Evaluation of Learning Collaboratives to Train Mental Health Providers in Trauma-Focused Cognitive Behavioral Therapy

Funded by: Minnesota Department of Human Services, Children's Mental Health Division
January 2009 – December 2012

February 2012

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Introduction

About Ambit Network

Ambit Network, established in 2005 as a National Child Traumatic Stress Network (NCTSN) Community Treatment and Services Center (Category 3), is a university-community partnership of non-profit, government, and community mental health agencies across Minnesota. NCTSN, which includes over 100 member sites, is funded by the Center for Mental Health Services Substance Abuse and Mental Health Services Administration (SAMHSA), US Department of Health and Human Services through a congressional initiative, The Donald J. Cohen National Child Traumatic Stress Initiative (National Child Traumatic Stress Network [NCTSN], n.d.-b). The NCTSN mission is "to raise the standard of care and improve access to services for traumatized children, their families and communities" through "treatment, intervention development, training, data analysis, program evaluation, policy analysis, systems change, and integration of trauma-informed and evidence-based practices in all child-serving systems" (NCTSN, n.d.-a).

Ambit fulfills the NCTSN mission by implementing and disseminating trauma-informed evidence-based practices (EBPs) through training community mental health providers and providing technical assistance, evaluation, and support to ensure the long-term sustainability of these practices in Minnesota. Ambit provides training across the mental health continuum to outpatient, inpatient, and residential treatment facilities. With its community and government partners, Ambit connects "front-door agencies" to this network of trauma-trained providers to ensure that all children who have experienced trauma have the opportunity to access high quality, trauma-informed care and overcome the effects of their traumatic experiences.

Purpose of the Evaluation

In January 2009, Ambit signed a contract with the Minnesota Department of Human Services (DHS), agreeing to complete a two-year evaluation of its DHS-funded TF-CBT Learning Collaboratives (LC) through December 31, 2010. In December 2010, the contract was extended for an additional two years to December 31, 2012. The contract extension stipulated that the evaluation activities outlined in the original contract would continue. These evaluation activities included:

- Collection and analysis of clinical assessments to assess change in client outcomes; reports from clinical assessments would be sent to each trainee after an assessment was submitted.
- Collection and analysis of fidelity measures to assess fidelity to the treatment model; fidelity measures would be maintained by Ambit Network.
- Monthly tracking of treatment components, including the use of clinical assessments and fidelity measures; reports would be sent to both trainees and supervisors.
- Pre- and post-assessment of trainee attitudes toward evidence-based practices.
- Evaluations of in-person training days; findings from training evaluations would be sent to DHS and shared with the TF-CBT trainer(s).
- Interviews with clinical supervisors at six months and at the end of the LC regarding successes and challenges of training and implementing TF-CBT.

- Monthly evaluations of consultation calls with a TF-CBT trainer; findings from monthly evaluations would be sent to DHS and shared with the TF-CBT trainer(s).

This report provides a final comprehensive evaluation of the TF-CBT LCs initiated and implemented by DHS between January 1, 2009 and December 31, 2012, in accordance with the requirements of the contract between DHS and Ambit. This report has two additional purposes:

1. Determine the appropriateness of the LC model to train community mental health providers in an EBP (specifically, TF-CBT).

2. Report preliminary findings on the successes and challenges of training mental health providers in TF-CBT and of implementing TF-CBT in community settings.

Program Description

About TF-CBT

Trauma-Focused Cognitive Behavioral Therapy (TF-CBT) is an evidence-based treatment used to help children overcome the effects of traumatic events. TF-CBT provides treatment for posttraumatic stress symptoms in addition to addressing behavior problems, depression, anxiety, and inappropriate sexual behaviors (Cohen & Mannarino, 1996, 1998; Deblinger, Lippmann, & Steer, 1996; Deblinger, McLeer, & Henry, 1990; Deblinger, Stauffer, & Steer, 2001; King et al., 2000). TF-CBT has also been shown to improve children's safety skills, parenting practices, and parental coping skills (Deblinger, et al., 1996; Deblinger, et al., 2001). Follow-up studies found that these improvements were maintained one- and two-years post-treatment for children who received TF-CBT (Cohen & Mannarino, 1997; Cohen, Mannarino, & Knudsen, 2005; Deblinger, et al., 1996). TF-CBT is an assessment-based and components-based model; treatment planning and client progress is monitored through the use of standardized clinical assessments (Cohen, Mannarino, & Deblinger, 2006). Therapists utilizing TF-CBT to treat trauma follow a sequence of components signified by the acronym PRACTICE.

- P: Psychoeducation and Parenting Skills
- R: Relaxation
- A: Affect Regulation
- C: Cognitive Coping
- T: Trauma Narrative Development
- I: In-Vivo Exposure
- C: Conjoint Parent-Child Sessions
- E: Enhancing Safety and Future Development

Ambit Network's Training Model

Ambit Network provided training in TF-CBT to community mental health providers using a Learning Collaborative (LC) model, an evidence-based quality improvement training model developed by the Institute for Healthcare Improvement (Institute for Healthcare Improvement, 2003) and adapted and

utilized by the National Child Traumatic Stress Network (Ebert, Amaya-Jackson, Markiewicz, & Fairbank, 2012; Ebert, Amaya-Jackson, Markiewicz, Kisiel, & Fairbank, 2012). TF-CBT LC activities are provided over the course of one year and include three trainings (a total of five in-person training days) and 18 consultation calls. A nationally approved TF-CBT trainer led both the in-person trainings and the consultation calls. In addition to attending training days and consultation calls, trainees are required to provide TF-CBT treatment to a minimum of six clients over the course of the LC.

Recruitment for the Learning Collaborative

A general overview of the recruitment process is provided in this section. Recruitment strategies specific to each LC cohort are described in a later section. Trainees for LC cohorts were recruited through a request for proposals (RFP) from the Children's Mental Health Division at the Minnesota Department of Human Services (DHS). The purpose of the RFPs was to develop the clinical capacity of community mental health providers to utilize emerging research on evidence-based practices to inform treatment and improve the outcomes for children and families in Minnesota. Interested agencies were required to apply as a team comprised of one clinical supervisor and as many as five direct service providers. Agencies selected to participate entered into a contract with DHS, which reimbursed agencies for participation in the grant. Grant funds could be used to cover tuition, fees, training costs, consultation costs, and costs incurred by agencies to release staff for participation in training and consultation. Grant funds could also be used to cover lodging and per diem expenses but could not be used to pay for direct services or administrative costs.

Trainees who participated in the grant were required to:

- Attend in-person trainings and complete required training materials and online trainings
- Participate in case consultation calls
- Provide direct therapy to clients using the TF-CBT treatment model and monitor fidelity to the model
- Utilize standardized clinical assessments over the course of TF-CBT treatment
- Submit clinical assessments and fidelity measures to Ambit Network

In-Person Trainings

Ambit Network's TF-CBT LCs included three in-person trainings (a total of five full days of training), hosted at a location central to the participating agencies. The components of each training are described below.

Training 1

Training 1 occurred at the beginning of the LC and included two days of in-person training. This training provided an overview of trauma ("Trauma 101") and child traumatic stress as well as an introduction to trauma-informed assessments and TF-CBT implementation. The lecture on childhood trauma covered the following topics:

- Trauma Principles
- Facts About Child Traumatic Stress
- Clinical Diagnosis of Trauma

- Trauma and Development

This training also included a role-play about conducting trauma assessments and providing results to clients and caregivers and reviewed the first four components of the TF-CBT treatment model (PRAC).

Training 2

Training 2 occurred approximately three months after Training 1 and included two days of in-person training. At the second training, trainees received instruction in the last four components of the TF-CBT treatment model (TICE). This training included a lecture on developmental trauma disorder and a group discussion about trainee experiences using clinical trauma assessments.

Training 3

The final TF-CBT training (a daylong in-person training) focused on sustaining TF-CBT after the LC and included discussions on a variety of topics, including compassion fatigue, avoidance as a clinical issue, and child traumatic grief. It also included a discussion on successful and unsuccessful strategies for implementing TF-CBT.

Consultation Calls

Bimonthly consultation calls began one month after the first training. Over the course of nine months, trainees participated in consultation calls led by a nationally certified TF-CBT trainer. In addition to reviewing PRACTICE components, trainees were required to give presentations on actual clients and ask a clinical question or discuss a clinical issue during the presentation. Consultation calls utilized an online component that allowed the trainer and other trainees to view the clinical assessments, fidelity monitoring tools, and trauma narratives of the presenters' client during the case presentation. Trainees were required to attend a minimum of 12 calls over the course of the LC.

Supervisor Calls

Supervisor calls began one month after the first training. Over the course of the LC, supervisors from each agency participated in consultation calls with a nationally certified TF-CBT trainer, an Ambit Network staff member, and a representative from DHS. In addition to case consultation, supervisors participated in conversations about successes and challenges of implementing TF-CBT and developed sustainability plans for after the LC.

Follow-up and Practicum Period

Trainees were required to provide treatment using the TF-CBT model to a minimum of six clients, utilizing standardized clinical assessments and fidelity monitoring tools with each client receiving treatment. Clinical assessments were used to monitor client symptoms over the course of treatment and were administered at baseline and three-month follow-up intervals until the end of treatment. Fidelity monitoring tools were to be used by trainees to monitor their adherence to the TF-CBT treatment model (PRACTICE) for each client receiving treatment.

Description of Learning Collaborative cohorts

A brief description of each cohort is provided, including recruitment details, duration of the LC activities (in-person trainings and consultation calls), duration of the LC tracking period (if applicable), and a detailed description of LC activities.

Beta

Trainees for the Beta cohort were recruited through a Request for Proposals (RFP) from the Minnesota Department of Human Services (DHS). The Children's Mental Health Division at DHS released a RFP to develop the clinical capacity of providers to provide trauma-informed evidence-based services to children and families. Agencies responded to the RFP by submitting proposals with a description of the team that would participate in the LC. Agencies were required to apply as a team with one clinical supervisor and two or three additional providers.

Beta cohort Statistics

LC Duration: December 2008 – May 2010 (18 months)
Tracking Duration: January 2009 – May 2011
Region: Statewide
Beta LC Activities

- Four in-person trainings (six total days)
  - Training1: December 2008 (two days)
    - Trauma 101, trauma-informed assessments
  - Training 2: January 2009 (two days)
    - TF-CBT treatment model; PRACTICE
  - Training 3: May 2009 (one day)
    - Check-in training
  - Training 4: October 2009 (one day)
    - Sustainability and clinical issues
- Consultation calls
  - Two call periods were provided each month, and trainees had the option to attend one of two calls during that call period.
  - 18 call periods (36 calls) were scheduled from February 2009 to October 2009.
- Supervisor calls
  - Monthly supervisor calls were scheduled for supervisors. Data is missing on the number of calls scheduled for this cohort.

Gamma

Gamma trainees were recruited through a DHS RFP. The Children's Mental Health Division at DHS released a RFP to develop the clinical capacity of providers to provide trauma-informed evidence-based services to children and families. Agencies responded to the RFP by submitting proposals with a description of the team that would participate in the LC. Agencies were required to apply as a team with one clinical supervisor and two or three additional participants.

Gamma cohort Statistics

Tracking Duration: January 2010 – May 2011 (11 months)
Region: Statewide
Gamma LC Activities:

- Four in-person trainings (five total days)
  - Training 1: January 2010 (two days)
    - Trauma 101, trauma-informed assessments
  - Training 2: February 2010 (two days)
    - TF-CBT treatment model; PRACTICE
  - Training3: November 2010 (one day)
    - Sustainability and clinical issues
- Consultation calls
  - Two call periods were provided each month, and trainees had the option to attend one of two calls during that call period.
  - 16 call periods (32 calls) were scheduled from March 2010 to November 2010.
- Supervisor calls
  - Supervisor calls were not provided for this cohort.

Delta

Trainees for the Delta cohort were recruited through a Request for Proposals (RFP) from the Minnesota Department of Human Services (DHS). The Children's Mental Health Division at DHS released an RFP specifically for residential treatment providers. The agencies submitting RFPs had to be residential treatment centers to be included in this LC.

Delta cohort Statistics

LC Duration: October 2010 – October 2011 (12 months)
Tracking Duration: October 2010 – May 2012
Region: Statewide
Delta LC Activities:

- Four in-person trainings (six total days)
  - Training 1: October 2010 (two days)
    - Trauma 101, trauma-informed assessments
  - Training 2: November 2010 (two days)
    - TF-CBT treatment model; PRACTICE
  - Training3: May 2011 (one day)
    - Check-in training
  - Training 4: October 2011 (one day)
    - Sustainability and clinical issues
- Consultation calls
  - Four calls scheduled each month. Trainees required to attend at least two calls per month.
  - 32 consultation calls were scheduled from December 2010 to September 2011.
- Supervisor Calls

- Monthly supervisor calls were scheduled.
- 9 supervisor calls were scheduled from December 2010 to September 2011.

Theta

Before participating in an Ambit Network LC, trainees for the Theta cohort were involved in two pilot projects funded by DHS, which covered the integration of mental health and primary care with a focus on depression. DHS opted to train these pilot project participants in TF-CBT as well.

Theta cohort Statistics

LC Duration: October 2011 – September 2012 (11 months)
Tracking Duration: October 2011 – Present
Region: Statewide (majority in Twin Cities-Metro and northern Minnesota)
Theta LC Activities:

- Two in-person trainings (four total days)
  - Training 1: October 2011 (two days)
    - Trauma 101, trauma-informed assessments
    - First part of TF-CBT treatment model (PRAC)
  - Training 2: November 2011 (two days)
    - Second part of TF-CBT treatment model (TICE)
- Consultation calls
  - Two calls scheduled per month, and trainees were required to attend a minimum of 12 calls.
  - 16 consultation calls were scheduled from December 2011 to September 2012.
- Supervisor Calls
  - Monthly supervisor calls were scheduled.
  - 10 supervisor calls were scheduled from December 2011 to September 2012.

Lambda

Trainees in the Lambda cohort were recruited through a RFP from DHS. The Children's Mental Health Division at DHS released a RFP to develop the clinical capacity of providers in Southern Minnesota to provide trauma-informed evidence-based services to children and families. Agencies responded to the RFP by submitting proposals and providing a description of the team that would participate in the LC. Agencies were required to apply as a team with one clinical supervisor and two or three additional participants.

Lambda cohort Statistics

LC Duration: January 2012 – December 2012 (12 months)
Tracking Duration: January 2012 - Present
Region: Southern Minnesota
Lambda LC Activities:

- Three in-person trainings (five total days)
  - Training 1: January 2012 (two days)
    - Trauma 101, trauma-informed assessments
    - First part of the TF-CBT treatment model (PRAC)

  - Training 2: April 2012 (two days)
    - Second part of the TF-CBT treatment model (TICE)
  - Training 3: October 2012 (one day)
    - Sustainability and clinical issues
- Consultation calls
  - Two calls scheduled per month, and trainees were required to attend a minimum of 12 calls.
  - 21 consultation calls were scheduled from February 2012 to December 2012.
- Supervisor Calls
  - Monthly supervisor calls were scheduled.
  - 9 supervisor calls were scheduled from February 2012 to December 2012

Kappa

Kappa trainees were originally part of a grant designed to provide training for clinicians serving children, especially American Indian children, in and around the Mahnomen County area. DHS decided to include these providers in an Ambit LC as well.

Kappa cohort Statistics

LC Duration: February 2012 – November 2012 (9 months)
Tracking Duration: February 2012 – Present
Region: Northern Minnesota
Kappa LC Activities:

- Three in-person trainings (five total days)
  - Training 1: February 2012 (two days)
    - Trauma 101, trauma-informed assessments
    - First part of the TF-CBT treatment model (PRAC)
  - Training 2: May 2012 (two days)
    - Second part of the TF-CBT treatment model (TICE)
  - Training 3: October 2012 (one day)
    - Sustainability and clinical issues
- Consultation calls
  - Two calls scheduled per month, and trainees were required to attend a minimum of 12 calls.
  - 17 consultation calls were scheduled from March 2012 to November 2012.
- Supervisor Calls
  - Monthly supervisor calls were scheduled.
  - 9 supervisor calls were scheduled from March 2012 to November 2012.

Methods

Sample

The sample for this report is comprised of trainees from the six LC cohorts implemented over the course of the evaluation contract period (January 1, 2009 – December 31, 2012). Each cohort had one to five individuals drop out early, but the sample for this report includes all individuals who started a LC (N=150). A total of 36 agencies across the state of Minnesota participated in a LC cohort from January 2009 to December 2012. Out of those agencies, 30.5% (N=11) were located in the Minneapolis-St. Paul metropolitan area (Hennepin, Ramsey, and Anoka counties; see Appendix A for a map of Minnesota with agency locations).

Description of the Trainees

The trainees were 78.6% female (N=118) and 21.3% male (N=32). Data on professional degree and licensure is available for a portion of the trainees. Prior to 2012, degree and licensure information was collected from agency applications. Beginning in 2012, trainees were required to complete Clinician Information forms to provide additional information about themselves, including their contact information, for tracking and referral purposes. The tables below do not represent unique counts of trainees, as some trainees had multiple degrees and/or licensures.

Type of Degree	Number
Masters of Arts	29
Masters in Social Work	28
Masters of Science	17
Doctor of Psychology	6
Doctor of Philosophy	4
Master of Divinity	1
Masters of Education	1
Total	**86**

Type of License	Number
Licensed Independent Clinical Social Worker	52
Licensed Marriage and Family Therapist	30
Licensed Psychologist	19
Licensed Professional Clinical Counselor	10
Licensed Graduate Social Worker	8
Licensed Professional Counselor	7
Licensed Alcohol and Drug Counselor	4
Nationally Certified Counselor	4
Licensed Social Worker	1
Licensed Independent Social Worker	1
Total	**136**

Data Collection Methods

Trainee Attitudes toward Evidence-Based Practices

Ambit Network used the Evidence-Based Practice Attitude Scale (EBPAS; Aarons, 2004) to assess changes in provider attitudes toward EBPs over the course of the LC. The EBPAS assesses provider attitudes toward key determinants for predicting provider adoption of EBPs, including the appeal of using an EBP, provider openness to using EBPs, and the perceived divergence of the EBP from "practice as usual." Providers were surveyed at three timepoints during the LC: at baseline, during the middle of the LC, and at the end of the LC.

When possible, EBPAS surveys were administered at the beginning of in-person trainings and were collected at the end of the training. When it was not possible to administer at in-person training (e.g., in-person training did not occur in the middle of the LC), trainees received an electronic copy of the EBPAS via email. Over the course of the month after this initial email was sent, trainees received reminders to complete and submit the EBPAS. Ambit Network staff entered EBPAS data into an SPSS dataset after each data collection timepoint for the EBPAS.

Evaluation of and Satisfaction with In-Person Trainings

At each of the four in-person trainings, an attendance sheet was posted at the room entrance. Trainees were asked to sign their name and indicate their time of arrival and departure from the training. Ambit Network staff reviewed attendance sheets and filled in missing information at the end of training. Attendance records were entered into a Microsoft Excel spreadsheet by Ambit Network staff.

Trainees received a brief evaluation and check-in survey at the beginning of in-person trainings. The survey included open-ended questions to evaluate trainee satisfaction with the training and the LC process and Likert scale items to evaluate training components used in a specific training. Completed surveys were collected at the end of trainings and entered into an SPSS dataset by Ambit Network staff.

Evaluation of and Satisfaction with Consultation Calls

Roll call was taken by Ambit Network staff within the first five minutes of each consultation call. If trainees joined the call after roll call, they were instructed to announce their attendance upon joining the call to be marked as "present." Attendance records for consultation calls were stored in Microsoft Excel and were updated while calls were in progress.

Due to limited staffing, Ambit was unable to conduct monthly survey evaluations of LC trainees regarding satisfaction with LC consultation calls and consultation with the TF-CBT trainer. Informal feedback was provided by trainees throughout each LC cohort either through email or during consultation calls. Feedback about the call contents was documented in Microsoft Word and/or Microsoft OneNote. If feedback was emailed to Ambit Network, copies of these emails were stored and archived in the Ambit Network inbox.

Successes and Challenges in Training and Implementing TF-CBT

Due to limited staffing, Ambit was unable to conduct interviews with clinical supervisors at a six month timepoint during each LC cohort. At the end of each LC, Ambit Network conducted focus groups with

both the trainees and supervisors and asked questions about sustainability and successes and challenges with implementing TF-CBT. Trainees were asked to discuss these topics at the final training in their LC cohort. Clinical supervisors were asked sustainability questions during the final supervisor call as well. During both of these discussions, Ambit Network staff took notes in Microsoft Word or Microsoft OneNote and saved them on the Ambit Network server at the University of Minnesota.

Client Outcomes

During the follow-up and practicum period, trainees submitted de-identified clinical assessments at baseline, at three-month follow-ups, and at the end of treatment to Ambit Network. Trainees were provided with copies of the Trauma Symptom Checklist for Children (TSCC-A; Briere, 1996), the UCLA PTSD Index for DSM-IV (UCLA; Steinberg, Brymer, Decker, & Pynoos, 2004), the Trauma Symptom Checklist for Young Children (TSCYC; Briere, 2005), and the Strengths and Difficulties Questionnaire (developed by Goodman; Parent, Self, and Teacher versions available; SDQ; Youthinmind.org, n.d.).

Trainees were required to submit a baseline assessment interview with new clients.

After the baseline interview, Ambit Network staff sent client-specific email reminders to individual trainees and prompted them to complete a follow-up assessment interview for each TF-CBT client every three months. These emails specified a one month window during which the client was "due" for follow-up assessments. If follow-up assessments were submitted during this timeframe, Ambit Network staff entered the clinical data into a web-based database. If the follow-up assessment window ended and assessments were not submitted, the interview was considered missing. Trainees were also required to submit end of treatment interviews when clients ended TF-CBT treatment.

Clinical outcomes data was entered in a web-based electronic database provided by SAMHSA, Ambit's federal funding agency, until August 2012. This database was managed by an external evaluation agency contracted by SAMHSA to conduct SAMHSA's evaluation. In August 2012, the database shut down when the contract between SAMHSA and the external agency ended. In September 2012, Ambit Network staff began to enter clinical outcomes data into an SPSS dataset downloaded directly from the electronic database prior to its close.

Fidelity

Two types of data were collected to evaluate fidelity to the TF-CBT model: 1) implementing TF-CBT as an assessment-based treatment model and 2) implementing TF-CBT as a components-based treatment model. Data collected to assess fidelity to TF-CBT as an assessment-based model was analyzed for this report. Data collection methods for this data are described below.

Implementing TF-CBT as an Assessment-based Treatment Model

To assess trainee fidelity to TF-CBT as an assessment-based treatment model, Ambit Network collected data at baseline, follow-up, and end of treatment interview timepoints and recorded this information in an internal database separate from the web-based database. Each assessment interview was coded by type of interview (baseline, follow-up, closed, or re-opened) and interview status (complete, incomplete). Follow-up assessment interviews were coded as late, on-time, or missed. End of treatment interviews were coded by the reason the case closed.

This interview data was collected using a Microsoft Access database built by Ambit Network to monitor and track trainee participation and compliance with RFP requirements. This database was stored on a secure network at the University of Minnesota, and only individuals trained in Microsoft Access had access to it. The Access database used two main forms for data entry, a Client Profile form and an Interview Profile form. Demographic information on clients treated by trainees entered into the Client Profile form. Fidelity data was entered into the Interview Profile form.

Indicators for the Evaluation

Five indicators were developed to measure the two parts of this evaluation.

Indicator 1: Change in provider attitudes about evidence-based practices.

Indicator 2: Participation and completion of required LC activities.

Indicator 3: Successes and challenges of TF-CBT and the LC.

Indicator 4: Change in client posttraumatic stress symptoms.

Indicator 5: National TF-CBT certification.

To determine the appropriateness of using the LC model to train community mental health providers

- An improvement would be seen in trainee attitudes toward the use of EBPs in their clinical practice (Indicator 1)
- Providers would complete all requirements of their contract with the state (Indicator 2), specifically
    - Attend all days of training provided by Ambit
    - Participate in a minimum of 12 consultation calls
    - Begin treatment with a minimum of six clients
    - Complete assessments at baseline and at follow-up intervals
- An improvement will be seen in client posttraumatic stress symptoms over the course of treatment (Indicator 4), specifically
    - For clients between the ages of 7-18, a decrease in overall posttraumatic stress disorder (PTSD) symptoms as assessed by the UCLA PTSD Index for DSM-IV (UCLA).
    - For clients between the ages of 8-16, a decrease in posttraumatic stress symptoms (anger, anxiety, dissociation, depression, and PTSD) as assessed by the Trauma Symptom Checklist for Children – Abbreviated version (TSCC-A).
- Providers would meet the minimum requirements and be eligible to apply for national certification as a trained TF-CBT therapist (Indicator 5)

To document the successes and challenges of the LC model and in implementing TF-CBT in Minnesota.

- Providers would provide comprehensive feedback at in-person trainings and during consultation calls (Indicator 3)

Results

Indicator 1: Change in Provider Attitudes about Evidence-Based Practices

At the first data collection timepoint, almost all trainees (98%, N=147) completed the EBPAS survey. At the last timepoint for EBPAS data collection, 122 trainees submitted EBPAS assessments to Ambit Network. The decrease in numbers was due to individuals who left the LC early or to non-responses from trainees.

The results show that the average scores on EBPAS scales at the first timepoint were relatively close to the ends of the spectrum used to assess trainee attitudes toward EBPs. These average scores were maintained over the course of the LC with very little change between the first and last timepoints. On average, trainees who participated and completed the LCs were likely to:

- Have a more global positive attitude toward adopting and utilizing evidence-based practices (Total)
- Adopt a new practice if required by a governing organization (e.g., agency, supervisor, or state requirements; Requirements scale)
- Utilize a new practice if intuitively or practically appealing, or if colleagues were satisfied with the practice (Appeal scale)
- Be open to learning a new practice, intervention, or type of therapy (Openness scale)

These trainees were also likely to see the clinical usefulness and application of TF-CBT to their everyday practice, as evidenced by the lower scores on the Divergence scale. Lower scores on the Divergence scales indicate that trainees had more positive attitudes about using manualized treatments and were not deterred by the treatment's research base (see Appendix B for EBPAS scores by cohort).

Average Scores on EBPAS Scales at First and Last Timepoints; All Trainees.

Scale	First Timepoint	Last Timepoint	Actual Change	Percent Change
Total Overall	3.0347	3.1401	.1054	3%
Requirements	2.7007	2.7350	.0343	1%
Appeal	3.2772	3.3934	.1162	4%
Openness	2.9898	3.1803	.1905	6%
Divergence	.9127	.8641	-.0486	-5%

Because of the lack of variation between the two timepoints on average scores, no tests of significance were conducted to determine if a change occurred over the course of the LC. The percent of trainees with positive or negative changes on their EBPAS scales over time was calculated. A total of 76 trainees were included in this analysis. The smaller number for this analysis is due to a lack of linking information (Clinician IDs) from two cohorts. During most cohorts, providers were asked to include their unique identifying Clinician ID number when submitting their EBPAS surveys, however, during the Gamma and Delta cohorts, Clinician IDs were not utilized during the data collection process. As a result, these cases had to be excluded from data analysis because without the Clinician IDs, it was not possible to analyze

changes in their data. A review of the paper copies of the EBPAS surveys show that no Clinician IDs were recorded on the hardcopies of the assessments. Therefore, the lack of linking information was not due to data entry error.

Analysis of the EBPAS scales shows that for all scales and the total overall score on the EBPAS, the scores of a majority of trainees changed in a positive direction between the first and last assessment timepoints. However, a relatively large percentage of providers had negative changes in their scores, and a large percentage of providers indicated no change. For example, on the Openness scale, the difference between the percentage of trainees with no change in their scores and the percentage of trainees with a positive change in their scores was small.

Direction of Change between First and Last Timepoints; All Trainees.

		Number	Percent
Total Overall			
	Positive	***43***	***56.6%***
	Negative	30	39.5%
	No Change	3	3.9%
Requirements Scale			
	Positive	***32***	***42.1%***
	Negative	29	38.2%
	No change	15	19.7%
Appeal Scale			
	Positive	***31***	***40.8%***
	Negative	26	34.2%
	No Change	19	25.0%
Openness Scale			
	Positive	***30***	***39.5%***
	Negative	19	25.0%
	No change	27	35.5%
Divergence Scale			
	Positive	***31***	***40.8%***
	Negative	29	38.2%
	No change	16	21.1%

Note: Directions of change are bolded and italicized to indicate the direction of change a majority of the providers moved between the first and last timepoint.

Indicator 2: Participation and Completion of Required LC Activities

Of the 150 trainees who started a LC, 132 completed the entire LC and 18 trainees dropped out early. Of the six cohorts, the Gamma cohort had the largest number of trainees leave early. Reasons that trainees left a LC early included taking a new position at a different agency, going on maternity leave, and retiring.

Number of Trainees who Enrolled, Completed, or Dropped Early from a LC

cohort Name	Enrolled	Completed	Dropped
Beta	22	19	3
Gamma	26	21	5
Delta	25	24	1
Theta	32	28	4
Lambda	20	18	2
Kappa	25	22	3

In-Person Trainings

Over the past four years, Ambit has provided a total of 31 days of training (183.75 hours) to TF-CBT cohorts. Training hours include only the time trainees spent actively participating in training. Break times, including a lunch hour, were excluded from the total training hours.

Each cohort had four to six days of training. The average hours of total training time per cohort was 30.7 hours. Beta and Delta had the most training days (N=6), while the Theta cohort had the fewest days (N=4). Lambda, Kappa, and Gamma each had five days of training.

Number of Training Days and Hours, by cohort

cohort	Number of Trainings	Number of Days	Total Hours
Beta	4	6	36.75
Gamma	3	5	29.25
Delta	4	6	34.5
Theta	2	4	24.5
Lambda	3	5	28.75
Kappa	3	5	30

The average number of days attended by trainees (N=150) was 4.81. The average number of hours trainees spent in training was 28.24. A little more than half of the trainees attended all hours of training provided by Ambit (60.7%, N=91). The table below provides a breakdown by cohort of the numbers and percentages of trainees who attended all hours of training versus the numbers and percentages of trainees who did not. The cohorts with the best attendance records at all trainings were Lambda (90%) and Theta (72%), while Gamma and Beta had the lowest percentages of trainees complete all hours. Some reasons for not attending trainings included being on maternity leave and having other personal and professional commitments on training days. One possible reason for lower percentages in the Beta,

Gamma, and Delta cohorts specifically may be that these cohorts were statewide instead of regional. Due to distance, some agencies may have decided not to attend the one-day trainings at the end of the LCs.

Number of Trainees who Participated in All Hours of Training Provided

		Participated in All Hours (Yes)		Did Not Participate in All Hours (No)	
cohort	Total	Number	Percent	Number	Percent
Beta	22	9	40.9%	13	59.1%
Gamma	26	5	19.2%	21	80.8%
Delta	25	17	68.0%	8	32.0%
Theta	32	24	75%	8	25.0%
Lambda	20	18	90.0%	2	10.0%
Kappa	25	18	72.0%	7	28.0%

While this data provides an accurate representation of participation in training requirements as outlined in agency contracts with DHS, it does not provide the information necessary to determine the number of trainees who would meet the national certification requirement for TF-CBT training. National certification requires trainees to participate in trainings on trauma-informed assessment and the TF-CBT model (the PRACTICE components). All LC cohorts completed training on these components in the first two trainings (first four days of training). Data analysis was done to determine whether or not individual trainees attended **all** hours of the first two trainings, and the percentage of individuals who did attend was calculated.

Of the 150 trainees who began a LC cohort, 92% (N=138) of trainees met the training requirement for national certification. The table below demonstrates that of all six LC cohorts, four of the six cohorts have 90% or more trainees who met this certification requirement.

Number of Trainees who Attended First Two Trainings Covering the PRACTICE Components

cohort	Number Yes	Percent
Beta	21	95.5%
Gamma	23	88.5%
Delta	24	96.0%
Theta	27	84.4%
Lambda	20	100%
Kappa	23	92.0%

Consultation Calls

Since January 2009, Ambit has provided a total of 147 calls across all six LC cohorts. Trainees attended an average of 11.2 calls during a LC. Each trainee was required to attend a minimum of 12 calls over the course of the LC. This requirement was stipulated in their contract and is also a requirement for national certification. Of the 150 trainees who participated in a LC, only 60% (N=90) attended a minimum of 12

calls. The table below shows the total number of calls scheduled, the number of calls cancelled, the number of calls provided, and the average attendance for each cohort. Delta and Beta cohorts were the only cohorts to have an average **above** the minimum number of calls required (N=12).

Average Attendance on Consultation Calls, by cohort

cohort	Method	Scheduled	Cancelled	Provided	Average
Beta	1	36	2	34	13.7
Gamma	1	30	3	27	7.46
Delta	1	36	4	32	14.48
Theta	2	19	3	16	11.75
Lambda	2	22	1	21	11.5
Kappa	2	18	1	17	10.4

Note: The column "Method" indicates the type of scheduling and communication used with each cohort. Methods for communicating and scheduling are described in further detail in the Program Description section in this report.

Because two different methods were used for scheduling and communication consultation calls (three cohorts used Method 1 and three cohorts used Method 2), analyses were run to determine if there was a difference between average attendance and the number of trainees who met the consultation call requirement. While a test for significance was not conducted for this report, the data in the table below indicates that Method 1 may be a more successful method for scheduling and communicating about consultation calls with cohorts. While neither method has an average attendance above the requirement level, there is a higher average attendance for Method 1, as well as a larger number of individuals who attended a minimum of 12 consultation calls during their LC.

Average Attendance, by Method of Consultation Call Scheduling

	Number	Average Attendance	Requirement Met
Method 1	73	11.77	50
Method 2	77	10.68	40

Supervisor Calls

Supervisor call data was available for three of the six cohorts (Theta, Lambda, Kappa). Attendance data for supervisor calls was missing for the Beta, Gamma, and Delta cohorts. Data on supervisor calls was available for 20 of the 36 agencies included in this report. Two of the agencies that participated in the Theta, Lambda, and Kappa cohorts did not have designated supervisors during their LC. One agency completed the LC without a supervisor, and trainees at the second agency had a supervisor on-site who had previously completed a TF-CBT LC but did not participate in supervisor calls for the cohort in which the second group of trainees was participating.

At four agencies, designated clinical supervisors left their TF-CBT supervisory role during the LC. Only one of these agencies had a second supervisor take over when the first supervisor left. Of the 20 supervisors included in this analysis, less than half (N=9; 45%) of the supervisors attended between 75-

100% of the calls provided by Ambit Network. Most supervisors (N=15; 75%) attended 50 to 100% of the supervisor calls provided by Ambit Network. Only four of the 20 supervisors attended all calls provided during their respective cohorts. The table below provides the number of supervisors who attended 0-25%, 25-50%, 50-75%, and 75-100% of supervisor calls.

Attendance on Supervisor Calls, by cohort

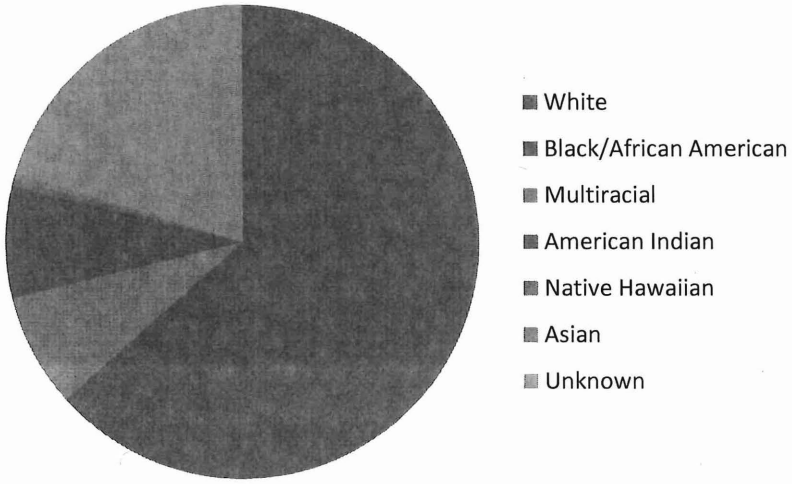
		Attendance on Calls			
cohort	Number of Calls Provided	0-25%	25-50%	50-75%	75-100%
Theta	10	1	3	2	3
Lambda	9	0	0	3	2
Kappa	9	0	1	1	4

Fidelity to TF-CBT as an Assessment-based Model

A total of 141 (94.0%) trainees submitted paperwork on at least one client during or after their respective LCs. Trainees screened and/or treated a total of 1,242 clients (herein referred to as "clients screened for TF-CBT") during the reporting period. A majority of the clients screened for TF-CBT were female (56.0%, N=695), not Hispanic/Latino (68.0%, N=844), and white (54.6%, N=678). Data on race was missing for 252 clients and data on ethnicity was missing for 315 clients[1]. A majority of the clients were between the ages of 5-18 (97%, N=1,202), and a small number of clients was four years of age or younger (N=27) or 19 years of age or older (N=10).

[1] Three of the six cohorts (Beta, Gamma, and Delta) had the option to screen clients for posttraumatic stress symptoms before beginning treatment with TF-CBT by sending at least one clinical assessment to Ambit Network. Trainees **were not required** to report race or ethnicity information during these screening interviews, and would provide race and ethnicity information if a screening client began treatment with TF-CBT.

Race of Clients Screened for TF-CBT

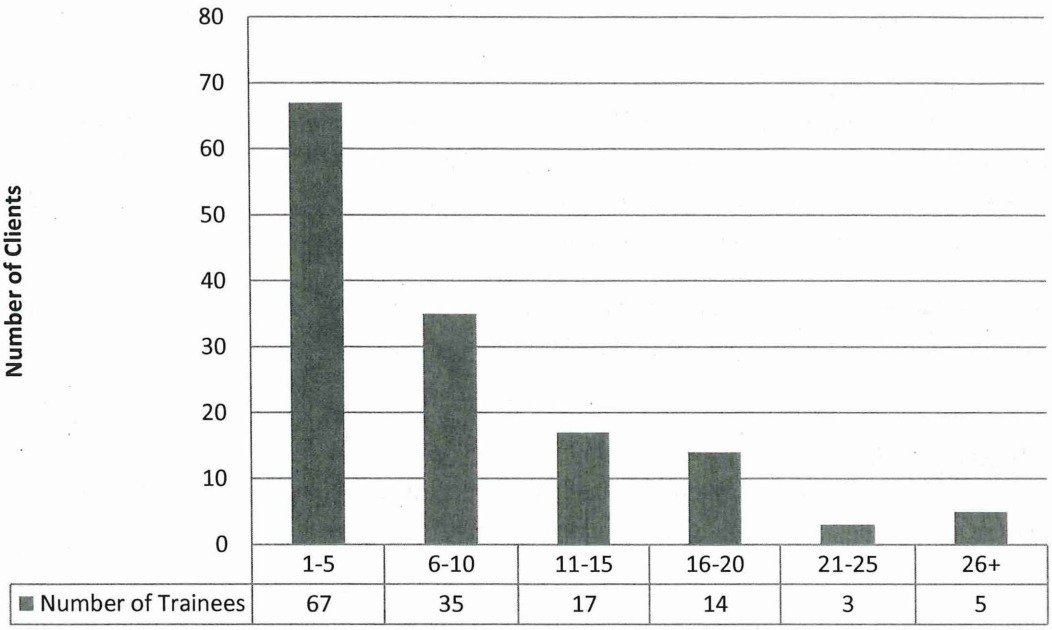


	Number	Percent
Black/African American	110	8.9%
Asian	5	.4%
White	678	54.6%
Native Hawaiian or other Pacific Islander	6	.5%
American Indian/Alaskan Native	95	7.6%
Multiracial[2]	96	7.7%
Unknown	252	20.3%

Trainees screened an average of 8.8 clients each, but less than half of the trainees who began a LC screened and/or began treatment with at least six clients (49.3%, N=74). The minimum number of clients screened by a trainee was one, and the maximum number of clients screened by a trainee was 75. Of the 1,242 clients included in this report, 51 clients saw two trained therapists during their TF-CBT treatment. These clients were transferred in the middle of treatment, or their case was closed and reopened at a later date.

[2] Clients were coded as multiracial if the trainee identified multiple races on the baseline demographics data collection form.

Total Number of Clients Screened, by Count of Trainees



Note: Five trainees screened 26 or more clients for TF-CBT; number of clients screened in this group includes 29, 38, 52, 54, and 75. A majority of these clients were screened during the time period in which trainees were allowed to screen and all clients and submit to Ambit Network.

Status of Assessment Interviews

Definitions

Screening Assessment Interview: Trainees submitted at least one clinical assessment to determine if the client had posttraumatic stress symptoms and if TF-CBT was an appropriate treatment.

Three of the six cohorts trained in TF-CBT had the option to screen clients for trauma and TF-CBT prior to beginning treatment with TF-CBT. Trainees who chose to screen clients were required to submit at least one clinical assessment to Ambit for scoring. Trainees had one month to respond to Ambit with information about whether the client would begin TF-CBT or not. Trainees had to submit any remaining clinical assessments for clients who began TF-CBT treatment. Clients who did not begin treatment had their cases closed, and no follow-up interviews were conducted. The option to screen was discontinued in September 2011, because the response rate from trainees was low and screening required an extensive amount of time and follow-up from Ambit Network, which did not have the capacity to track screening for trainees.

Baseline Assessment Interview: Trainees submitted clinical assessments as part of a baseline interview for clients who began TF-CBT treatment.

Initial Assessment Interview: The first point of contact a client had with a trainee – either as a screening or baseline interview. Clients who were screened first and then began TF-CBT treatment had their screening interviews coded as baseline interviews for the purpose of this data analysis.

Follow-up Assessment Interview: Follow-up interviews include interviews conducted after the initial interview. Follow-up interviews were scheduled at three-month intervals following the baseline interview until the end of treatment. Trainees received email prompts from Ambit Network at the beginning of each of their clients' follow-up interview windows and were required to complete and submit assessment paperwork during the month-long follow-up window.

End of Treatment (Closed) Assessment Interview: Client is no longer receiving treatment, and trainees submitted assessment paperwork to Ambit to close the case and discontinue follow-up reminder prompts.

Re-opened Assessment Interview: A trainee submitted baseline paperwork for a new case, and the client was previously being seen by an Ambit trained TF-CBT therapist. A second round of treatment is started, the case is reopened, and follow-up reminders are reinstated for the client.

Initial Interviews

A majority of the TF-CBT clients had their first point of contact with a TF-CBT trainee at a baseline interview. The remaining clients were either screening clients who did not begin TF-CBT treatment or were seen as part of another type of interview. Two clients had their first contact with a TF-CBT trainee during a follow-up interview, and two clients had their first contact with a TF-CBT trainee during a re-opened interview. The two clients who had their first point of contact in a follow-up interview were unique circumstances. When screening was allowed, Ambit partnered with two agencies in Minnesota where other (non-TF-CBT trained) therapists would submit screening assessment paperwork for potential trauma clients.

Although 163 clients were coded as having a screening interview for the initial point of contact, a total of 239 clients were actually screened by TF-CBT trainees. Only one-third of these clients (31.8%, N=76) began TF-CBT treatment and were included in the final baseline number in the table below.

Types of Initial Interviews Seen by TF-CBT Trainees

Type of Interview	Number	Percent
Screening	163	13.1%
Baseline	1075	86.6%
Follow-up 1	1	.1%
Follow-up 2	1	.1%
Re-opened case	2	.2%

Because trainees were not required to submit all clinical assessments for screening interviews, the 163 screening cases were excluded from the analysis of complete initial assessment interviews (all required clinical assessments submitted) and incomplete initial assessment interviews (at least one clinical

assessment was missing). Of the 1,079 cases eligible for analysis, a majority of the initial interviews were complete (86.8%, N=936).

Follow-up Interviews

Ambit monitored a total of 1,254 follow-up assessment interviews over the course of the reporting period. A majority of the follow-up interviews (93.1%) occurred within nine months of the baseline interview (Follow-up 3). A little over half of the follow-up interviews were considered "complete." A large portion of follow-up interviews were considered "missed" when trainees did not submit clinical assessments for a certain timepoint.

Status of Follow-up Interviews, Complete/Incomplete/Missed

		Complete		Incomplete		Missed	
	Total N	N	%	N	%	N	%
Follow-up 1	658	398	60.5%	27	4.1	233	35.4
Follow-up 2	356	167	46.9%	14	3.9	175	49.2
Follow-up 3	153	60	39.2%	6	3.9	87	56.9
Follow-up 4	59	17	28.8%	3	5.1	39	66.1
Follow-up 5	20	4	20.0%	0	---	16	80.0
Follow-up 6	4	2	50.0%	0	---	2	50.0
Follow-up 7	3	0		0		3	100.0
Follow-up 8	1	0		0		1	100.0
Totals	1,254	648	51.7%	50	4.0%	556	44.3%

Follow-up interviews were also coded for whether the assessment interview was completed on-time (during the one-month follow-up window) or whether the assessment was completed late (after the one-month follow-up window). Interviews coded as "complete" or "incomplete" in the above table were included in this data analysis because at least one clinical assessment was submitted at the follow-up interview timepoint. Missed follow-up interviews were excluded from further analysis.

Of the 1,254 follow-up interviews monitored by Ambit, 55.7% (N=698) were included in the following data analysis. Over three-quarters of all follow-up interviews were completed on-time. However, it appears that the percentage of follow-up interviews that were on-time decreased over time, while the percentage of follow-up interviews submitted late increased over time, with the exception of interviews at Follow-up 5 (15 months after baseline) and Follow-up 6 (18 months after baseline). The percentage of on-time follow-up interviews decreased from 80.9% at Follow-up 1 (three months after baseline) to 45% at Follow-up 4 (12 months after baseline), and the percentage of late follow-up interviews increased from 19.1% at Follow-up 1 to 55% at Follow-up 4.

Status of Follow-up Interviews, On-Time/Late

		On-Time		Late	
	Total N	N	%	N	%
Follow-up 1	425	344	80.9%	81	19.1%
Follow-up 2	181	142	78.5%	39	21.5%
Follow-up 3	66	48	72.7%	18	27.3%
Follow-up 4	20	9	45%	11	55%
Follow-up 5	4	4	100.0%	0	---
Follow-up 6	2	2	100.0%	0	---
Total	698	549	78.7%	149	21.3%

End of Treatment Interviews

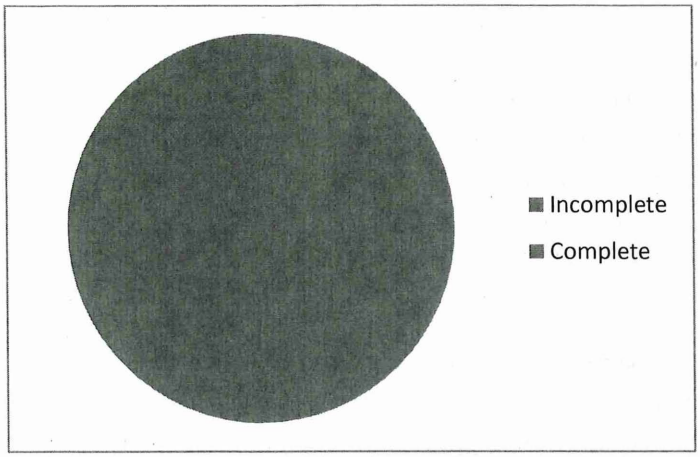
Three-quarters of the clients who were screened or started TF-CBT during the reporting period also ended treatment during the reporting period (72.1%; N=896). Of those clients who ended treatment, one-quarter completed treatment as planned and another 20% dropped out prior to end of planned treatment. However, nearly half of the clients ended treatment for other reasons. Appendix C provides a summary of other reasons clients ended treatment.

Reasons Cases Closed, Number of Clients

	Number	Percent
TF-CBT treatment Completed as planned	206	23.0
Client dropped prior to end of planned treatment	193	21.6
Case was transferred to another clinic or program	53	5.9
Case was lost, no follow-up assessments performed	22	2.5
Other (please specify)	422	47.0

End of treatment interviews were coded for whether or not all clinical assessments were submitted at the time of the interview. A large proportion of end of treatment interviews were coded as "incomplete" – 81.3% (N=728) – and were either missing clinical assessments at the end of treatment or did not have assessments completed at all.

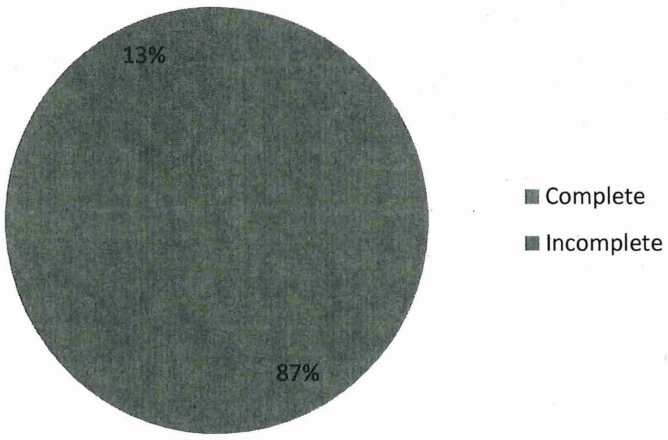
Status of End of Treatment Interviews, Complete/Incomplete



Re-opening Interviews

A small percentage of cases that were closed reopened for a new round of treatment at a later date. A total of 30 clients (3.3% of the 896 clients who ended treatment during the reporting period) reopened and began a second round of TF-CBT treatment. A majority of reopening interviews (86.7%) was complete and included all required assessment materials.

Percent of Complete and Incomplete Reopened Interviews



Average Length of Treatment

Average length of treatment data is available on 1,118 clients (90.0% of the 1,242 clients screened for TF-CBT). Clients were included in this analysis if two timepoints were available for data analysis (first interview timepoint and last interview timepoint). Clients selected for the analysis were divided into two groups, clients who had ended treatment (N=890) and clients who were actively receiving treatment at the end of the reporting period (N=228). Clients who had ended treatment were in treatment for an

average of 21.97 weeks. Clients actively receiving treatment at the end of the reporting period had been in treatment for an average of 24.4 weeks.

Fidelity Requirements

In addition to attending trainings and participating in consultation calls, trainees were required to complete assessments and treatment with a minimum of six clients over the course of the LC. This requirement was established to ensure that trainees would meet the requirement for national certification. As of this report, national certification requirements tentatively stipulate that trainees complete treatment, including documented clinical assessments at baseline and end of treatment, with a minimum of three clients.

To provide a more comprehensive view of client participation and completion of the fidelity requirement (both for state and national requirements), assessment interviews were coded into four separate groups (listed below)[3]. The number of trainees who met these requirements was then calculated. Overall, 478 of the 1,242 clients who were screened for TF-CBT (38.5%) had assessments completed during the initial assessment interview and during at least one follow-up assessment interview. Only 189 of the 896 clients who ended treatment (21.9%) had assessments completed at baseline and at the end of treatment.

1. Number of trainees who completed a baseline assessment interview and at least one follow-up interview for a minimum of six clients (state requirement): 29

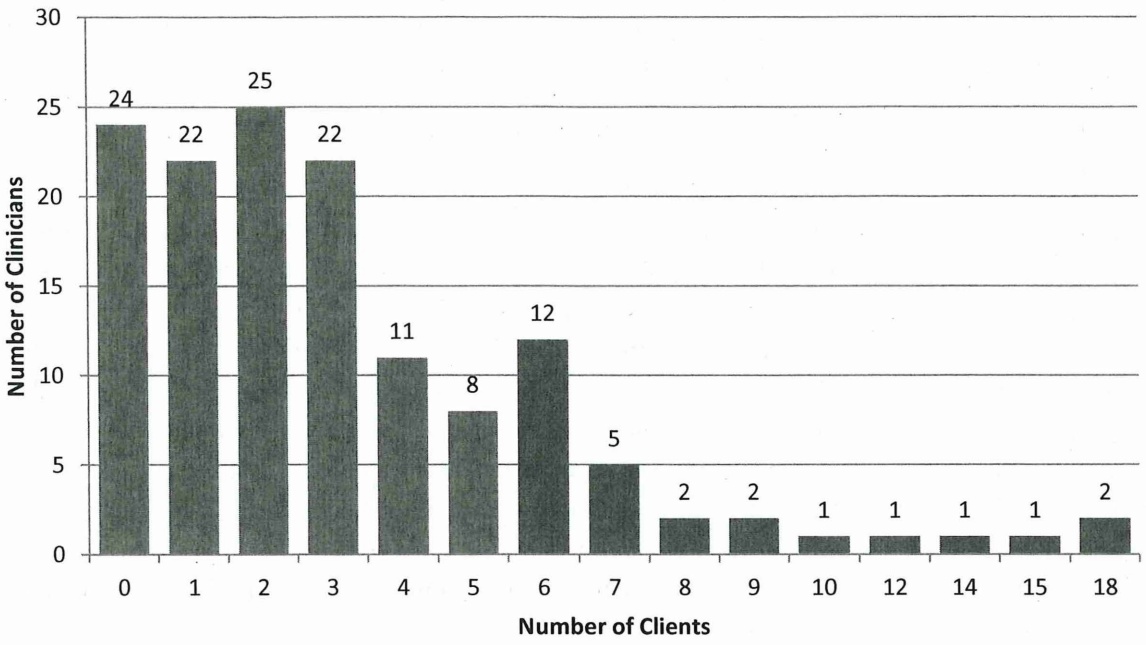
2. Number of trainees who completed a baseline assessment interview and an end of treatment interview for a minimum of six clients (state requirement): 9

3. Number of trainees who completed a baseline assessment interview and at least one follow-up interview for a minimum of three clients (national requirement): 70

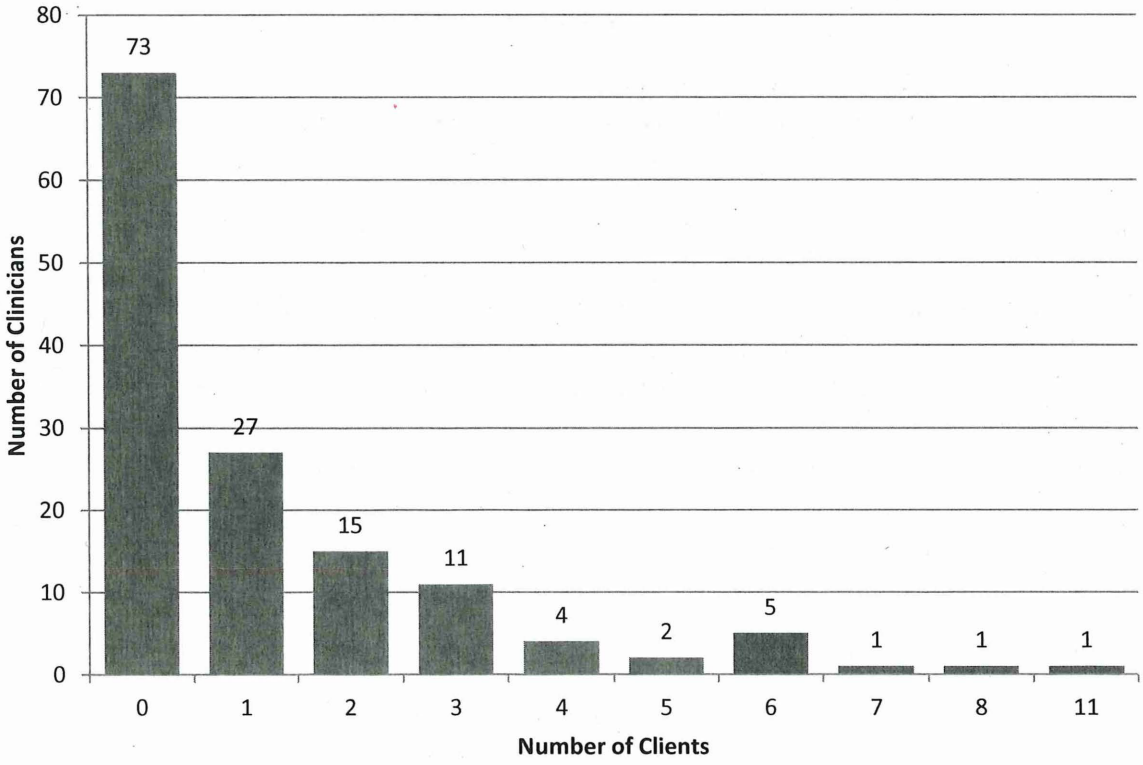
4. Number of trainees who completed a baseline assessment interview and an end of treatment interview for a minimum of three clients (national requirement): 26

[3] Assessment interviews were coded for whether or not at least one assessment was sent. Because this was a preliminary analysis of fidelity data to capture trainee completion of the requirement, it was not determined if the same assessment was sent at each timepoint. This requirement will be reviewed on a case-by-case basis at the time of application for national certification.

Number of Clients with a Baseline and Follow-up Assessment Interview Completed



Number of Clients with a Baseline and End of Treatment Assessment Interview Completed



Indicator 3: Successes and Challenges of TF-CBT and the LC

Data for Indicator 3 was collected from three data sources: 1) in-person training evaluation and check-in surveys, 2) supervisor calls, and 3) sustainability discussions at the final in-person trainings. Qualitative data from these sources was reviewed, and its themes were identified and summarized for this report.

Themes on Implementing TF-CBT and Participating in the LC

Theme: Anxious and Overwhelmed About TF-CBT

Trainees consistently reported feeling anxious and overwhelmed about the TF-CBT model over the course of the LC. Trainees reported anxiety about the model, finding it complicated and "structured," with many elements to learn, organize, and implement. Trainees also felt anxious about using the model with clients and learning to use and incorporate in treatment. In addition, trainees were anxious about specific components of the TF-CBT model, especially the trauma narrative. Trainees also expressed their concerns about working with caregivers and older clients, including their worries about obtaining caregiver and client "buy-in" to treatment. According to trainees, barriers to the trauma narrative piece of TF-CBT included starting the narrative, completing and processing the narrative, and preparing the witness for the witnessing section. Trainees expressed concern about avoiding "COWS" (crises of the week), adhering to the TF-CBT model during each therapy session, and assessing minimal mastery in their clients.

I am anxious about...

"Using the assessments; being kid-friendly with the assessment, finding the right words to interpret"

"Affirming while restructuring thoughts and emotions. Working with children who have learned to deny all aspects of their trauma and their experiences."

A number of trainees expressed self-doubt and apprehension about their ability to incorporate TF-CBT into their practice, to implement the model "right," and to complete all the requirements, including completing treatment with six clients, finding enough trauma clients, and fulfilling "all the other county and state requirements." Trainees found the model complicated and doubted their ability to find time to implement all the pieces of TF-CBT treatment, especially the components of the model, the paperwork, and the requirements, correctly. However, although a majority of the trainees reported feeling anxious and overwhelmed in the beginning of the LC, these feelings were reported less frequently by the end of the LC. This decrease may have been due to trainees recognizing their competency in implementing the TF-CBT model and observing the effectiveness of the TF-CBT model with the children and families being treated.

Thoughts on TF-CBT and the LC...

"I provide services in seven locations and am spread too thin. Finding time to prep will be difficult."

"How will I do this justice for kids when [already] spread so thin?

"Am I able to be effective in practicing this treatment?"

Trainees identified these barriers but mentioned plans to overcome their self-doubt, including:

- Getting organized
- Jump in, start identifying clients, and administer that first assessment
- Be an active participant in consultation
- Change supervisee schedules to be able to do phone calls
- Learn background materials

Theme: Excitement about the Model and the LC Process

Despite feeling anxiety about actual implementation and overwhelmed by all the pieces of the model, trainees reported feeling excited about TF-CBT and the LC process. Trainees expressed their belief that TF-CBT was going to help clients on their caseload. Many trainees commented that they had already identified clients with whom they were going to begin TF-CBT treatment. Some trainees reported that they were going to begin immediately, while other trainees planned a more gradual approach to learning and implementing the model. During the LC, trainees became more excited about implementing components they had previously reported feeling anxious about, including the trauma narrative.

I am excited about...

"Having a comprehensive approach to do diagnosis, treatment, evaluation"

"Having a new therapeutic approaching and having tools, seeing change"

"Having a research/evidence-based structure that I'll be able to apply to treatment of trauma, a serious problem experienced by many of our child/adolescent clients"

"Working through a trauma narrative"

Thoughts on TF-CBT and the LC...

"I like the model and the structure. I think this might make me more effective."

"I'm not completely sure how to organize it, but I need some tools to work with my kiddos"

"I am not sure how this will go but okay with finding out"

Trainees were also excited about the LC process and the potential of the LC model to help them learn TF-CBT and therapeutic techniques as well as increase their knowledge and improve their confidence with TF-CBT. Some major themes in trainee response to the LC were an enjoyment of the collaborative experience of working with others and an appreciation for the breadth of resources available, including hard copy and electronic resources, other team members and cohort members, Ambit staff, consultation calls, and the ability to contact the TF-CBT trainer for assistance.

I am excited about...

"Working with the team to do good work back at the agency"

"Having guidance and assistance"

Thoughts on TF-CBT and the LC...

"I think going through with others is much more effective than individual learning"

Theme: The Importance of Resources

Resources from Ambit Network gave confidence to trainees working to implement and market to their respective communities. Trainees remarked that the availability and recommendation of resources (e.g., the resource binder provided to all new LC trainees, the National Child Traumatic Stress Network) from an authoritative body like Ambit Network reduced the amount of time they had to spend finding high-quality resources and allowed them to speak more authoritatively on the TF-CBT. At the end of the Lambda LC cohort, clinical supervisors requested a TF-CBT brochure from Ambit Network and the University of Minnesota. The authority and legitimacy associated with University of Minnesota gave supervisors confidence when discussing the science behind TF-CBT with families and agency staff.

Theme: The Importance of Strategies

Trainees stressed the importance of developing effective strategies to support implementation of TF-CBT. These strategies included planning prior to the session, training other staff in the agency, and ensuring monitoring and accountability as a team after the LC. Trainees reported that commitment to TF-CBT was extremely important and that training other staff and influencing the mental health system with trauma-informed language were crucial to implementation and sustainability. The concept of influencing the system was emphasized during the Delta cohort, comprised primarily of providers from residential treatment facilities. Trainees and clinical supervisors also stressed the importance of incorporating assessments and the model into treatment planning while participating in the LC. Learning to incorporate the assessments and the model with the support of a team and other trainees in the LC were identified as critical elements of sustainability.

Theme: Increased Competency

Feedback from trainees showed that participation in the LC helped them become more focused and structured therapists, especially when treating clients with trauma. Participating in the LC and learning the practice of TF-CBT taught trainees to work with children and families in a different way and to better understand the impact of trauma, the possibility of healing, and the healing process. A large number of

trainees discussed how the support of the LC, along with support from others in their agency, encouraged them to continue learning TF-CBT and helped them feel more confident providing treatment to their clients. Trainees felt the most supported in their efforts to learn TF-CBT when their agencies prioritized learning TF-CBT and participating in the LC.

Feelings on TF-CBT and the LC...

"I feel like I have a decent understanding of the model – enough to try it out"

"I understand the components ever clearer"

Theme: Sustaining TF-CBT after the LC

Although sustainability was discussed throughout the LC, clinical supervisors stressed that it remained a challenge even at the conclusion of the LC. One major concern was maintaining LC practices, such as regular TF-CBT supervision, access to assessments, and scoring services, after the LC. Supervisors had concerns about their ability to continue providing TF-CBT supervision after the grant period ended. Some agencies expressed interest in being trained to score their TF-CBT assessments internally, but a large number of them wanted to continue relying on Ambit for scoring and tracking after the LC. Agencies interested in continuing to work with Ambit appreciated the "customer service" provided by Ambit to help them with monitoring client outcomes, planning treatment, and maintaining fidelity to the model.

Additional obstacles to sustaining TF-CBT that trainees mentioned were the lack of knowledge other staff members in their agencies had about trauma and their caseloads. Supervisors and trainees mentioned that without "buy-in" from other agency staff who work with families and children on the use of evidence-based practices and TF-CBT, the processes of implementing and sustaining TF-CBT would remain extremely difficult. Trainees identified having a group of trauma-informed staff within an agency as critical to supporting TF-CBT and informing the community about it. Many supervisors requested additional training for these staff members, including general training on trauma-informed services and TF-CBT training. In addition, agencies expressed a need to train intake staff to identify, screen, and refer trauma cases to trained therapists and train milieu staff in residential treatment settings to reinforce TF-CBT components and strategies with clients outside of therapy. Supervisors felt unsure about how to find the trainings they knew other agency staff members needed. Caseload balance for trainees posed another challenge to TF-CBT sustainability. Supervisors discussed needs to reduce the overall number of cases trainees had to allow them to spend more time with TF-CBT clients.

Feedback about LC Activities

In-Person Trainings

Trainees were generally satisfied with the in-person trainings and the material presented at the trainings. According to trainees, they felt satisfied with the teaching techniques used, including lectures, role-plays, small group discussions, and videos. When asked about challenges with the trainings, most trainees focused on difficulties with implementing TF-CBT rather than on problems with the actual

training. Some trainees did acknowledge that the length of training was "too long," especially during the first training, which involves more lectures and fewer group activities.

Many trainees reported being very happy with the TF-CBT trainer Jennifer Wilgocki and TF-CBT consultant Sara Younge and their abilities to normalize the challenges of implementing TF-CBT. Both the trainer and the consultant had positive teaching styles and effectively translated skills and concepts into clinical language, using case examples to help trainees learn to apply new concepts.

Most helpful part of the trainings...

"Jennifer turning the clinical concepts into practical, user-friendly language and activities"

"Jennifer provided not only examples of trauma narratives to read, but video of her working through process with clients – VERY helpful!! Jennifer and Sara are incredibly gifted trainers and consultants"

"Jennifer is...very thoughtful, and client centered"

While trainees expressed general overall satisfaction with the trainings, they identified some specific "helpful" and "challenging" parts. They also identified some additional topics they wished to have covered in more depth during the TF-CBT trainings.

Helpful Components

- Principles of Trauma lecture
- Clinical Assessments (learning the Northshore, learning the assessment measures)
- Actual case examples to learn from
- Opportunity to read actual trauma narratives: one trainee commented that reading the trauma narratives "made it seem more doable and not so large of a task"
- Trainer videos of working through trauma narratives
- The "trauma suitcase"
- The "iceberg"

Challenges

- Understanding the re-enactment process: this concept was difficult to understand if trainees did not have a client to whom they could apply it
- Understanding the assessments
- Understanding the requirements
- Working with the cognitive triangle
- Disliking the role plays
- Wanting to have some emphasis on exposure skills during the first training so they could be used during the first 3 months of the practicum period, according to one trainee

Topics to Cover in Greater Detail

- Avoidance
- Compassion fatigue, clinician self-care
- Cognitive distortions, processing
- Traumatic grief
- Adaptations for younger clients
- Sustainability
- Barriers to implementation

Consultation Calls and Data Feedback

Consultation calls were restructured in 2010 to require all trainees to conduct a case presentation on one of the calls. Trainees were given a case presentation outline to help them structure their presentation. Ambit added an online component for use during consultation calls to facilitate case presentations. Trainees called into the conference line and logged into the web component as well. With the online component, Ambit Network staff was able to display the clinical assessments, fidelity tool, and trauma narrative (when available) of the client being presented. Trainees reported that with the change in call structure and the ability to see the successful cases of other trainees, TF-CBT implementation and completion seemed less daunting.

Trainees and clinical supervisors requested some changes to assessment tracking and the data submission process. In response to these suggestions, Ambit Network modified the fidelity monitoring system and submission process and enhanced monthly tracking reports. With the modification of these elements, Ambit Network staff noticed an increase in compliance with data collection and reporting processes, and trainees reported higher satisfaction with the clinical utility of the assessment reports and fidelity monitoring tools.

Indicator 4: Change in Client Posttraumatic Stress Symptoms

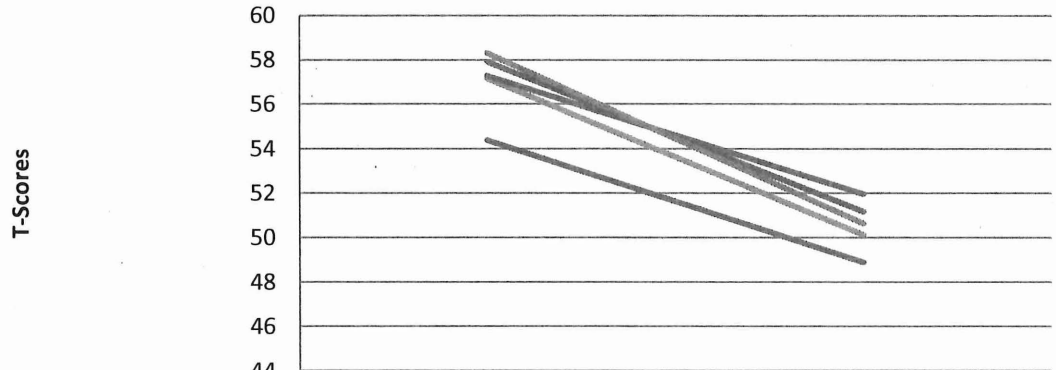
To determine changes in client posttraumatic stress symptoms, clients with valid scores from their initial assessment interview (first timepoint) and their most recent follow-up assessment interview (last timepoint, either a follow-up interview or end of treatment interview) were identified. Average scores were calculated from the first timepoint and the last timepoint using symptom scales. After average scores were calculated, a subset of clients was selected. Clients were selected if the last timepoint was an end of treatment interview and if treatment was completed as planned. Then, the average length of treatment for these clients was determined. This same data analysis process was used for the Trauma Symptom Checklist for Children (TSCC-A) and the UCLA PTSD Index for DSM-IV (UCLA). Because the "Overall" scale on the UCLA can be used to diagnose PTSD, the average amount and direction of change in the "Overall" UCLA scores were also determined.

Trauma Symptom Checklist for Children (TSCC-A)

A total of 923 clients completed the TSCC-A at their baseline interview. Approximately one-third (N=385) of these clients had a TSCC-A completed at a follow-up timepoint as well. Scores from the TSCC-A are reported as T-scores. T-scores of 50-65 are considered subclinical but suggestive of significant difficulties for the client. The average scores at the first timepoint for all scales were in the "subclinical" range. Clients with a TSCC-A completed at a first and last timepoint had a decrease in posttraumatic stress symptoms, including anger, anxiety, depression, dissociation, and posttraumatic stress. Average scores between the first and last timepoint fell between five and eight points on all scales.

Of the 385 clients with a first and last timepoint for the TSCC-A, 114 clients completed the assessment at the end of treatment with treatment completed as planned. The average length of treatment for these 114 clients was 31.3 weeks.

Change in Average Scores at First and Last Timepoints on the TSCC-A (N=385)

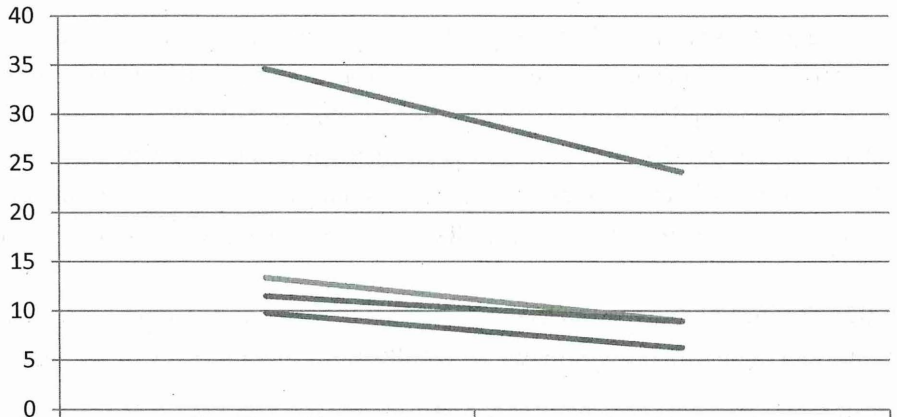


	First Timepoint	Last Timepoint
Anger	54.39	48.89
Anxiety	57.93	51.17
Depression	57.17	50.13
Dissociation	57.29	51.97
Posttraumatic Stress	58.31	50.63

UCLA PTSD Index for DSM-IV (UCLA)

A UCLA was completed at the initial interview for 1,048 clients, and 43% (N=454) of these clients completed a UCLA at a follow-up timepoint. On the "Overall" scale of the UCLA, scores of 38 and higher are considered clinically significant, while scores from 17-37 are considered borderline clinical. The average score from the first timepoint for the Overall UCLA scale was a few points lower than the clinical significant cut-off score. Of the 454 clients who had a first and last timepoint with a UCLA assessment, 137 of these clients ended treatment and completed treatment as planned. The average length of treatment for this subset of 137 clients was 31.2 weeks.

Changes in Average Scores at First and Last Timepoints on the UCLA (N=454)



	First Timepoint	Last Timepoint
Overall UCLA	34.64	24.14
Criteria B	9.78	6.23
Criteria C	13.35	8.99
Criteria D	11.51	8.93

A majority of the clients with a UCLA at their first and last timepoints (78.6%, N=357) had their scores on the Overall UCLA scale decrease over time. A small subset of clients (N=97) had increased scores over time. The average change in Overall UCLA scores for clients with an increase in symptoms was 7.95 points. Most of these clients were still receiving treatment at their most recent follow-up. Clients often experience an increase in symptomatology during treatment as part of the gradual exposure piece of TF-CBT and when developing and processing the trauma narrative. Clients with a decrease in Overall UCLA scores had an average decrease of 15.5 points between the first and last timepoints.

Indicator 5: National TF-CBT Certification

Information from Indicator 2 was used to determine the number of trainees eligible to apply for national certification as trained TF-CBT therapists. Therapists must meet the following requirements to apply:

1. Trainee must attend a two-day training covering the TF-CBT treatment model (PRACTICE).
2. Trainee must participate in a minimum of 12 consultation calls with an approved TF-CBT trainer.
3. Trainee must complete treatment with a minimum of three clients and have completed clinical assessments at baseline and an additional follow-up timepoint.

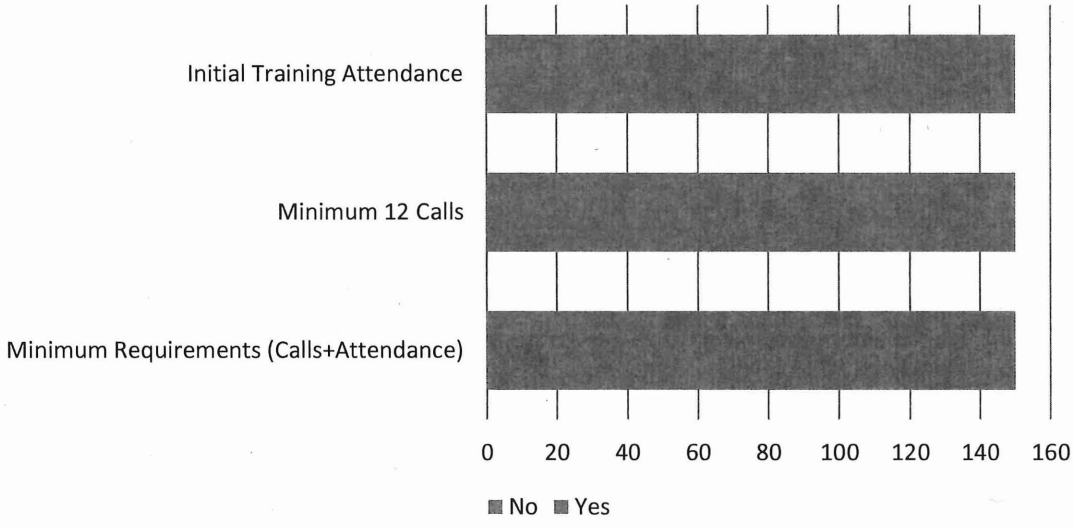
After meeting these requirements, trainees will be required to submit training and client documentation for review and pass an exam about TF-CBT to be certified.

Because these requirements are still tentative[4], two processes for data analysis were used to determine the number of trainees eligible for certification. Both processes first calculated the number of trainees who met the minimum requirements for certification (attendance at initial training and participation in a minimum of 12 calls). Then, the trainee data was analyzed using the following questions:

1) Did the trainee have three or more clients with a baseline and follow-up timepoint?
2) Did the trainee have three or more clients with a baseline and end of treatment timepoint?

Of the 150 trainees included in the sample, 92% of trainees attended all days of training, but only 56% of all trainees met the minimum requirements for certification (training attendance and call participation).

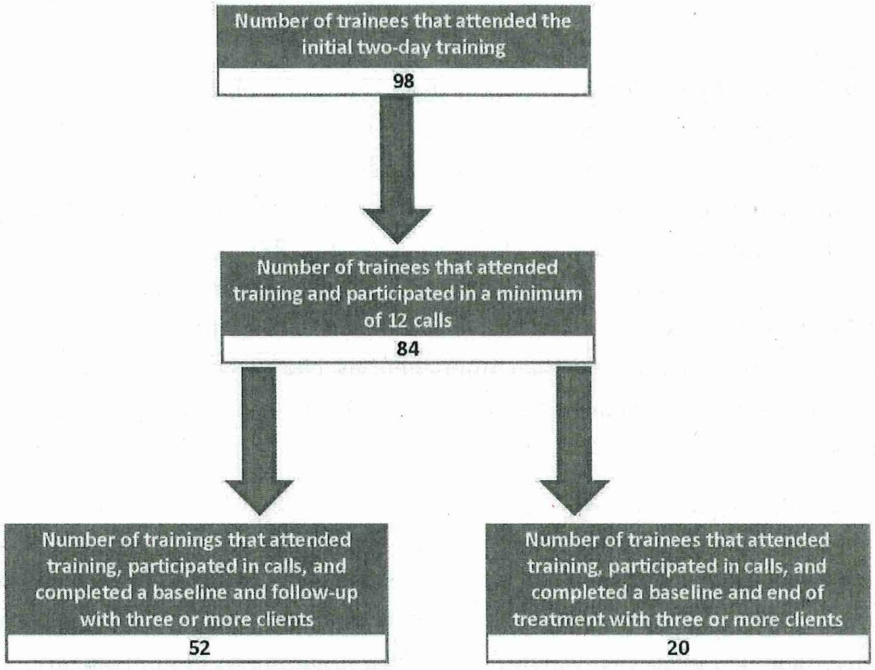
Number of Trainees who Met Minimum Requirements for Certification



[4] At the time of this report, certification for TF-CBT therapists was still unavailable. The requirements used for this report were communicated from the developers of TF-CBT but will not be finalized until certification is open to the public.

Depending on the method used for the third requirement (completion of treatment and assessments), either 52 trainees (34.7% of the trainee sample) or 20 trainees (13.3% of the trainee sample) will be eligible to apply for certification once it is available to the public. These final numbers include the number of trainees who met the requirements for training attendance, call participation, and completion of treatment with three or more clients (with assessments completed at either baseline/follow-up or baseline/end of treatment).

Number of Trainees who Met Sequential Requirements for Certification



Number of Trainees (By cohort) who are Not Eligible for Certification[5]

	3+ Clients with Baseline/Follow-up	3+ Clients with Baseline/End of Treatment
Beta	9	16
Gamma	22	25
Delta	9	16
Theta	25	30
Lambda	12	19
Kappa	21	24
Total	**98**	**130**

[5] These numbers represent the number of trainees who are not eligible for certification at the time of this report.

Summary and Recommendations

The purpose of this evaluation was to determine if the LC model was an appropriate model for training community mental health providers in TF-CBT and to document the successes and challenges of the LC model and implementing TF-CBT in community settings across Minnesota. The results of this evaluation will be used to formulate recommendations for future training and consultation efforts.

Determining the appropriateness of using the LC model to train community mental health providers

1. **An improvement would be seen in trainee attitudes toward the use of EBPs in their clinical practice.**

Overall, trainees had relatively high positive attitudes about the use of EBPs in their clinical practice – an attitude that remained relatively high over the course of the LC. There was little change in attitude over the course of treatment. A test of significance was not conducted to determine if change over time was significant due to the lack of variation across timepoints. However, the percentage of trainees with a positive change versus a negative change was calculated. On all scales of the EBPAS (Overall, Requirements, Appeal, Openness, and Divergence), a majority of the providers reported a more positive attitude toward the use of EBPs. One possible explanation for this finding is that agencies selected to participate in LCs may be considered more innovative than other agencies, characterized as "early adopters" of new treatments and practices, and have an organizational culture that supports the implementation of new practices.

2. **Providers would complete all requirements of their contract with the state.**

Trainees were expected to complete four requirements by the conclusion of their respective LC cohorts: 1) attend all days of training provided by Ambit Network, 2) participate in a minimum of 12 consultation calls, 3) begin treatment with a minimum of six clients, and 4) complete assessments at baseline and follow-up intervals.

A majority of the trainees were able to complete the first two of the four requirements of the LC. In-person trainings were typically well attended, especially the first two trainings held in each cohort. All cohorts had over 85% of individuals attend the first two trainings. These first two trainings are critical, as those four days provide the foundational training in TF-CBT and are a requirement for national certification. By the final trainings (check-in trainings held six to nine months into the LC), attendance dropped, however, and the overall percentage of trainees who attended all trainings was lower than the percentage of trainees who attended the first two days. One possible explanation for this attendance change is that check-in and final trainings were typically one-day trainings, and trainees opted out of attending because of the travel and time commitments. While attendance at one-day trainings for regional cohorts (e.g., Lambda, Kappa) may have been easier to attend because the travel distance was lessened, travel to one-day trainings for statewide cohorts may have been more difficult, especially for agencies four or more hours away.

Overall participation in consultation calls was not as high as expected. The overall average attendance for calls was 11.2 calls, which is lower than the minimum required for consultation. Of the six cohorts

included in this report, only two cohorts had an average that was above the minimum 12 call requirement. Average attendance was slightly higher when more calls here scheduled per month (four calls versus two calls), but the difference was minimal – average call attendance was 11.8 calls when four calls were scheduled each month compared to 10.7 calls when two calls were scheduled each month. One possible explanation for the low call participation is the inability of trainees to reschedule their day to make call participation work, while a second possible explanation could be that trainees are unaware of how many calls they attend due to their own incomplete record keeping or inadequate reporting from Ambit Network.

The follow-up and practicum requirement for the LC (begin treatment with a minimum of six clients, and conduct baseline and follow-up assessments) proved to be a more difficult requirement to meet for LC trainees. Only half of trainees started providing treatment to the required minimum six clients (49.7%), and the number of trainees who completed baseline and follow-up assessments was even lower. Of the 150 clinicians who began an LC, only 19.3% (N=29) completed a baseline and follow-up assessment for six or more clients, while only 6% (N=9) completed a baseline and end of treatment assessment for six or more clients.

While these numbers are low and possibly indicative of a failure of the LC model to train providers in TF-CBT, they are also reflective of the difficulties involved in making changes to community settings and trying to change practice behaviors in adult learners. One possible explanation for the low number of completed follow-up assessments (both follow-up and at end of treatment) is the difficulty providers experience with retaining clients. The data from this report shows that almost all baseline interviews submitted to Ambit were complete, but almost half of all follow-up interviews were coded as "missed" and 81% of the end of treatment interviews were incomplete. While there is data on the interview status (missed, incomplete interviews), there is little data explaining why. The available data on the "why" question shows that clients typically either do not come in during follow-up time periods or do not return for treatment at all. This change in client attendance is demonstrated in the fact that 77% of cases the ended treatment closed because the client dropped prior to treatment or the case was lost for future follow-up.

3. **An improvement would be seen in client posttraumatic stress symptoms over the course of treatment.**

While a small portion of the clients screened for TF-CBT had a TSCC (N=385) and/or a UCLA (N=454) at a follow-up assessment interview, the average scores on assessment scales did decrease over time. Clients who received treatment using the TF-CBT model by a trained TF-CBT therapist saw a decrease in anger, anxiety, depression, dissociation, and posttraumatic stress symptoms – including the re-experiencing and avoidance of trauma triggers and arousal of trauma symptoms as a result of trauma triggers.

4. **Providers would meet minimum requirements and be eligible to apply for national certification as a trained therapist.**

While 56% of the total sample met the minimum requirements for certification (training and call attendance), only 13.3% of trainees are eligible for certification once data on clients is considered. Of the 150 trainees who began an LC, only 20 were able to attend the initial training days, participate in a minimum of 12 consultation calls, and complete assessments at baseline and end of treatment for a minimum of three clients. However, considering the difficulties of client retention, this low number may be simply a reflection of the reality of community mental health settings– trainees are to find and retain enough clients to meet this requirement. As a result, obtaining certification may take longer than the LC time period. Another explanation for the low numbers is that data collection on LC trainees ends after the LC ends because trainees are no longer required to submit assessments or fidelity data. It is possible that trainees and agencies continue to assess clients, monitor fidelity, and implement TF-CBT outside of their relationship with Ambit as part of their sustainability plan developed during the LC. However, Ambit is limited to reporting certification requirements and eligibility based on LC time periods, and Ambit does not always receive data regarding continued use of TF-CBT by trainees after the LC ends.

Documenting the successes and challenges in implementing in TF-CBT and utilizing the LC training model

The successes and challenges that trainees faced in implementing TF-CBT and in participating in the LC were similar across cohorts. At the beginning of the LC, trainees were anxious and overwhelmed at the complexity of the treatment model and by the requirements of the LC. Over the course of the LC, trainees gained more confidence in both the model and in their own ability to implement it after witnessing the treatment's effectiveness with their caseload. At the end of the LC, many trainees expressed concerns about sustainability, including how to get more staff at their agency trained and how to continue to implement TF-CBT at the same level.

One of the primary challenges of the LC was low attendance on supervisor calls, which was consistent across cohorts. One of the fundamental aspects of the LC is the participation of agency leadership as part of the LC team, in this case, the clinical supervisor for the clinical staff. Without adequate participation by agency leadership, clinical staff face significant difficulties in agency "buy-in," implementation, and sustainability.

One of the successes of the LC is the model itself. It provides a collaborative structure that plays a critical role in supporting trainee learning. The collaborative nature provides multiple options for trainees to use as resources and support, including other team members and cohort members as well as experts in the field (e.g., TF-CBT trainer). The LC model was also successful in challenging teams to develop and implement sustainability plans. After participating in an LC for a year or more, trainees were immersed in implementation and TF-CBT, and were forced to consider continuing to implement the effective new practice they learned.

Recommendations

Conclusion: Based on findings, the LC model is an appropriate model to train providers in the fundamentals of TF-CBT and provide the level of support needed for trainees to begin and complete

treatment with clients while managing the typical client engagement and retention barriers seen in community settings.

The following recommendations to improve the training of community mental health providers in TF-CBT are made based on evaluation findings:

1. **Invite and include agencies that have previously participated in a LC to participate in new LCs.** Including past participant agencies not only helps agencies implement sustainability plans (to train additional therapists) but also changes the culture of the LC. On an individual level during the LC, supervisors often reported that early adopting trainees were influential in challenging late adopting trainees to begin to learn the model and implement. It is possible that including early adopting agencies can have an influential role on new agencies to challenge themselves to learn and implement when participating with supervisors and agencies that have already successfully done so.

2. **Work with agencies during the application process to identify team members that will be more likely to participate in the LC and implement TF-CBT as a practice.** Disseminating trauma-informed practices is more effective when working with individuals who are more likely to adopt. By identifying and working with individuals who want to learn the model, the number of trainees who complete requirements and are eligible for certification may increase.

3. **Modify the supervisor call scheduling and call structure to increase attendance and participation.** One option may be to extend the number of months calls are held (12 months instead of nine) or schedule calls more frequently (e.g., every three weeks). In addition, discussing sustainability and other implementation challenges earlier in calls is recommended. Trainees began mentioning sustainability concerns relatively early in the LC, and discussing these issues earlier may help supervisors work with their team to successfully implement and integrate TF-CBT into practice.

4. **Modify the monitoring and reporting process for agencies and trainees to improve compliance with LC requirements and increase the number of trainees who are eligible for certification.** Most of the feedback provided by Ambit Network to trainees focused on client outcomes and fidelity work (are assessments completed, are clients ending treatment, are dashboards being submitted). However, without meeting training and call requirements, trainees will not be eligible for certification, and Ambit provided little feedback to trainees on their progress toward this requirement. One recommendation is to simplify the data being reported to trainees (focus specifically on certification requirements) as well as provide feedback more frequently (quarterly versus halfway through the LC).

5. **Modify how trainees receiving training on the assessment-based part of the TF-CBT model.** While it is critical to maintain the level of training on the components-based part of the model, modifying how training is provided on the assessment-based part of the model may be

influential in changing trainee perceptions about the assessment and in increasing the use and completion of the assessments with clients. Trainees typically viewed the assessments as "just another requirement" instead of recognizing them as part of the TF-CBT model critical to fidelity and client outcomes.

6. **Incorporate training modules on engagement and retention of clients to increase the number of clients who complete treatment with trainees.** LCs have been conducted that have trained therapists in evidence-based engagement strategies, and the available research shows that it has been successful in both engaging new clients and retaining existing clients. (Cavaleri et al., 2007; Cavaleri et al., 2006; Cavaleri et al., 2010).

7. **Continue to offer technical support and assistance to trainee participants.** The benefit of an external source providing technical support and assistance allows trainees to focus on learning the model and implementing while participating in the LC without needing to spend a significant amount of time figuring out logistics (like scoring assessments and data collection) until the agency is ready to incorporate those pieces into their sustainability plan. One option to consider is an electronic database that trainees who complete LCs can use for scoring clinical assessments and scheduling follow-up reminders. This option also provides the opportunity to conduct longer monitoring and evaluation of TF-CBT implementation instead of limiting the evaluation period to the LC.

References

Aarons, G. A. (2004). Mental health provider attitudes toward adoption of evidence-based practice: The Evidence-Based Practice Attitude Scale (EBPAS). *Mental Health Services Research, 6*(2), 61-74.

Briere, J. (1996). *Trauma Symptom Checklist for Children*. Lutz, FL: Psychological Assessment Resources.

Briere, J. (2005). *Trauma Symptom Checklist for Young Children*. Lutz, FL: Psychological Assessment Resources.

Cavaleri, M. A., Franco, L. M., McKay, M. M., Appel, A., Bannon, W. M., Bigley, M. F., . . . Salerno, A. (2007). The sustainability of a learning collaborative to improve mental health service use among low-income urban youth and families. *Best Practices in Mental Health, 3*(2), 52-61.

Cavaleri, M. A., Gopalan, G., McKay, M. M., Appel, A., Bannon, W. M., Bigley, M. F., . . . Salerno, A. (2006). Impact of a learning collaborative to improve child mental health service use among low-income urban youth and families. *Best Practices in Mental Health: An International Journal, 2*(2), 67-79.

Cavaleri, M. A., Gopalan, G., McKay, M. M., Messam, T., Velez, E., & Elwyn, L. (2010). The effect of a learning collaborative to improve engagement in child mental health services. *Children and Youth Services Review, 32*(2), 281-285.

Cohen, J. A., & Mannarino, A. P. (1996). A treatment outcome study for sexually abused preschool children: Initial findings. *Journal of the American Academy of Child & Adolescent Psychiatry, 35*(1), 42-50.

Cohen, J. A., & Mannarino, A. P. (1997). A treatment study for sexually abused preschool children: Outcome during a one-year follow-up. *Journal of the American Academy of Child & Adolescent Psychiatry, 36*(9), 1228-1235.

Cohen, J. A., & Mannarino, A. P. (1998). Interventions for sexually abused children: Initial treatment outcome findings. . *Child Maltreatment, 3*(1), 17-26.

Cohen, J. A., Mannarino, A. P., & Deblinger, E. (2006). *Treating trauma and traumatic grief in children and adolescents*. New York: Guilford Press.

Cohen, J. A., Mannarino, A. P., & Knudsen, K. (2005). Treating sexually abused children: 1 year follow-up of a randomized controlled trial. *Child Abuse & Neglect, 29*(2), 135-145.

Deblinger, E., Lippmann, J., & Steer, R. (1996). Sexually abused children suffering posttraumatic stress symptoms: Initial treatment outcome findings. . *Child Maltreatment, 1*(4), 310-321.

Deblinger, E., McLeer, S. V., & Henry, D. (1990). Cognitive behavioral treatment for sexually abused children suffering post-traumatic stress: Preliminary findings. *Journal of the American Academy of Child & Adolescent Psychiatry, 29*(5), 747-752.

Deblinger, E., Stauffer, L. B., & Steer, R. A. (2001). Comparative efficacies of supportive and cognitive behavioral group therapies for young children who have been sexually abused and their nonoffending mothers. *Child Maltreatment, 6*(4), 332-343.

Ebert, L., Amaya-Jackson, L., Markiewicz, J., & Fairbank, J. A. (2012). Development and application of the NCCTS Learning Collaborative Model for the implementation of evidence-based child trauma treatment. In K. McHugh & D. Barlow (Eds.), *Dissemination and Implementation of Evidence-Based Psychological Interventions*. New York, NY: Oxford University Press.

Ebert, L., Amaya-Jackson, L., Markiewicz, J. M., Kisiel, C., & Fairbank, J. A. (2012). Use of the Breakthrough Series Collaborative to support broad and sustained use of evidence-based trauma treatment for children in community practice settings. *Administration and Policy in Mental Health and Mental Health Services Research, 39*(3), 187-199.

Institute for Healthcare Improvement. (2003). The Breakthrough Series: IHI's collaborative model for achieving breakthrough improvement Retrieved February 1, 2013, from www.IHI.org

King, N. J., Tonge, B. J., Mullen, P., Myerson, N., Heyne, D., Rollings, S., . . . Ollendick, T. H. (2000). Treating sexually abused children with posttraumatic stress symptoms: A randomized clinical trial. . *Journal of the American Academy of Child & Adolescent Psychiatry, 39*(11), 1347-1355.

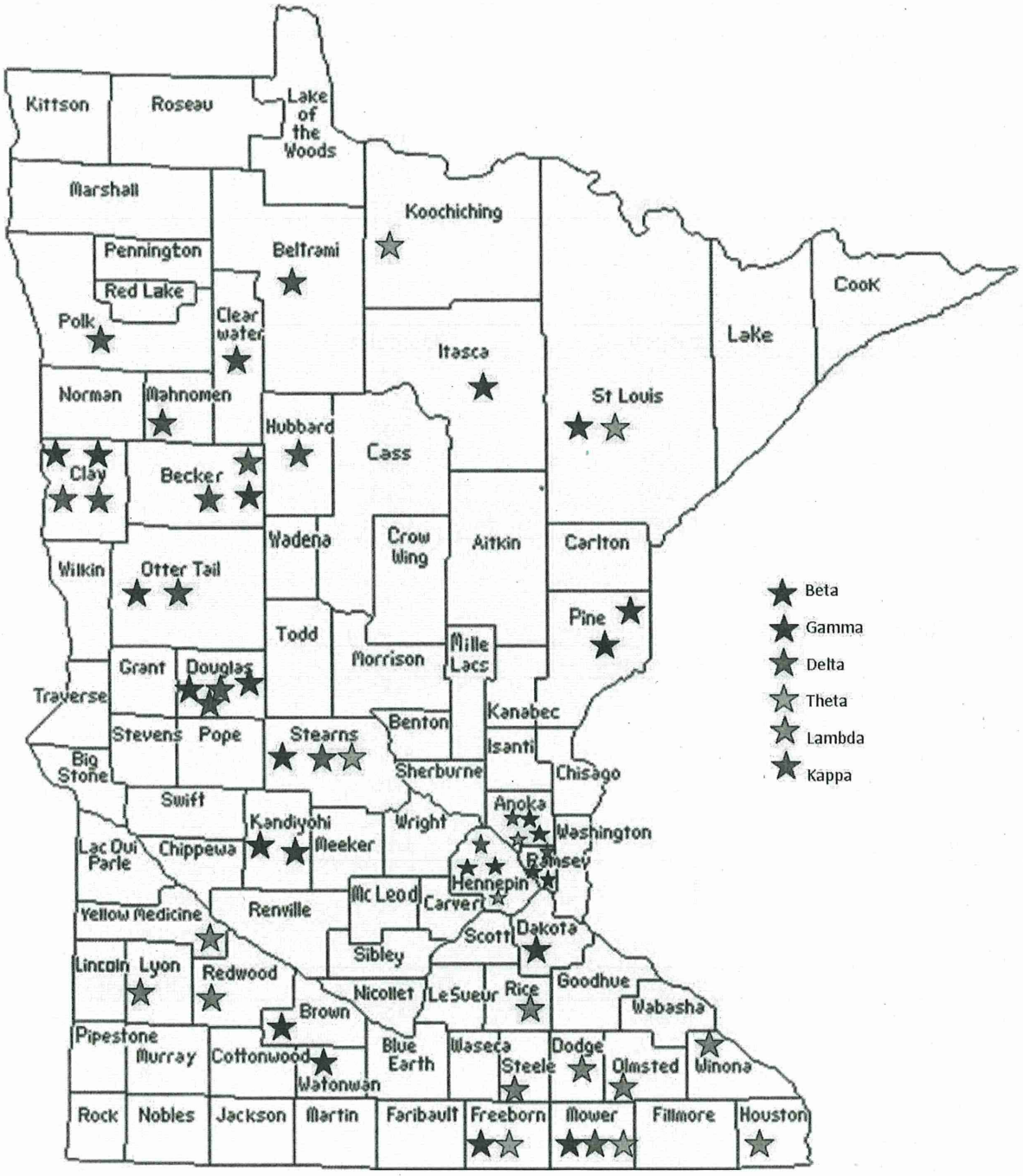
National Child Traumatic Stress Network. (n.d.-a). The History of the NCTSN Retrieved February 13, 2013, from http://www.nctsn.org/about-us/history-of-the-nctsn

National Child Traumatic Stress Network. (n.d.-b). Who We Are Retrieved February 13, 2013, from http://www.nctsn.org/about-us/who-we-are

Steinberg, A. M., Brymer, M. J., Decker, K. B., & Pynoos, R. S. (2004). The University of California at Los Angeles Post-Traumatic Stress Disorder Reaction Index. *Current Psychiatry Reports, 6*(2), 96-100.

Youthinmind.org. (n.d.). Strength and difficulties questionnaire Retrieved March 13, 2013, from www.sdqinfo.org

Appendix A: Map of Minnesota Highlighting Counties that Participated in a Department of Human Services TF-CBT Learning Collaborative



Appendix B: Evidence-Based Practice Attitude Scale (EBPAS) Averages, by cohort

Beta cohort

	Timepoint 2	Timepoint 3	Timepoint 4
Number collected (n)	23	18	21
Total	2.86	2.89	3.12
Appeal	3.08	3.22	3.37
Requirements	2.35	2.09	2.63
Openness	2.89	3.04	3.19
Divergence	1.00	0.98	0.83

Delta cohort

	Timepoint 1	Timepoint 4
Number collected (n)	25	24
Total	3.09	3.21
Appeal	3.33	3.48
Requirements	2.75	2.85
Openness	3.07	3.23
Divergence	0.88	0.82

Gamma cohort

	Timepoint 2	Timepoint 3
Number collected (n)	25	15
Total	2.81	2.94
Appeal	2.99	3.27
Requirements	2.35	2.16
Openness	2.81	3.10
Divergence	1.03	1.08

Kappa cohort

	Timepoint 1	Timepoint 2	Timepoint 3
Number collected (n)	24	17	9
Total	3.22	3.32	3.15
Appeal	3.39	3.43	3.33
Requirements	3.10	3.27	2.93
Openness	3.06	3.33	3.19
Divergence	0.70	0.75	0.92

Lambda cohort

	Timepoint 1	Timepoint 2	Timepoint 3
Number collected (n)	19	12	14
Total	3.07	3.14	3.13
Appeal	3.45	3.50	3.41
Requirements	2.67	2.81	2.95
Openness	3.05	3.24	3.16
Divergence	0.99	1.10	1.05

Theta cohort

	Timepoint 1	Timepoint 2	Timepoint 3
Number collected (n)	31	26	9
Total	3.14	3.12	3.10
Appeal	3.43	3.46	3.33
Requirements	2.92	2.69	2.85
Openness	3.05	3.15	2.97
Divergence	0.90	0.76	0.83

Appendix C: Reason Cases Closed

Reason Closed	Number of Clients
LC Tracking Period Ended and Ambit closed; no follow-up assessments were submitted after case was closed.	151
Screening Case, not continuing TF-CBT	150
TF-CBT not appropriate treatment for this client (or client not prepared for TF-CBT yet)	49
Never started treatment	9
Client did not want to participate in TF-CBT	6
Client attendance not consistent enough for TF-CBT	4
Client moved	8
Client no longer receiving TF-CBT	9
Client discharged from residential treatment	8
Trainee changed agencies or went on maternity leave	12
Client sent to residential treatment	3
Agency closed	3
Insurance problems	2
Assigned to another trainee	3
Parents decided not to pursue TF-CBT or to pursue other options	3
No identifiable trauma, client only completed PRAC skills	1
Client was almost done with treatment at baseline- Ambit recommended not counting this case (originally a practice case)	1
Total	**422**