2010/2011 Learning Collaborative in Trauma Focused Cognitive Behavioral Therapy Application Packet

Thank you for your interest in the NC Child Treatment Program's 2010/2011 Learning Collaborative in Trauma Focused Cognitive Behavioral Therapy. We look forward to learning about your proposed learning collaborative team!

Agency / Team Information

AGENCY / TEAM NAME	
Name of Team Leader	
Contact person phone	
Contact person e-mail	

*Team Leader is not necessarily a Senior Leader

Proposed Team			
	Senior Leader	Clinical Supervisor/Clinician #1	Clinician #2
Name			
Highest Degree			
Licensure status			
Title			
Years in practice (serving children 3-18)			
Telephone Number			
E-mail Address			
Is this person a clinical supervisor			
Name of clinical supervisor			
Full or part time clinical work			
Supervisor contact information (e-mail and phone)			

Proposed Team Cont.			
	Clinician #3	Clinician #4	Clinician #5
Name			
Highest Degree			
Licensure status			
Title			
Years in practice (serving children 3-18)			
Telephone Number			
E-mail Address			
Is this person a clinical supervisor			
Name of clinical supervisor			
Full or part time clinical work			
Supervisor contact information (e-mail and phone)			

Questions to Be Completed by Agency Team

Agency / Practice Overview:

1. Briefly describe your agency or individual practice.

2. Of those listed in your proposed agency team, please provide information on current case loads and average length of clinical sessions.

	CURRENT CASE LOAD (AVERAGE CASES/WEEK, CHILDREN 3-18)	AVERAGE SESSION LENGTH (CHILDREN 3-18)	AVERAGE SESSION FREQUENCY (I.E., WEEKLY, BIWEEKLY)	IS CASELOAD EXPECTED TO CHANGE OVER NEXT 12 MONTHS?
Identified Supervisor/ clinician # 1				☐ Yes – increase ☐ Yes – decrease ☐ No
Identified clinician # 2				☐ Yes – increase ☐ Yes – decrease ☐ No
Identified clinician # 3				☐ Yes – increase ☐ Yes – decrease ☐ No
Identified clinician # 4				
Identified clinician # 5				

3. Have any team members received previous training in TF-CBT?

*No prior training experience is required for enrollment in the CTP Learning Collaborative.

If yes, please provide the following information:

- Who has received training?
- When was this training received?
- Where was the training received?
- Did this training include follow up case consultation?
- Has this employee received any continuing education / advanced training in TF-CBT?
- If so, please provide a description of this training (e.g., attending local workshops)?
- Approximately how many TF-CBT cases has this employee seen subsequent to their initial training?

4. Please indicate the types of services directly provided by your agency or team members practice:

☐ Clinical assessment
☐ Mental health treatment/counseling
☐ Case management
☐ Medication management
☐ Substance abuse services
☐ Parenting classes
☐ Other: ____

5. Please provide, if applicable, the following regarding supervision within your agency.

	HOURS OF SUPERVISION PER CLINICIAN PER WEEK	% OF TIME FOR ADMINISTRATIVE ISSUES (E.G., POLICIES & PROCEDURES)	% OF TIME EVALUATING CLINICAL SKILL	
			EBP	Non-EBP
Individual supervision				
Group supervision				
Peer supervision				

6. Briefly describe the child population directly served by your agency each month (Please approximate the % of your overall client population for each sub-group).

   Average number of clients served per month: ____________________

Age	**%**	**Race**	**%**	**Gender**	**%**	**Primary Language**	**%**
Birth – 3 years		White		Male		English	
4-6 years		Black		Female		Spanish	
7-10 years		Hispanic				Other (please list)	
11-14 years		Asian					
15-19 years		American Indian / Alaskan Native					

7. Of the number of children aged 3-18 served at your agency each month, approximately what percentage would benefit from services targeting the following:

BEHAVIOR PROBLEMS	PERCENT
Trauma related symptoms	
Parenting skills	
Appropriate discipline techniques	

8. Of the clients directly served by your agency each month, please indicate the approximate percentage that is referred through the Department of Social Services (DSS)/Child Protective Services (CPS) or other government agencies: ______%

   Of the clients directly served by your agency each month, please indicate the approximate percentage that is in foster care: _____%

9. a) Describe the training your team has received regarding evidenced-based practices (EBP's), if any.
*Prior experience is not required for acceptance.

NAME OF EVIDENCE BASED PRACTICE	WHO RECEIVED THIS TRAINING?	DATES OF TRAINING	TYPE OF TRAINING (CHECK ALL THAT APPLY)	HAS THE EBP BEEN IMPLEMENTED SUCCESSFULLY WITHIN THE AGENCY?
			☐ In-person ☐ Video or web-based ☐ Follow-up consultation	☐ Yes, implemented with full fidelity ☐ Yes, implemented with adaptation ☐ Not successfully implemented
			☐ In-person ☐ Video or web-based ☐ Follow-up consultation	☐ Yes, implemented with full fidelity ☐ Yes, implemented with adaptation ☐ Not successfully implemented
			☐ In-person ☐ Video or web-based ☐ Follow-up consultation i	☐ Yes, implemented with full fidelity ☐ Yes, implemented with adaptation ☐ Not successfully implemented
			☐ In-person ☐ Video or web-based ☐ Follow-up consultation	☐ Yes, implemented with full fidelity ☐ Yes, implemented with adaptation ☐ Not successfully implemented

12 b) Regarding implementation of the above EBPs:

IS DATA ROUTINELY COLLECTED		
Related to clinical competency in the model?	☐ Yes ☐ No	If yes, please indicate these data and frequency of collection:
Regarding supervision in the model?	☐ Yes ☐ No	If so, please indicate these data and frequency of collection:
Regarding consumer satisfaction with service?	☐ Yes ☐ No	If so, please indicate these data and frequency of collection:

10. What are the key challenges you face in the implementation of evidence-based practices? What are the lessons learned from your experiences in training and implementation of evidenced-based practice that would be helpful to your/other sites' ability to implement evidenced-based practices in your/their setting?

11. Please indicate any standardized assessment/tools regularly used by your agency.

- ☐ Eyberg Child Behavior Inventory (ECBI)
- ☐ Child Sexual Behavior Inventory (CSBI)
- ☐ Adolescent Sexual Behavior Inventory (ASBI)
- ☐ Brief Symptoms Inventory (BSI)
- ☐ Strengths and Difficulties Questionnaire (SDQ)
- ☐ Alabama Parenting Questionnaire (APQ)
- ☐ UCLA PTSD-RI Parent
- ☐ UCLA PTSD-RI Child
- ☐ Child Behavior Check List (CBCL)
- ☐ Parenting Stress Inventory (PSI)
- ☐ Behavior Assessment System for Children (BASC)
- ☐ Children's Depression Inventory (CDI)
- ☐ Connors Behavior Rating Scale (parent and/or teacher)
- ☐ Trauma Screen (please specify: ______________________________)
- ☐ Developmental / Adaptive Behavior measure (please specify: ___________________________)
- ☐ Measure of parent psychopathology (please specify: ___________________________________)
- ☐ Other: ____

12. What percentage of clients directly served by your agency or team's practice receives standardized assessments? ______%

13. Please indicate the following for clinicians currently practicing within your agency:

CLINICIANS ARE FAMILIAR WITH:	NOT FAMILIAR	SOMEWHAT UNFAMILIAR	NEUTRAL	SOMEWHAT FAMILIAR	VERY FAMILIAR
Scoring standardized assessments	☐	☐	☐	☐	☐
Interpretation of standardized assessments	☐	☐	☐	☐	☐
Use of assessment data to plan treatment	☐	☐	☐	☐	☐

14. Please describe your agency's system for identifying clients with possible trauma or PTSD.

Clinician Practice Overview:

Each participating clinical supervisor and clinician should complete this section separately.

Clinician name: ______________________________

1. Are you a Medicaid Provider?

   ☐ Yes ☐ No

   Please provide your Medicaid provider number: ____________________

2. In what counties do you currently provide office based treatment?

3. In a typical week, what percentage of your clinical case load are children between the ages of 3-18.

4. In the past 6 months, how many clients/patients have you treated in your practice that were between the ages of 3-18?

   ________(Please provide a single number estimate, rather than percentage or range)

5. In the past 6 months, how many "*traumatized*" clients/patients have you treated in your practice that were between the ages of 3-18?

   ________(Please provide a single number estimate, rather than percentage or range)

   What types of trauma have you treated in clients/patients? (Check all that apply)

   ☐ *Sexual Abuse/assault*

   ☐ *Physical abuse/assault*

   ☐ *Neglect*

   ☐ *Exposure to violence (interpersonal or community violence)*

   ☐ *Serious accidents*

   ☐ *Traumatic death*

   ☐ *Traumatic medical experiences /procedures/treatments*

   ☐ *Other (Please Specify:* ____)

   ☐ Not Applicable

6. Over the past 12 months, approximately how many "sexually-traumatized" clients/patients have you treated in your practice (3-18 years of age)

   ________(Please provide a single number estimate, rather than percentage or range

*"Sexually-Traumatized" children and adolescents including males and females between the ages of 3 and 18 years of age who have experienced sexual abuse, sexual assault, and/or sexual victimization (+/- other forms of trauma). Cases can be acute or remote. Involvement of DSS, law enforcement, and/or the court system is not required.

7. In the past six months, when treating a client between the ages of 3-18 years, what percentage of the time was spent with the:

CHILD ALONE	PARENT ALONE	CHILD & PARENT TOGETHER
☐ < or equal to 10%	☐ < or equal to 10%	☐ < or equal to 10%
☐ Between 11 and 25%	☐ Between 11 and 25%	☐ Between 11 and 25%
☐ Between 26 and 50%	☐ Between 26 and 50%	☐ Between 26 and 50%
☐ Between 51 and 75%	☐ Between 51 and 75%	☐ Between 51 and 75%
☐ Between 76 and 100%	☐ Between 76 and 100%	☐ Between 76 and 100%

8. In the past 6 months, how many clients/patients have been referred to you for treatment of child behavior problems, specifically?

9. In the past 6 months, how often have you worked in collaboration with DSS/CPS on your cases involving children?

   ☐ Less than or equal to 10%
   ☐ Between 11 and 25%
   ☐ Between 26 and 50%
   ☐ Between 51 and 75%
   ☐ Between 76 and 100%

10. In the past 6 months, what has been the length of an average course of treatment for a child in your practice, assuming successful treatment completion?

   ☐ 1-5 sessions
   ☐ 6-10 sessions
   ☐ 11-15 sessions
   ☐ 16-20 sessions
   ☐ 21-25 sessions
   ☐ 26-30 sessions
   ☐ 31-35 sessions
   ☐ 36-40 sessions
   ☐ 41-45 sessions
   ☐ More than 45 sessions

11. In the past 6 months, what has been the rate of clients failing to successfully complete treatment (e.g., the drop-out rate)?

   ☐ Less than or equal to 10%
   ☐ Between 11 and 25%
   ☐ Between 26 and 50%
   ☐ Between 51 and 75%
   ☐ Between 76 and 100%

12. What do you consider to be the most common reasons clients/patients drop out of treatment prior to completion?

13. Are you able to provide mental health treatment in any other language other than English (Are you Bilingual)?

☐ Yes (If yes, please describe: ____)
☐ No

14. Do you work with any clinicians who have received formal TF-CBT training and/or provide TF-CBT in their clinical practices?

☐ Yes (If yes, please describe: ____)
☐ No

15. Do you plan to provide therapy in North Carolina through June of 2011?

☐ Yes ☐ No

16. Please rate your comfort level in adhering to a manualized, evidenced-based practice.

VERY UNCOMFORTABLE	SOMEWHAT UNCOMFORTABLE	UNSURE	SOMEWHAT COMFORTABLE	VERY COMFORTABLE
☐	☐	☐	☐	☐

17. Please list any evidence-based practices you currently use in your clinical practice, regardless of whether they are child/family focused.

18. Please list any other clinical training programs in which you are currently enrolled or that you will be involved in during the timeframe of this TF-CBT training curriculum.

19. Are you willing to accept treatment referrals from DSS (knowing that some cases may go to court)?

    ☐ Yes ☐ No

20. Participation in a NC CTP Learning Collaborative is both time consuming and clinically challenging; fully-engaged trainees will master an evidence-based treatment model. Trainees will be expected to meet face to face on 7 days; participate in monthly group consultation calls; participate in bi weekly one on one consultation calls with their assigned faculty member; submit electronic documentation in a timely fashion; and provide a full course of TF-CBT to at least one sexually traumatized client/patient.

    Will your schedule allow you to participate on this intense Learning Collaborative in 2010/2011?

    ☐ Yes ☐ No
    Comments:

21. In order to complete all NC-CTP graduation requirements, each clinician-trainee must complete a full course of TF-CBT (with fidelity to the model) with at least one sexually-traumatized client/patient. Each clinician-trainee is responsible for securing a "sexually-traumatized" referral case by December 15, 2010

    Will you be able to fulfill this requirement?

    ☐ Yes ☐ No
    What will be your strategy to secure an appropriate referral/case?

22. What do you hope to achieve by participating in this training?