

Texas Children Recovering from Trauma

Annual Evaluation Report

Grant Year 2



**Texas Institute for Excellence
in Mental Health**

Advancing Resilience and Recovery in Systems of Care

Molly A. Lopez
Tina Adkins

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

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Texas Children Recovering from Trauma

Overview of Project

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

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

Evaluation Overview

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

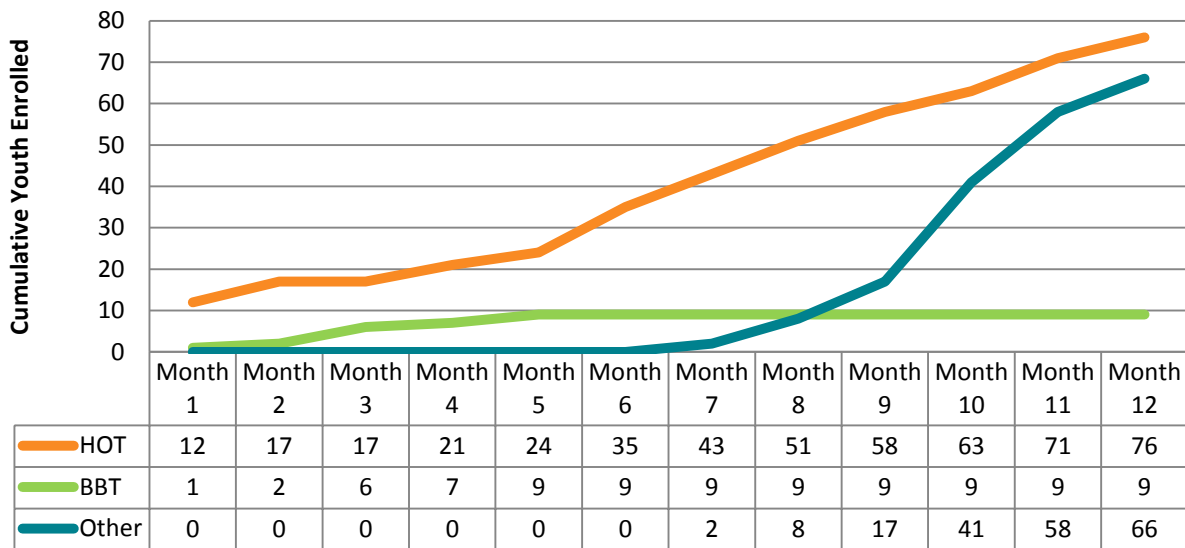
toward evidence-based treatments and experiences with training. In addition, agency wide measures are collected to assess overall system readiness and impact.

Results Child, Adolescent, and Family Level

Access to Trauma Treatments

One hundred and fifty-one youth were enrolled in the trauma services over the grant year, which is three times as many youth as were served in Grant Year 1 (GY1). In the first half of GY2, Heart of Texas MHMR and Bluebonnet Trails Community Center were the two service sites. Bluebonnet withdrew from the project mid-year and the enrollment strategy shifted to include other sites across the state that agreed to participate in provider training in TF-CBT or PCIT and implement the treatments within their organization. As indicated by the rate of enrollment presented in Figure 1, this shift in strategy was effective in allowing the project to exceed overall recruitment goals of 100 youth.

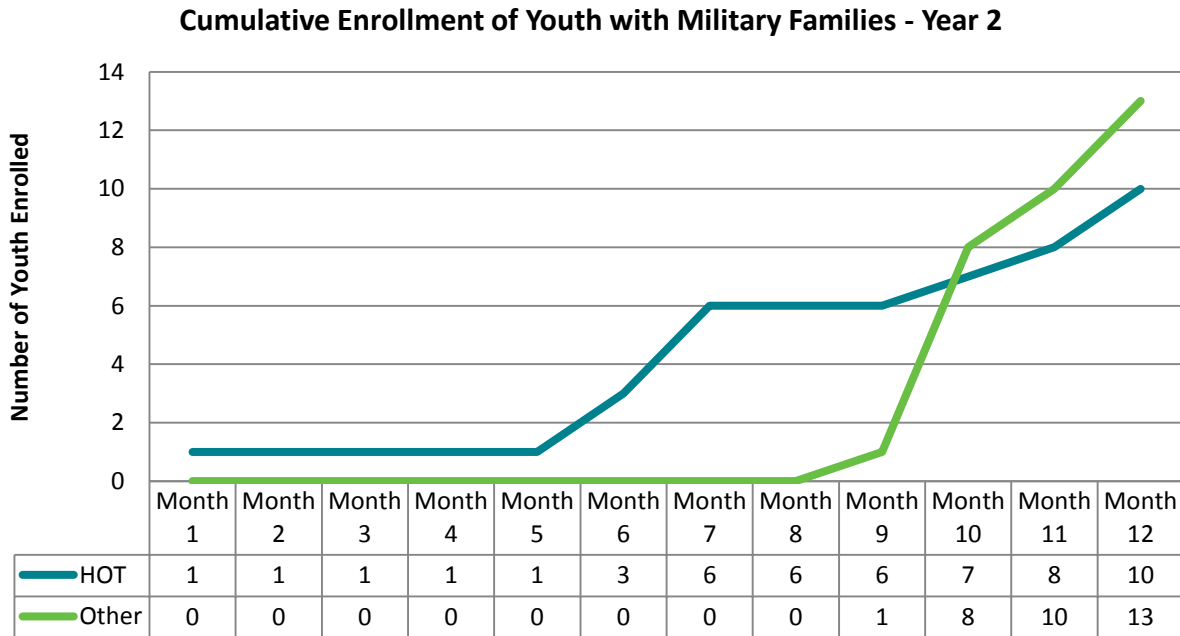
Cumulative Enrollment - Year 2



Note: HOT=Heart of Texas; BBT=Bluebonnet Trails Community Center; Other=Additional sites enrolling families.

The initiative has purposefully set out to engage families with military ties into the project. Outreach increased this grant year, with the inclusion of the local Veteran’s agency on the Local Steering Committee in Waco, leadership of a state planning group for military children and families, and a training in TF-CBT targeted to providers working with military families. The number of youth with military ties engaged in services is tracked monthly in Figure 2. This tracking will allow for the identification of trends over time and the assessment of the impact of

outreach efforts in the local communities. This grant year, twenty-three youth have been enrolled with identified ties to the military. Data forms have been changed by the sponsor, so the nature of these relationships is no longer collected.



Other child and family-level information is presented on all 188 children served during GY2. This includes some youth that were enrolled in the first year of the project, but remained in treatment in the second year.

Characteristics of Youth Served in Year 2

Interviews were conducted with both youth (41.6%) and caregivers (58.4%). Demographics of the youth served are presented in Table 1. The samples are similar, but the Heart of Texas sample has a greater proportion of African-American youth and smaller proportion of Caucasian youth. The Heart of Texas sample was also somewhat older than the youth served within other sites.

Table 1. Demographics of Youth Served in Year 1

	Heart of Texas n=94 (%)	Other Sites* n=94 (%)	Total n=188 (%)
Gender – Female	38 (40.4%)	41 (43.6%)	79 (42.0%)
Gender - Male	56 (59.6%)	52 (55.3%)	108 (57.4%)
Ethnicity – Hispanic	28 (29.8%)	27 (28.7%)	55 (29.3%)
Race – African American	32 (34.0%)	16 (17.0%)	48 (25.5%)

Race – Asian	0 (0%)	0 (0%)	0 (0%)
Race – Native Hawaiian	1 (1.1%)	2 (2.1%)	3 (1.6%)
Race – Alaska Native	0 (0%)	1 (1.1%)	1 (0.5%)
Race – White	54 (57.4%)	69 (73.4%)	123 (65.4%)
Race – American Indian	4 (4.3%)	2 (2.1%)	6 (3.2%)
	Mean (SD)	Mean (SD)	Mean (SD)
Age of Child	11.1 (4.3)	9.6 (4.4)	10.4 (4.7)

Note: Other sites includes Bluebonnet Trails Community Center.

Nature of Traumatic Exposure

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

Table 2. Trauma Experiences by Respondent Type

Trauma Types	Parent Report	Youth Report
	N (%) (n=88)	N (%) (n=99)
Being in a big earthquake that badly damaged the building the child was in.	0 (0%)	2 (2.0%)
Being in another kind of disaster, like a fire, tornado, flood, or hurricane.	15 (17.0%)	26 (26.3%)
Being in a bad accident, like a very serious car accident.	17 (19.3%)	22 (22.2%)
Being in a place where a war was going on around your child.	0 (0%)	2 (2.0%)
Being hit, punched, or kicked very hard at home.	25 (28.4%)	36 (36.4%)
Seeing a family member being hit, punched or kicked very hard at home.	52 (59.1%)	51 (51.5%)
Being beaten up, shot at or threatened to be hurt badly in your town.	23 (26.1%)	37 (37.4%)
Seeing someone in your town being beaten up, shot at or killed.	23 (26.1%)	37 (37.4%)
Seeing a dead body in your town (not at funeral).	9 (10.2%)	11 (11.1%)
Having an adult or someone much older touch the	26 (29.5%)	30 (30.3%)

child’s private sexual body parts when your child did not want them to.		
Hearing about the violent death or serious injury of a loved one.	31 (35.2%)	54 (54.5%)
Having painful and scary medical treatment in a hospital when your child was very sick or badly injured.	15 (17.0%)	24 (24.2%)
Other situation that was really scary, dangerous or violent.	37 (42.0%)	39 (39.4%)

Note. Respondents can indicate more than one trauma type.

Functioning of Children Served

Several measures of baseline functioning are available to describe the population of youth served. The majority of youth completed the UCLA PTSD Reaction Index, as did the parents of these youth. Responses to these measures indicate that youth have significant trauma-related distress at entry to services. Parents reported an average UCLA symptom score of 33.8 (*sd*=12.9; range 4-62), while children and adolescents reported average symptom scores of 33.2 (*sd*=15.0, range 1-67). Symptom severity scores of 25 are generally considered clinically elevated, with scores of 39 or higher being the optimal cut-off for a diagnosis of PTSD. Younger children were assessed with the Trauma Symptom Checklist for Young Children (TSCYC). The children had a mean baseline score of 49.3, which translates into an age and gender-adjusted T-score of 76.1. A T-score within this range suggests that, on average, these youth scored higher on traumatic stress than 96% of the normative population.

Table 3. Trauma Symptom Severity at Enrollment

	Mean	Standard Deviation	Percent above Clinical Cut-off >24 / >38
UCLA Parent Symptom Total (n=47)	33.8	12.9	75.3% / 36.2%
UCLA Child/Youth Symptom Total (n= 62)	33.2	15.0	76.6% / 45.7%
			T-Score Cutoff >65T / >70T
TSCYC PTS Raw Score (n=38)	49.3	12.4	
TSCYC PTS T-Score (n=38)	76.1	19.3	68.4% / 60.5%

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=141, 82.5%). Only three youth were reported to have “poor” overall health (1.8%), with 27 (15.8%) reported to have fair health. Respondents also indicated their agreement with several statements measuring overall daily functioning during the previous 30 days, and responses are

reported in Table 2. Youth were generally reported to be functioning well. However, the majority of respondents did indicate difficulty with coping (59.5%).

Table 4. Youth Functioning

Item	Strongly Disagree/ Disagree N=173	Undecided N=173	Strongly Agree/ Agree N=173
I am [my child is] handling daily life.	37 (21.4%)	25 (14.5%)	113 (65.3%)
I get [my child gets] along with family members.	49 (28.3%)	27 (15.6%)	97 (56.1%)
I get [my child gets] along with friends and other people.	37 (21.4%)	30 (17.3%)	106 (57.2%)
I am [my child is] doing well in school and/or work.	37 (21.4%)	24 (13.9%)	99 (54.3%)
I am [my child is] able to cope when things go wrong.	103 (59.5%)	37 (21.4%)	33 (19.1%)
I am satisfied with our family life right now.	59 (34.1%)	35 (20.2%)	77 (44.5%)

Fifty-eight youth (42.3%) were reported to have no absences from school, with 35 youth (25.5%) reporting absences for 1 or 2 days out of the last 30, 38 youth (27.7%) reporting between 3 and 10 days absent, and 6 youth (4.4%) reporting more than 10 days absent. Forty-four percent of those reporting absences indicated that they were unexcused. Eighty-five percent of the youth lived in a caregiver’s home, apartment, or room as the primary residence in the past month, with others reporting their own independent home/apartment (2.1%), someone else’s home/apartment (7.5%), a foster care treatment residence (.5%), and a correctional facility (.5%). Three families reported being homeless (1.6%). The majority of participating youth (87.7%) had no out-of-home days during the past month, with twelve youth (7.0%) reporting between one and ten days outside the home and nine (5.3%) reporting more than 10 days outside the home. Three of the participating youth (1.8%) reported arrests within the past month.

Treatment Sessions

Session forms were submitted for most youth served over the GY. The majority of youth (n=102; 54.6%) received TF-CBT only and a smaller number (n=24, 12.8%) received PCIT only. Twelve youth (6.4%) received both TF-CBT and PCIT over the year. No session forms were submitted for 49 youth (26.2%); this is likely to include some youth that did not return for a subsequent appointment and some missing data. For youth who have been discharged from care, the average number of TF-CBT sessions is 8.7 (*sd*=8.0) and the average number of PCIT

sessions is 5.3 ($sd=5.0$). Table 5 presents information about the total number of sessions completed by youth discharged from care.

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

Number of Sessions	TF-CBT N=57 (%)	PCIT N=10 (%)
1 Session	8 (14.0%)	0 (0%)
2 – 5 sessions	13 (22.8%)	9 (90.0%)
6 – 10 sessions	12 (21.1%)	0 (0%)
11 – 15 sessions	13 (22.8%)	1 (10.0%)
16 – 20 sessions	5 (8.8%)	0 (0%)
More than 20 sessions	6 (10.5%)	0 (0%)

Trauma Focused Cognitive Behavioral Therapy

One hundred and fourteen youth who were served in GY2 had documentation of TF-CBT sessions. These youth had a total of 991 documented sessions. Parents were involved in just under half of the TF-CBT sessions (47.3%). Although TF-CBT can be conducted with a child alone, the expectation is for parents or caregivers to be involved in every TF-CBT session. This may reflect some difficulty engaging parents or lack of understanding of the role parents play in trauma treatment. Therapists are also expected to utilize home assignments at most sessions to ensure children and their parents are practicing newly learned skills and generalizing these new skills in their home, school, and community environments. Therapists appear to be assigning homework infrequently, with homework not assigned in 46.9% of sessions (excluding initial appointments). When homework was assigned, 30.7% of youth or parents completed the assignment fully and another 34.3% partially completed it.

Information on adherence to the TF-CBT model was collected through a therapist checklist of core treatment elements. The results are presented in Table 6. Analyses are focused on only those 57 youth discharged from care to provide further information about treatment adherence. The core component is reflected as covered if any sessions targeted that component, so the data will not reflect whether the component activities were completed or the quality of the intervention.

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

Core Component	Number N=57 (%)	Percent
Psychoeducation	55	96.5%
Parenting Skills	31	54.4%
Relaxation	39	68.4%

Affective Regulation	45	78.6%
Cognitive Coping	36	63.2%
Trauma Narrative	25	43.9%
In Vivo Desensitization	16	28.1%
Conjoint Sessions	16	28.1%
Safety Planning	18	31.6%
Skill Development	31	54.4%

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 54.4% of families had any sessions focused on parenting skills. Similarly, although 43.9% of youth were involved in creating a trauma narrative, only 28.1% participated in sessions in which the youth shares the trauma narrative with a caregiver. Together, this seems to suggest some difficulty with engagement of parents or other caregivers in the TF-CBT intervention. The percentage of youth participating in sessions focused on in vivo desensitization has increased, suggesting providers are becoming more comfortable with using this component of the model, although it is still less frequently used than other components.

PCIT Treatment Components

Thirty-six youth served in GY2 had documentation of receiving PCIT sessions. A total of 146 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 81.8% of the time (excluding initial appointments), so this component of the treatment structure was generally followed. Although few parents (23.3%) completed the homework all seven days of the week, 54.4% completed the assignment three or more days of the week. Only 13.3% of the time did parents fail to complete any of the homework assignments.

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

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

Core Component	Number N=36 (%)	Percent
Therapy Orientation Session	31	86.1%
CDI Teaching Session	22	61.1%
First CDI Coaching Session	16	44.4%
Second CDI Coaching Session	14	38.9%
Third CDI Coaching Session	11	30.6%
Fourth or Later CDI Coaching Session	9	25.0%
PDI Teaching Session	6	16.7%
First PDI Coaching Session	4	11.1%
Second PDI Coaching Session	2	5.6%
Third PDI Coaching Session	2	5.6%
Fourth PDI Coaching Session	2	5.6%
Fifth PDI Coaching Session	1	2.8%
Sixth PDI Coaching Session	0	0%
Seventh or Later PDI Coaching Session	0	0%
Graduation Session	1	2.8%

As illustrated in the table above, families are progressing through the components of treatment in the recommended order, but the majority remain in the early sessions. Only two children have progressed through almost all of the sessions and one has reached the graduation session. The Oversight team will continue to review information on PCIT implementation to identify trends and address any barriers to effective implementation.

Impact of Treatment

Initially, formal treatment outcomes were assessed at 6 months after program entry; however, this protocol was changed in GY2 to every 3 months in order to improve the number of follow-up assessments received. Depending on the youth’s age, either the UCLA PTSD Reaction Index or the Trauma Symptom Checklist for Young Children (TSCYC) was obtained. Results of those youth with both pre-test and post-test scores are provided in Table 8. Although the sample size is small, these results support a significant improvement in trauma symptom scores between baseline and the last available assessment. Information on youth receiving the TSCYC is even more limited, but results currently indicate no significant improvement between baseline and follow-up.

To increase the opportunity to gather outcome information at all points in time, therapists are asked to complete a Clinical Global Improvement (CGI) scale at each treatment session. Based

on the last reported session, TF-CBT therapists reported 31.6% of youth had no significant change, 34.2% were a little better and 14.0% were significantly better. A small percentage (8.2%) were either a little worse or significantly worse. PCIT therapists reported that 21.2% of the youth had no significant change, while 36.4% were a little better and 21.2% were significantly better. No youth in PCIT were reported to be a little worse or significantly worse.

Table 8. Outcomes of Children Receiving Trauma Care

Item	Mean Baseline Scores		Mean Follow-up Scores		Dependent t-test
UCLA PTSD Reaction Index – Parent Report (n=10)	33.8		23.4		t=3.27, p=.01
UCLA PTSD Reaction Index – Youth Report (n=17)	37.8		25.2		t=3.55, p<.01
TSCYC PTSD Raw Score (n=5)*	56.8		55.4		t=.27, p=.80
Clinical Global Impression Scale	Significantly Worse	A Little Worse	No Significant Change	A Little Better	Significantly Better
TF-CBT Participants (n=114)	3 (2.6%)	7 (6.1%)	36 (31.6%)	39 (34.2%)	16 (14.0%)
PCIT Participants (n= 33)	0 (0%)	0 (0%)	7 (21.2%)	12 (36.4%)	7 (21.2%)

Results System Level

Several trainings were conducted during the grant year; however, since the principal aim of year two was the implementation of Parent Child Interaction Therapy, information on the experiences of these trainees will be presented. Additional specialty trainings offered this grant year included Advanced Training in Trauma-Focused CBT and Trauma Focused CBT with Military Families.

Characteristics of Treatment Providers

Participants. The initial PCIT training was held in March 2014 for 19 treatment providers. Evaluation data was collected on 17 participants. About 76% of participants were between the ages of 26 and 45, with moderate diversity of race ethnicity. Forty-seven percent of participants were Caucasian, 24% African American and 18% Hispanic, and 11% other or unknown. The participants held a variety of degrees, with the majority (59%) having a Master’s degree in Counseling. About a third held a PhD and 18% reported having a Master’s in Social Work. This group reported a wide range of clinical experience from 1 to 17 years, with 8 years being the average.

Knowledge and Experience. The majority of participants (88%) reported having at least some knowledge of parent training interventions, with over half stating they had “a lot” or an “extensive” amount of knowledge in this area. Approximately 82% reported having at least some experience using parent training techniques with clients. Almost half reported having “a lot” of experience using parent training techniques with clients. The greatest number of participants (41%) reported having minimal or no knowledge about PCIT, while 35% had at least “some” knowledge of PCIT. The majority (65%) of the participants reported having no (59%) or minimal (6%) experience using PCIT with their clients.

Attitudes Toward the Adoption of Evidence-Based Practice. The participants completed the Evidenced-Based Practice Attitude Scale (EBPAS), which measures the extent to which individuals are likely to implement evidence-based practices. Mean scores for the Total Score and four subscales are presented in comparison to national norms of mental health providers:

Table 9. PCIT Training Participants’ Attitudes toward EBPs

Domain	PCIT Providers (mean)	National Norm (mean)
EBPAS Total Score	2.54	2.33
Appeal	3.54	2.91
Requirements	2.80	2.41
Openness	3.28	2.76
Divergence	.52	1.25

Note: 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.

Providers were more open to the use of evidence-based practices than national normative groups. Providers were especially likely to be influenced by the general appeal of the practice and the extent to which it aligns with their current practices.

Impact of Training. Participant ratings of the training experience are presented in Table 10. Providers reported minimal competence with PCIT prior to training and moderate perceptions of mastery at the end of the training event. Participants found the trainer to be extremely credible and engaging.

Table 10: Evaluation of PCIT Training

Item	Average	Standard Deviation
Existing mastery/competence	1.86	2.29
Post-training mastery/competence	5.50	2.01
Importance of training goals	9.14	1.19
Trainer credibility	9.93	0.26
Training organization	9.14	0.99
Training interest	9.57	0.62
Overall impact on work	9.00	0.85
Impact on assessment & service planning	8.71	1.34

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

Participants reported that they were somewhat likely to share the information with their colleagues (average rating of 3.0 out of 4) and that they were moderately likely to make changes at work based on the training (average rating of 2.86 out of 4).

Qualitative comments from participants demonstrated that they found the structured protocol, video examples, and role-plays most useful. They indicated that they would like to have the materials and equipment prior to the training, so that they could begin right away. Several participants indicated that there was a lot of information for a two-day training and that they could benefit from more review of the manual, more hands on practice, and more ideas on how to tailor to individual families.

Follow-up Survey for Parent Child Interaction Therapy Implementation

In addition to a post-training survey, the evaluation team conducted a 6-month follow-up survey with the individuals who attended PCIT training. It was designed to assess the impact of the training and technical assistance that participants have received, as well as supports and barriers for local implementation. Fifteen individuals were invited to complete this survey online and 12 participated, resulting in a response rate of 80%. Respondents were mostly from other areas of the state (75%) with one falling inside the Bluebonnet Trails area and two from the Heart of Texas area.

PCIT Consultation Calls. All of the participants (100%) indicated they participated in the PCIT consultation calls following training. Overall, the majority of providers were very satisfied with the coaching calls, actively participated in the calls and felt the calls improved their clinical skills. The greatest area of disagreement was providers indicating they would have like the calls to be more frequent or longer.

Table 11. Perceptions of PCIT Consultation Calls

	Mean (n=12)	Standard Deviation
I am very satisfied with the content of the coaching calls.	4.33	.47
I feel more competent at providing PCIT as a result of the coaching calls.	4.27	.45
I actively participated in the coaching calls.	4.17	.80
I frequently thought about not calling in for the coaching calls.	2.00	1.15
I would have liked the calls to be more frequent or last for a longer period of time.	2.83	.99

Note: Rating 1="not at all true" to 5="very true"

PCIT Implementation and Use. Participants were also asked to what extent they were providing PCIT within their organization currently. The majority of respondents (67%) reported they have used PCIT with a small number of youth. However, three respondents (25%) reported to be using PCIT with between six and ten families.

Table 12. Extent Providers are Using PCIT

	Number (n=12)	Percentage
Not at all (0 clients)	1	8.3%
A little (1-2 clients or tried components)	4	33.3%
Some (3-5 clients)	4	33.3%
A lot (6-10 clients)	3	25.0%
Extensively (11 or more clients)	0	0%

Respondents were asked to rate the level of mastery they felt they now have with the different components of PCIT. They ranked each component on a 1-10 Likert scale with 1 representing "Complete Beginner" through 10 meaning "Fully Expert." Results indicate that overall, practitioners feel they have an intermediate level of mastery with all components of PCIT. They reported having the most mastery with the psychoeducation component ($m=6.58$) and the least mastery with coding the parents' PDI skills ($m=4.50$).

Table 13. Perceived Mastery of PCIT Components

Treatment Components	Mean Rank (n=12)	Standard Deviation
Psychoeducation	6.58	2.33
Using ECBI assessment with parents	6.33	2.59
Teaching parents CDI skills	6.17	2.54
Helping parents problem solve	5.75	2.42
Actively coaching parents in CDI skills	5.50	2.53
Handling behavior problems in session	5.33	2.53
Coding parents' CDI skills	5.25	2.42
Teaching parents PDI skills	4.67	3.09
Actively coaching parents in PDI skills	4.67	3.04
Teaching PDI to the child	4.67	3.04
Coding parents' PDI skills	4.50	2.57

Provider Attitudes Toward PCIT. Providers completed a selection of questions from the Texas Survey of Provider Characteristics and Attitudes (TX-CHAT). Providers were asked to rate statements on how well they reflect their experiences working with and using PCIT, using a 5-point Likert scale that ranged from 1=“Not at all true for me” to 5=“Very true for me.” Most providers felt that PCIT was highly effective, appropriate for the families they worked with and that the youth liked the treatment.

When comparing these results with those of the TF-CBT providers, results were similar. However, there were differences between these different treatment providers on a number of questions about organizational support. The largest difference between TF-CBT and PCIT providers resulted when asked if their agency or clinic viewed the treatment as a positive change. The PCIT providers indicated this is much less the case than the TF-CBT providers. Table 14 outlines several more questions that indicate PCIT providers felt less support from their agency and colleagues than TF-CBT providers, and that their work interfered more with using the treatment. These are interesting differences and could be accounted by the manualized and time-intensive nature of the PCIT protocol.

Table 14. Comparison of Organizational Support by Type of Intervention

	PCIT Sample Mean (n=11)	TF-CBT Sample Mean (n=27)
My agency/clinic views the treatment as a positive change to our treatment practices.	3.55	4.37
My agency/clinic does not support the treatment protocol.	1.36*	1.19*
The amount of work I have to do interferes with using the treatment.	2.91	2.44
My colleagues are happy with the treatment protocol.	3.36	3.62

*Lower rating indicates disagreement

Workforce Survey on Trauma Informed Care

A workforce survey was conducted during the fourth quarter across all local mental health authorities in Texas. The survey was closed on September 30, 2014, therefore the analysis of this survey will be shared in the first quarterly report for Year 3. The survey was accessed by 1,474 respondents and completed by 1,424 individuals, with 3.5% (n=50) of respondents from Central Office of DSHS, 80.3% (n=1,144) staff at local mental health authorities, and 16.6% (n=236) respondents from 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. Ninety-six respondents (6.7%) identified themselves as an administrator or program director, 14.8% (n=211) as a program manager or supervisor, 40.4% (n=575) as a direct service provider, and 24.2% (n=344) as administrative or support staff. Further analysis of respondents indicating “Other” will need to be completed to ensure this information is captured accurately. Table 15 illustrates the programmatic area that respondents identify with.

Table 15: Respondents from the Trauma Informed Care Survey

Item	Number (n=1,424)	Percentage
Community Mental Health	932	65.4%
Hospitals and Facilities	120	8.4%
Substance Abuse Prevention	126	8.5%
Substance Abuse Treatment	155	8.8%
Intellectual and Developmental Disorders	270	19.0%
Early Childhood Intervention	98	6.9%
Physical Health Care	46	3.2%

Other	221	15.5%
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Note: Respondents indicating “Other” will be reviewed to ensure information is captured and reported accurately.

Conclusions

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

- Expansion of TF-CBT implementation to additional providers across the state. Currently 75 organizations have participated in training and coaching in this trauma intervention.
- The project successfully outreached to military organizations, including new collaborations within the Heart of Texas region and new state-level collaborations. Additionally, the project offered training in TF-CBT targeted to providers working with military families, and this activity yielded increases in the number of families enrolled with military family ties.
- Nineteen individuals were selected through a competitive process to participate in a series of trainings to develop competence in Parent Child Interaction Therapy and then advance to become certified local trainers in the model. Participating therapists received tools and play materials to assist with implementation within their organization.
- A trauma-informed care subcommittee has interviewed several potential providers of consultation on trauma informed care and identified a collaborating organization. A statewide workforce survey has been completed by 1,424 individuals.
- Despite changes to the agencies participating in the project, goals for the number of children served and the number of family members impacted by treatment were surpassed.
- Although sample sizes remain small, outcome measures show significant reductions in trauma symptoms for those youth receiving follow-up assessments.

The results of the evaluation also lead to some suggested areas of focus for the upcoming year:

- Submission of follow-up assessments has improved with the addition of a 3-month data collection period; however, continued efforts should be made to improve re-assessment rates. Evaluation staff will pilot the use of individualized assessment reports provided to therapists to increase the ease of interpretation of assessment results and to enhance the meaningfulness of the data. Model coaches and local supervisors can also reinforce this effort by reviewing the results of trauma assessments when providing technical assistance.
- With the shift from two participating organizations to many, strategies for maintaining engagement and participation of treatment providers in project activities should be considered. As coaching calls complete, providers may lose touch with grant activities without concerted opportunities for continued involvement. Project leaders should consider the value of ongoing communication efforts to provide updates, on-going peer networking, refresher trainings, and other strategies.

- The engagement of parents or caregivers in TF-CBT and the assignment of regular homework to enhance skill development and increase generalization remain lower than would be expected. TF-CBT supervision should continue to examine barriers to the implementation of these two aspects of TF-CBT. Advanced training opportunities around these issues (e.g., suggestions for practice assignments in TF-CBT) may also be helpful.
- The oversight team should continue to monitor the implementation and effectiveness of PCIT as it evolves and ensure any barriers are being addressed. Clinician reports suggest that some of the agencies in which they work may not be providing the organizational support that is needed to implement this practice.