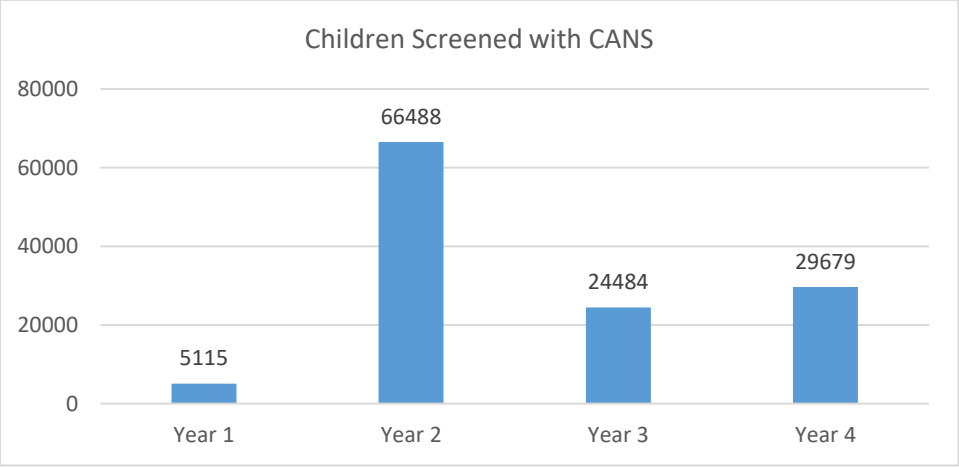


In Year 1, the initiative failed to meet the initial goal of 254 individuals served. In subsequent years, however, the initiative served a greater number of individuals than proposed and came very close to meeting the goal in the final year, when recruitment slowed down for project close-up activities. 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 6. 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 3. Overall, a total of 4,477 individuals at 24 different events were impacted by these activities

Table 3. 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 4 presents the average provider scores for the Total Score and four subscales in comparison to national norms of mental health providers.

Table 4. 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 5 by training type.

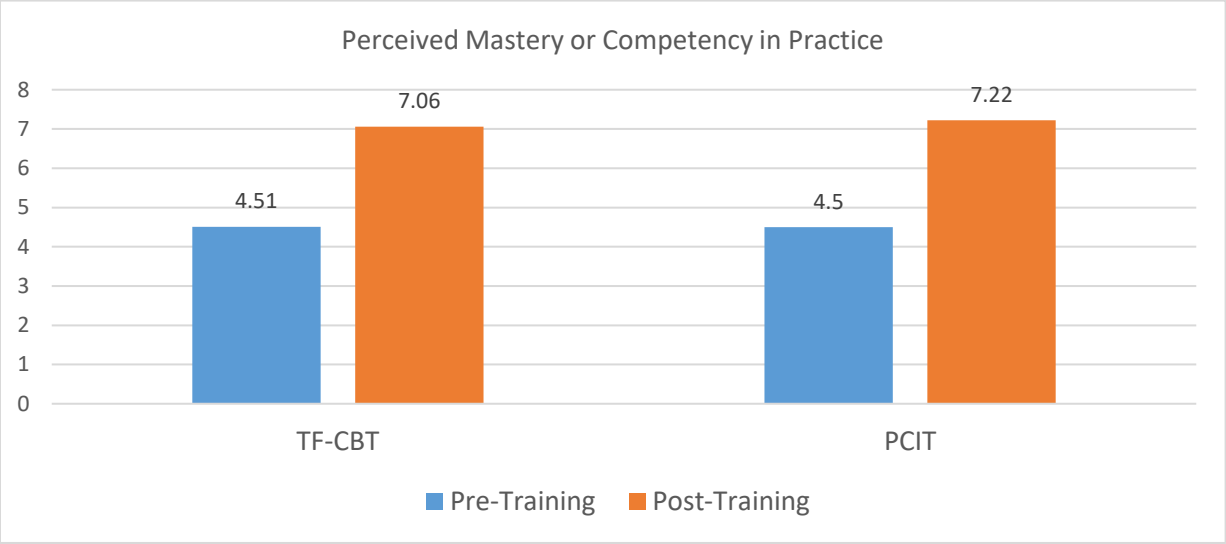
Table 5: Evaluation of Training

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 6.

Table 6. 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 7 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 7. 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 8. 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 8. 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 9. 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 9. 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 10. Results are presented separately for the Heart of Texas service site, as the primary partner in service delivery.

Table 10. 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 11 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 11. 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 12).

Table 12. 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 13. 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 13. 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 14. 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 Knowledge	7.1%	35.7%

Caregiver Strengths and Needs	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 15. 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 16 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 16. 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 17 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, administration). Other programmatic areas also included staff focused on special populations, such as the court system or foster children.

Table 17. 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 18. 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 19 and 20 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 19. 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 20. 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 21. 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 22 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 22. 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%

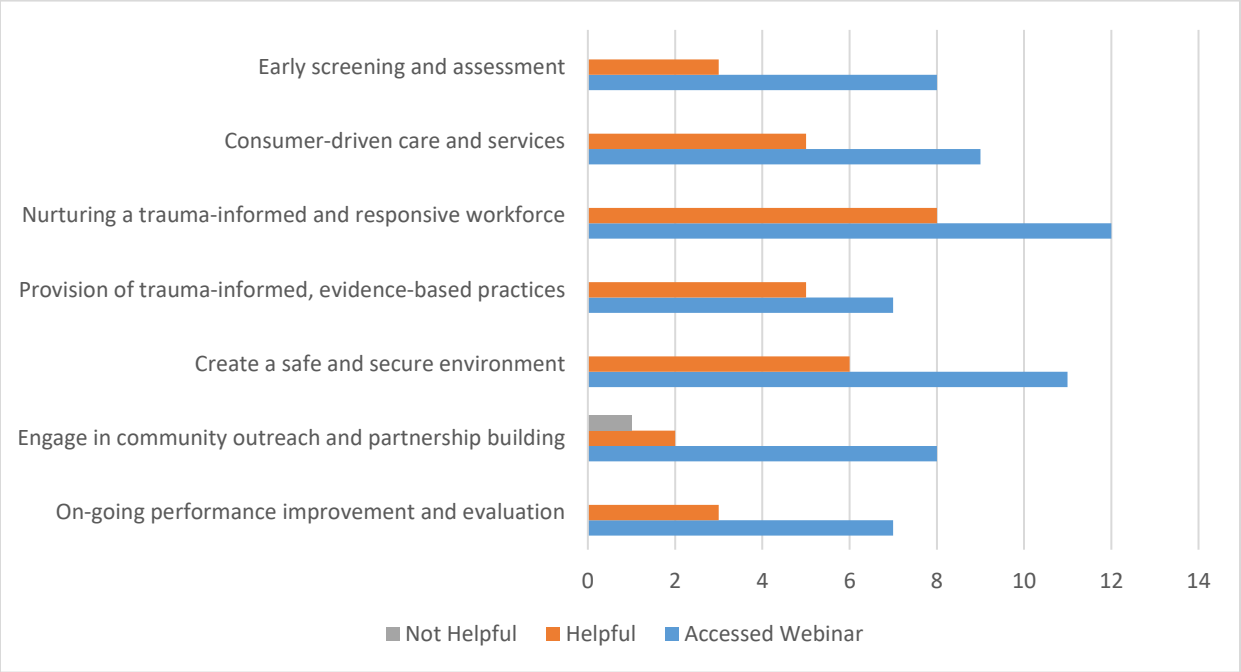
Participant Feedback on Resources

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 8: Perceptions and Use of National Council Webinars by Domain



<u>Progress on Trauma-Informed Care Domains</u>

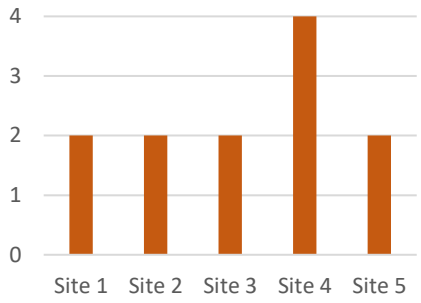
Team leads were asked to report on the progress that their team has made on each of the learning collaborative domains they had selected as well as to highlight the greatest accomplishment for the year.

<u>*Domain 1: Early Screening and Assessment.*</u> 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.

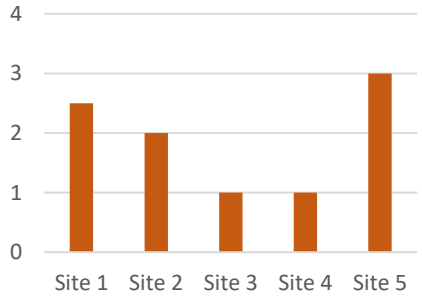
Figure 9. Progress on Domain 1
0=No progress, 2=Moderate progress, 4=Goals accomplished



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

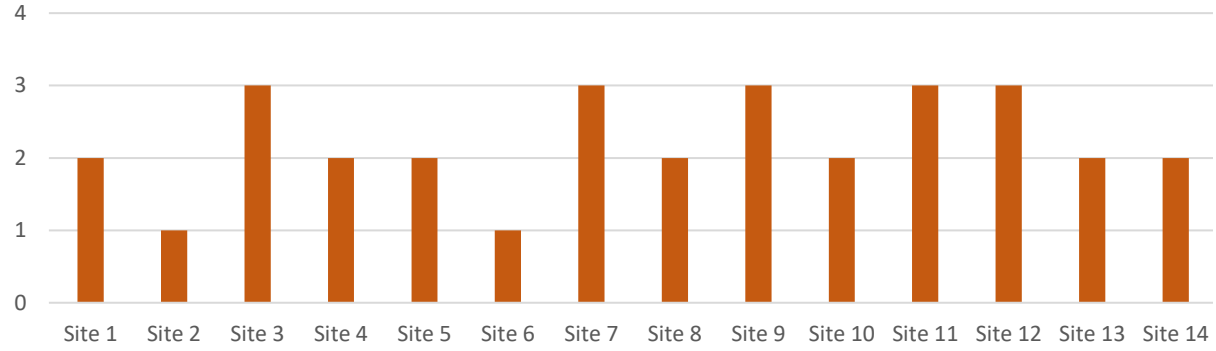


Domain 3: Trauma-Informed Workforce. All participating sites addressed Domain 3, *Nurturing a Trauma-Informed and Responsive Workforce* (100%). Two sites reported "a small amount" of progress. The majority of sites reported either "moderate" progress (50%) or "a great deal" of progress (35.7%). Many 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.

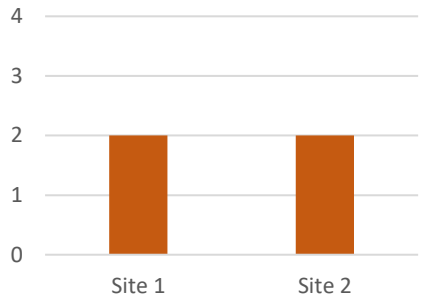
Figure 11. Progress on Domain 3
0=No progress, 2=Moderate progress, 4=Goals accomplished



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:

- 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.

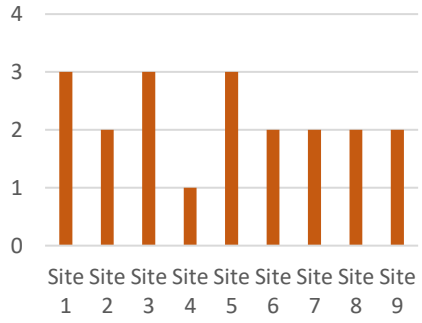
Figure 12. Progress on Domain 4
0=No progress, 2=Moderate progress, 4=Goals accomplished



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.
- 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.

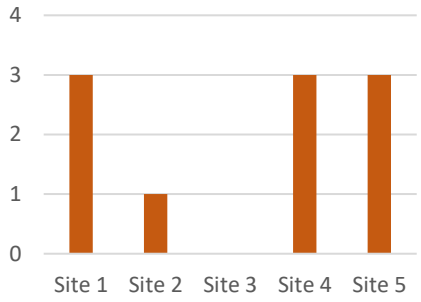
Figure 13. Progress on Domain 5
0=No progress, 2=Moderate progress, 4=Goals accomplished



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.
- One agency partnered with a county-wide program to bring information related to trauma to a larger audience, through outreach and education.

Figure 14. Progress on Domain 6
0=No progress, 2=Moderate progress, 4=Goals accomplished

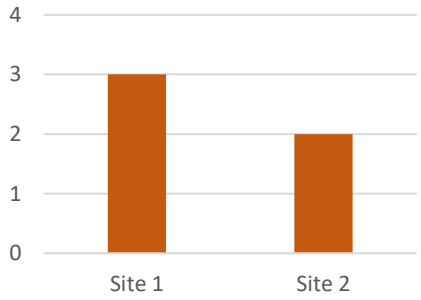


- On agency partnered with the Metro Dallas Homeless Alliance in North Texas to bring a trauma expert to the community for a leadership training.
- One organization hosted two 6-hour workshops in the community on trauma-informed care, training more than 70 individuals.

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:

- 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.

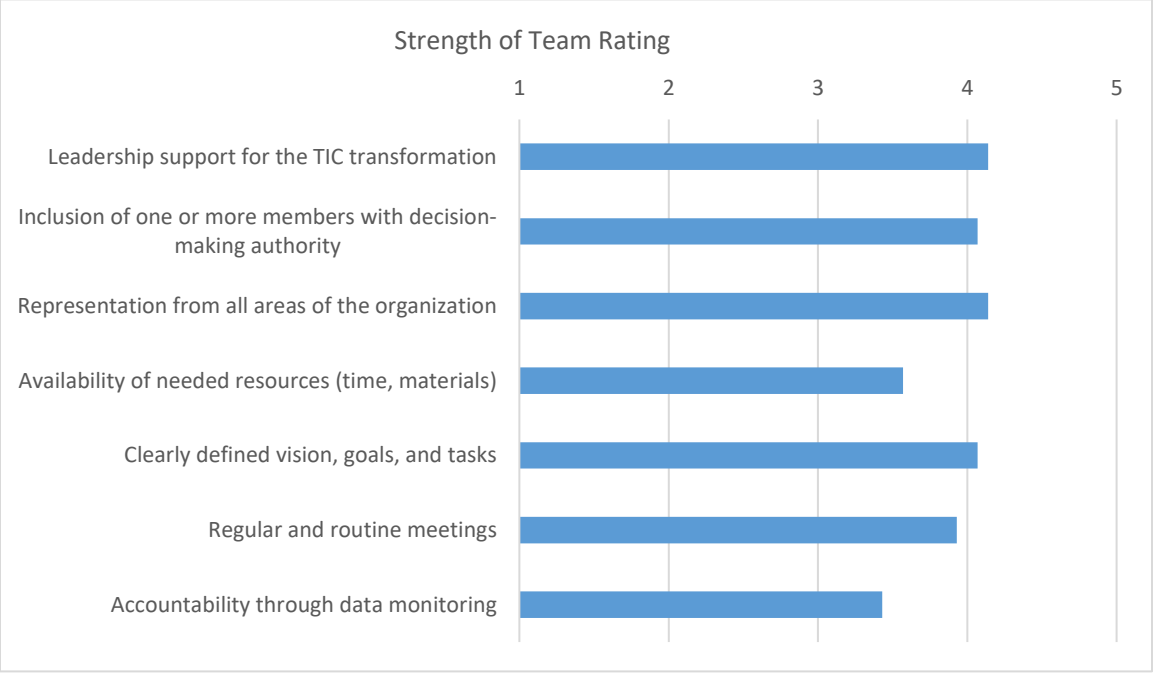
Figure 15. Progress on Domain 7
0=No progress, 2=Moderate progress, 4=Goals accomplished



Impact of Implementation Strength on Progress

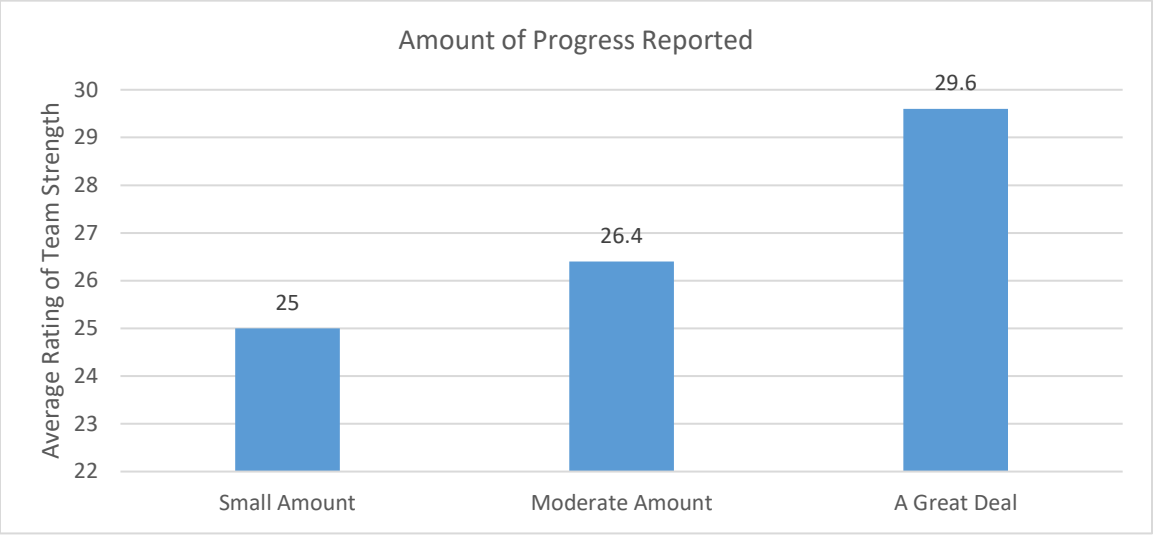
In order to understand the factors that may impact progress within the learning collaborative, teams (or team leads) were asked to report the strength of various aspects of their teams, including the level of leadership support, representation of decision makers on team, availability of resources, defined 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 16.

Figure 16: 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 17. 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 17. 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 23).

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 23. 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).

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.

<u>Lessons Learned:</u>

- 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.