

**Texas Children Recovering from Trauma
Annual Evaluation Report
Grant Year 1**

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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 Bluebonnet Trails Community Center and Heart of Texas MHMR Center, 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 initial year of the initiative focused on the establishment of state and local oversight committees, outreach to state and community partners, especially youth and parents with experience in the system, and the implementation of Trauma-Focused CBT within the two service delivery organizations. In addition, efforts to begin identifying strategies to assess for readiness to implement trauma-informed care initiatives were planned.

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 6 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.

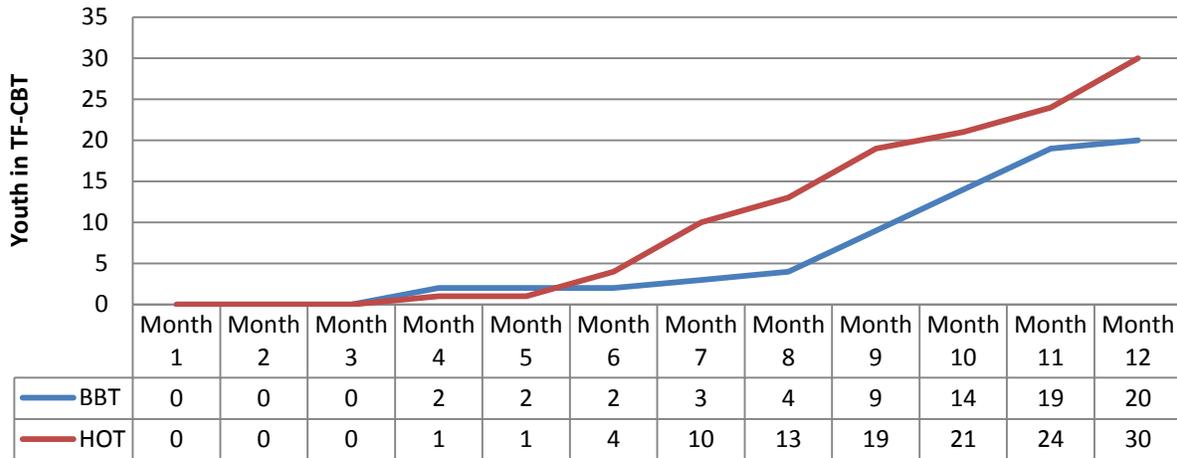
Results

Child, Adolescent, and Family Level

Demographics of Children Served

Fifty youth were enrolled in the TCRFT services over the grant year. Training in TF-CBT was initially only available to a few therapists, who had to travel to access it, and additional expansion of staffing occurred over the early months. The rate of enrollment is presented in Figure 1.

Cumulative Enrollment



Interviews were conducted with both youth (45.5%) and caregivers (54.2%), with 71.4% of the interviewers following the recommended guidelines of interviewing youth if over the age of 10. Demographics of the youth served are presented in Table 1.

Table 1. Demographics of Youth Served in Year 1

	Bluebonnet Trails	Heart of Texas	Total
	N (%)	N (%)	N (%)
Gender – Female	12 (60.0%)	16 (55.2%)	28 (57.1%)
Gender - Male	8 (40.0%)	13 (44.8%)	21 (42.9%)
Ethnicity – Hispanic	6 (30.0%)	9 (31.0%)	15 (30.6%)
Race – African American	2 (10.5%)	8 (33.3%)	10 (23.3%)
Race – Asian	0 (0%)	0 (0%)	0 (0%)
Race – Native Hawaiian	0 (0%)	0 (0%)	0 (0%)
Race – Alaska Native	0 (0%)	0 (0%)	0 (0%)
Race – White	14 (73.7%)	15 (62.5%)	29 (67.4%)
Race – American Indian	3 (15.8%)	2 (8.3%)	5 (11.6%)
	Mean (SD)	Mean (SD)	Mean (SD)
Age of Child	14.9 (2.6)	12.0 (3.9)	13.2 (3.7)

The initiative has purposefully set out to engage families with military experiences in the project. Although this outreach is in its initial stages, 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. To date, nine youth have been enrolled with identified ties to the military. Five youth identify one close friend or family member with military ties and four identify more than one friend/family member. In one instance, the family member is a parent, while others indicate other relationships (e.g., grandparent, aunt/uncle, or cousin).

Enrollment of Youth with Military Families



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. Parents reported the youth has experienced an average of 3.2 different types of trauma ($sd=1.7$; range 1 to 7), while the youth reported an average of 3.3 different trauma types ($sd=2.0$; range 1 to 8). Table 2 illustrates the percentage of children and youth who have had various traumatic experiences. The most commonly reported experiences were sexual abuse, traumatic death of a loved one, and witnessing domestic violence.

Table 2. Trauma Experiences by Respondent Type

Trauma Types	Parent Report	Youth Report
	N (%) (n=28)	N (%) (n=39)
Being in a big earthquake that badly damaged the building the child was in.	0 (0%)	0 (0%)
Being in another kind of disaster, like a fire, tornado, flood, or hurricane.	6 (21.4%)	9 (23.1%)
Being in a bad accident, like a very serious car accident.	6 (21.4%)	11 (28.2%)
Being in a place where a war was going on around your child.	0 (0%)	0 (0%)
Being hit, punched, or kicked very hard at home.	7 (25.0%)	13 (34.2%)
Seeing a family member being hit, punched or kicked very hard at home.	15 (53.6%)	14 (35.9%)
Being beaten up, shot at or threatened to be hurt badly in your town.	10 (37.0%)	15 (38.5%)
Seeing someone in your town being beaten up, shot at or killed.	3 (11.5%)	12 (30.8%)

Seeing a dead body in your town (not at funeral).	3 (11.5%)	4 (10.3%)
Having an adult or someone much older touch the child's private sexual body parts when your child did not want them to.	14 (56.0%)	17 (43.6%)
Hearing about the violent death or serious injury of a loved one.	9 (33.3%)	17 (43.6%)
Having painful and scary medical treatment in a hospital when your child was very sick or badly injured.	8 (28.6%)	7 (18.0%)
Other situation that was really scary, dangerous or violent.	12 (42.9%)	13 (33.3%)

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 34.1 ($sd=11.6$; range 13-58), while children and adolescents reported average symptom scores of 34.2 ($sd=15.3$, range 2-58). 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.

The majority of respondents indicated that the youth's overall health was good to excellent (79.2%). Only one youth was reported as having "poor" overall health (2.1%). 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 (58.3%).

Table 3. Youth Functioning

Item	Strongly Disagree/ Disagree	Undecided	Strongly Agree/ Agree
I am [my child is] handling daily life.	13 (27.1%)	6 (12.5%)	29 (60.4%)
I get [my child gets] along with family members.	11 (22.9%)	7 (14.6%)	30 (62.5%)
I get [my child gets] along with friends and other people.	11 (22.9%)	7 (14.6%)	30 (62.5%)
I am [my child is] doing well in school and/or work.	18 (39.1%)	3 (6.5%)	25 (54.3%)
I am [my child is] able to cope when things go wrong.	28 (58.3%)	11 (22.9%)	9 (18.8%)
I am satisfied with our family life right now.	17 (37.0%)	8 (17.4%)	22 (47.9%)

Fourteen youth (35.9%) were reported to have no absences from school, with 12 youth reporting absences for 1 or 2 days out of the last 30, 10 youth reporting between 3 and 10 days absent, and 3 youth reporting more than 10 days absent. Thirty-eight percent of those reporting absences indicated that they were unexcused. Eighty-three 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, someone else’s home/apartment, a foster care treatment residence, and a correctional facility. The majority of participating youth had no out-of-home days during the past month, with six youth (12.8%) reporting one or more days outside the home. None of the participating youth reported arrests within the past month.

Treatment Sessions

Therapists documented 313 TF-CBT treatment sessions during the year. A greater majority of sessions reflected the early treatment sessions, with 47.6% of sessions reflecting sessions 1 to 5, and only 14.3% reflecting what is typically defined as a complete course of TF-CBT (12 or more sessions). This is due to the early phase of this evaluation. Parents were involved in just under half of the TF-CBT sessions (47.9%). 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 frequently 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 61.2% of sessions. When homework was assigned, 54.9% of youth either partially or fully completed the assignment.

Information on adherence to the TF-CBT model was collected through a therapist checklist of core treatment elements. The results are presented in Table 4. The frequency of these elements is likely to be impacted by the skewed nature of the sessions, with components occurring in the early phases of treatment more likely to be reported. In future reports, analyses can focus on only those youth completing a full course of care to provide further information about treatment adherence.

Table 4. Frequency of TF-CBT Core Components Conducted During Treatment Sessions

Core Component	N (%)
Psychoeducation	209 (67.8%)
Parenting Skills	67 (21.4%)
Relaxation	53 (16.9%)
Affective Regulation	138 (44.1%)
Cognitive Coping	36 (11.5%)
Trauma Narrative	28 (9.0%)
In Vivo Desensitization	13 (4.2%)
Conjoint Sessions	14 (4.5%)
Safety Planning	15 (4.8%)
Skill Development	113 (36.1%)

Results would suggest that therapists may be overemphasizing some components of treatment and neglecting some others. In particular, psychoeducation and skills development may be occurring more than would be expected. Psychoeducation generally occurs early in treatment to ensure the youth and parent are aware of the impact of trauma on children, have knowledge about trauma triggers, and understand the rationale behind trauma treatment. Psychoeducation is likely to occur in more than one session, however is not necessarily intended to occur in most every session. Skill development within TF-CBT reflects the possible need to provide additional skills training that is not included as a primary component of TF-CBT. For example, if a child’s trauma experiences have impacted their ability to relate to peers, some social skills training may be warranted. However, the frequency of this category’s use in

the current sample may suggest that providers are incorporating non-trauma related interventions. Similarly, relaxation and cognitive coping are reflected relatively rarely. These are significant components with TF-CBT and generally are used in multiple treatment sessions. Youth and parents generally are taught multiple strategies for relaxation over the course of treatment and practice these skills during the treatment session as discussions of the trauma are intensified. Similarly, discussions of cognitive coping and practice using the cognitive triangle to examine inaccurate or unhelpful thoughts are expected to occur over multiple sessions. These lead to cognitive coping in the context of the trauma narrative, so this skill would likely be represented fairly frequently.

Impact of Treatment

Formal treatment outcomes are assessed at 6 months after program entry. Currently, only X youth have been assessed at this follow-up point so this outcome data is not currently. However, therapists are asked to complete a Clinical Global Improvement (CGI) scale at each treatment session. Based on the last reported session, therapists reported 33.3% of youth had no significant change, 40.0% were a little better and 26.7% were significantly better. No youth were reported to be a little worse or significantly worse.

Results System Level

Characteristics of Treatment Providers

Demographics. Data was collected on 57 providers. There was a wide range of ages, however about 60% were between the ages of 26 and 45 and another 33% was over the age of 45. Approximately 83% of the participants were Caucasian, 12% African American and 5% Hispanic. Participants held a variety of degrees, with the majority (over 55%) having a Master's degree in Counseling. About a third held a Master's in Social Work. Just under 90% of the participants hold licenses to practice in their particular field. This group reported a wide range of clinical experience from 0 to 30 years, with 10 years being the average. Overall this group leaned towards early career professionals, with over a third of the participants having less than 4 years experience.

Knowledge and Experience. The majority of participants (over 90%) reported having at least some knowledge of CBT, with about half stating they had "a lot" of knowledge. About 75% reported having at least some experience using CBT with clients. Almost a third reported having "a lot" of experiencing using CBT with clients. Almost 33% of respondents reported having minimal knowledge about TF-CBT, while almost 60% had "some" knowledge of TF-CBT. The majority (72%) of the participants reported having no (37%) or minimal (35%) experience using TF-CBT with their clients.

Attitudes Toward the Adoption of Evidence-Based Practice. The participants completed the Evidence-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 Table 5 with comparisons to national norms of mental health providers.

Table 5. Attitudes Towards Evidence Based Practices

Domain	TCRFT Providers Mean (sd)	National Norms Mean (sd)	Difference (p value)
EBPAS Total Score	2.87 (.49)	2.33 (.45)	.54 (p<.001)
Appeal	3.22 (.65)	2.91 (.68)	.31 (p<.001)
Requirements	2.89 (1.01)	2.41 (.99)	.48 (p<.001)
Openness	2.76 (.66)	2.76 (.75)	.00 (p=1.00)
Divergence	.93 (.63)	1.25 (.70)	-.32 (p<.001)

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 overall more open to implementing evidence-based practices than mental health clinicians in a national sample. Providers had higher scores on the Appeal subscale than national norms, suggesting they are more likely to implement EBPs when they are appealing to them or their colleagues. Providers had slightly higher scores on the Requirements subscale than national norms, indicating staff may be more motivated to implement EBPs if this is a requirement within their organization. Providers had slightly lower scores on Divergence than national norms, suggesting they were less likely to feel research-based treatments were not helpful and clinician judgment is more important than evidence.

Impact of Training

Training on Screening Measures. Two trainings were conducted on the Child and Adolescent Needs and Strengths (CANS), which includes a screening for trauma exposure and impact. Participants were asked to complete a questionnaire on the impact of the training and 35 participants responded related to the first training and 13 responded regarding the second training. Results of some of the questions are reflected in Table 6.

Table 6. Evaluation of CANS Training

Item	Training by Developer Average (sd) N=35	Training by Local Trainer Average (sd) N=13
Existing mastery/competence	3.03 (2.79)	4.50 (2.25)
Post-training mastery/competence	6.43 (1.68)	7.00 (1.80)
Importance of training goals	9.34 (0.98)	9.38 (0.74)
Trainer credibility	9.43 (0.73)	9.23 (1.19)
Training organization	8.80 (1.09)	8.92 (1.14)
Training interest	9.09 (1.08)	8.15 (1.10)
Overall impact on work	8.57 (1.27)	9.15 (0.86)
Impact on assessment & service planning	8.44 (1.42)	9.23 (0.80)

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

Training on TF-CBT. Two trainings were held on TF-CBT and participants were asked to complete questionnaires of impact. Trainees generally reported moderate levels of experience with TF-CBT prior to the training and moderate to high levels of mastery following training. Trainees found the trainer to be credible and organized. They reported they found information on the trauma narrative most helpful, followed by the trainer's use of real world examples. They indicated they would have liked more

opportunities for experiential learning and video examples of therapy sessions. Participant ratings are provided in Table 7.

Table 7. Evaluation of TF-CBT Training

Item	Initial Training Average (sd) N=56	Subsequent Training Average (sd) N=53
Existing mastery/competence	4.54 (1.63)	4.02 (2.26)
Post-training mastery/competence	7.14 (1.23)	6.92 (1.47)
Importance of training goals	7.59 (1.76)	7.82 (1.91)
Trainer credibility	8.91 (1.23)	9.34 (1.30)
Training organization	8.46 (1.56)	8.16 (1.56)
Training interest	8.02 (1.75)	8.64 (1.73)
Overall impact on work	7.80 (1.58)	8.50 (1.67)
Impact on assessment & service planning	7.86 (1.75)	8.24 (1.98)

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

Workforce Survey on Trauma Informed Care

Respondents. Fifty-five individuals working within the Texas behavioral health system participated in the workforce survey, which examined knowledge, attitudes and beliefs about trauma. The majority of respondents (83%) were employed by a Local Mental Health Authority (LMHA), and 17% were employed by the state mental health agency (DSHS). There was roughly equivalent representation from Bluebonnet Trails and Heart of Texas MHMR employees.

The majority of respondents were service providers, representing 60% of the sample, with 19% program managers/supervisors, 8% administrators/program directors, and 13% support staff. Employees recognized that trauma experiences were common in the population served by the agency, with just under half of staff (45%) reporting that “almost all” the individuals they serve have experienced traumatic events. Another 42% reported that “almost half” the individuals they serve have experienced trauma.

Training & Skills. A number of questions related to training, skills and supervision of trauma-focused treatment were presented to those respondents who identified as “Service Providers.” The majority of providers (n=19; 83%) felt they have received the training necessary to identify and assess those individuals who have experienced traumatic events. Almost the same number (n=20; 83%) felt they now have the necessary skills to do the same. The rest of the providers gave a “neutral” response to both questions, indicating they were unsure whether they had the training and skills necessary to identify and assess traumatic events in their clients. Only one provider reported to not have received such training.

In addition, 75% of providers (n=18) felt they have received the training necessary to engage and provide effective treatment to individuals who have experienced traumatic events. Slightly more (n=19; 79%) felt they now have the skills to do the same. The rest of the providers gave a “neutral” response to both questions, indicating they were unsure whether they had the training and skills necessary to engage and provide effective treatment to their clients. Only two providers reported to not have received the training needed to engage and provided effective treatment.

One last question probed respondents on whether they felt they had received the supervision necessary to engage and provide effective treatment to individuals who have experienced traumatic events. The

majority of providers (n=17, 71%) felt they did receive effective supervision. Four providers (17%) were not sure and three (13%) reported to have not received such supervision. Given this survey occurred following project trainings on screening, assessment and treatment of traumatic stress and targeted supervision by an expert trainer, this response may not generalize to other system providers who have not been impacted by the initiative.

Knowledge. Overall, most respondents appear to have a good understanding of trauma and its impact. Some questions were answered correctly by almost all respondents, such as a question concerning PTSD symptoms mirroring other psychiatric disorders (n=45; 90%), the possibility of experiencing of vicarious trauma within a cultural group (n=39; 83%), the potential for agencies to re-traumatize a consumer (n=45; 92%), and ways in which traumatic memories can be triggered (n=45; 92%).

There were a few questions about trauma that the respondents did not answer correctly or seemed unsure of the correct answer. For example, only 23% (n=11) knew that experiencing trauma in childhood increases an individual’s risk for developing asthma or lung problems. For another question, over half of the respondents (n=26; 53%) incorrectly thought that most people who experience traumatic events will develop PTSD. Another question respondents were not clear about was regarding the fact that chronic traumatic stress can lead to changes in genetic structures. Although most correctly answered this question (n=29; 60%); a third (n=16; 33%) indicated they were unsure. Most also understood that relational trauma is often more harmful than community trauma (n=26; 53%), but a large number (n=19; 39%) were uncertain.

Rating of Importance of Organizational and Service Delivery Changes. 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. Each potential activities was ranked from 1 to 7, with 1 representing the most important change and 7 the least important. Table 8 outlines the mean ranking of each organizational change, in order of highest to lowest. Training was clearly identified as the most important change respondents felt would contribute towards creating a trauma-informed organization.

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. Again, respondents were asked to rank these changes from 1-7. Screening for trauma experiences was ranked as the most important service change that would reflect a trauma-informed organization. The second most important service change was the implementation of trauma-focused treatments.

Table 8. Ratings of Organizational and Service Delivery Changes to Support Trauma-Informed Care

Organizational Changes	Average rank (sd)
Training for staff	2.04 (1.31)
Training for leadership	2.82 (1.76)
Creating an implementation team	3.53 (1.65)
Developing a written policy for trauma-informed care	3.65 (1.97)
Programs to reduce secondary stress for staff	4.17 (1.98)
Creating a welcoming environment	4.35 (1.93)
Establishing policies for restraint	5.69 (1.65)

Service Delivery Changes	Average rank (sd)
Screening for trauma experiences	2.34 (1.90)
Implementing trauma focused treatments	2.63 (1.55)
Assessments for trauma impacts	3.02 (1.83)
Providing trauma education to consumers	3.44 (1.87)
Implementing strategies to improve resilience	4.36 (1.80)
Establishing strong continuity of care practices	4.65 (2.11)
Implementing peer services	4.90 (1.88)

Readiness for Trauma Informed Care. Another series of questions were posed to behavioral health staff to understand the extent to which implementation has occurred for key activities needed to develop a trauma-informed organization. Respondents rated each activity on a Likert scale of 1 to 10, with one indicating that the activity had not been implemented at all and ten representing the activity has been fully implemented and sustained over time.

As shown in the Table 9, the activities that respondents believe are less fully realized are programs to reduce secondary stress and written policies for trauma-informed care. The activity that appears to have been implemented to the greatest degree is standardized screening for traumatic experiences, followed by standardized assessments and the availability of trauma-focused treatments.

Table 9. Ratings of Organizational and Service Delivery Changes to Support Trauma-Informed Care

Organizational Changes	Average rank (sd)
Programs to reduce secondary stress	4.19 (2.69)
Written policy for trauma-informed care	5.13 (2.97)
Welcoming waiting area and other spaces	5.59 (2.57)
Creating a change team focused on trauma informed approaches	5.60 (2.91)
Consistent education of consumers on trauma and its impact	5.60 (2.49)
Training on skills and strategies to improve resilience	5.98 (2.34)
Training for staff on trauma informed care approaches	5.98 (2.69)
Written policies on restraint	5.98 (2.88)
Training for leadership in trauma-informed values and culture	6.02 (2.81)
Accessible peer services	6.35 (2.40)
Strong continuity of care practices	6.57 (2.38)
Availability of trauma focused treatments	6.85 (2.87)
Standardized assessments for trauma symptoms	6.87 (2.69)
Standardized screening for traumatic experiences	7.09 (2.73)

Conclusion

Significant project accomplishments have occurred in the first year of the project. Robust, collaborative advisory boards have been established at the state and local levels to inform and guide project implementation. Organizational changes have occurred to allow for screening of all children and youth in Bluebonnet Trails Community Center and Heart of Texas MHMR for trauma experiences and impacts. Trauma-Focused CBT has been established at both sites and a significant number of partnering organizations in the two communities have also received training and supervision in TF-CBT. Participating therapists are open to evidence-based interventions and reporting moderate to high competence in the provision of TF-CBT. Parent Child Interaction Therapy (PCIT) is being established in Heart of Texas MHMR with four trained providers and a plan is being developed to implement PCIT in Bluebonnet Trails Community Center and other community mental health centers. Initial data indicates

that youth referred for TF-CBT show significant trauma symptoms at entry and can likely benefit from this intervention. The workforce survey shows that staff feel moderately to very competent in their ability to screen, assess, and treat children with traumatic stress and they feel their organization has adopted these values and principles to a large degree.

Some challenges have also been encountered in the initial year. Difficulties in establishing screening procedures caused some delay in the identification and referral processes, and enrollment in TF-CBT was slower than expected because of these challenges. Both sites had some challenges with recruitment and retention of therapists, resulting in enrollment challenges and the need for additional training opportunities for new staff. Challenges in identifying resources for training around trauma-informed care caused some delays. The evaluation also raises some potential areas for improvement. Data indicates that parents are involved in treatment sessions less than would be expected, so efforts to improve parental engagement may be necessary. In addition, providers seem to be relying on basic skill development activities and psychoeducation primarily, while relying less on core trauma interventions such as relaxation and cognitive coping strategies. This could be addressed through a web-based training update or through supervision processes. Initial therapist ratings of the child's progress seems promising, but formal analysis of outcomes will occur when more follow-up data is available.