A Survey of Pennsylvania Child Trauma Services: Key Findings

QUICK FACTS ABOUT THE SURVEY

The Scoping Survey was a collaborative effort between the Pennsylvania Commission on Crime and Delinquency and the Penn State EPISCenter, with guidance from an advisory workgroup that included representation from Children's Advocacy Centers and the victims' services field.

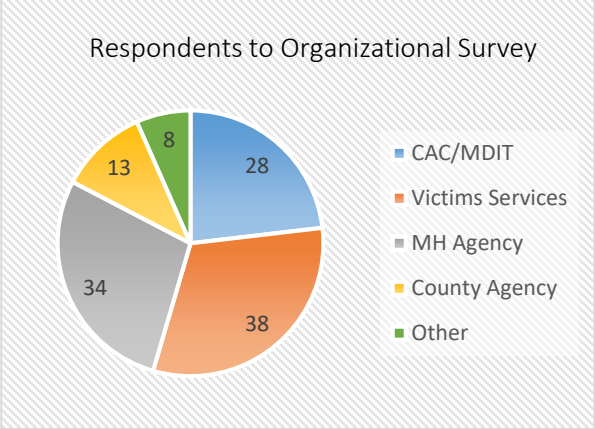
- Data was collected through two on-line surveys – one for individual practitioners and one for organizations.
- Participants were not randomly selected and may not be representative of all trauma services in Pennsylvania. The survey was distributed via "snowball method" – recipients were encouraged to forward the survey to others in the trauma services field.

GOALS of this exploratory survey included:

1. Gather general information regarding services provided to child trauma victims in Pennsylvania.
2. Assess the provision of Trauma-Focused Cognitive Behavioral Therapy specifically.
3. Identify what is working well and areas for improvement.

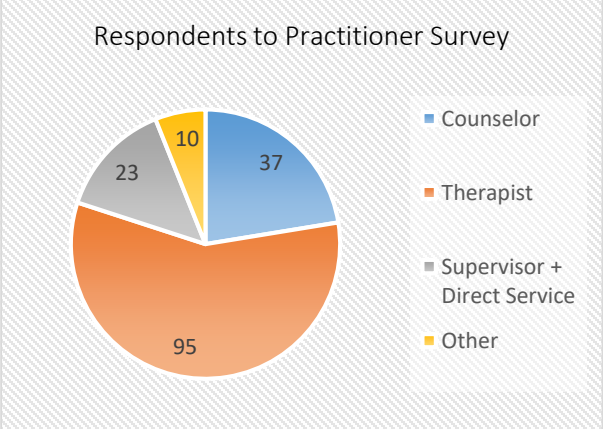
ORGANIZATIONAL SURVEY

- Completed by leadership at organizations serving child trauma victims and their families.
- Asked about staff qualifications, agency processes and protocols, use of evidence-based practices, and perceived strengths and needs of the field.
- Final sample included 121 respondents representing organizations from all 67 counties.



PRACTITIONER SURVEY

- Completed by individuals who provide direct care to child trauma victims and their families in office-based or community settings.
- Survey asked about qualifications, supervision, types of interventions used, and training in evidence-based models.
- Final sample included 165 individuals.



pennsylvania COMMISSION ON CRIME AND DELINQUENCY
pennsylvania DEPARTMENT OF HUMAN SERVICES
EDNA BENNETT PIERCE PREVENTION RESEARCH CENTER
EPISCenter EVIDENCE-BASED PREVENTION & INTERVENTION SUPPORT CENTER
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ORGANIZATIONS

In Pennsylvania, children who have been traumatized may pass through the doors of any number of organizations or programs. Different types of organizations are guided by different regulations and policies, often determined by their funders. Generally speaking:

- **Victims' Services Agencies (VSAs)** and programs are typically funded by and must abide by the standards of the Pennsylvania Coalition Against Rape (sexual assault/rape crisis centers), the Pennsylvania Coalition Against Domestic Violence (domestic violence shelters), and/or the Pennsylvania Commission on Crime and Delinquency (other victim services).

- **Mental Health Agencies (MHAs)** are typically licensed by the Pennsylvania Office of Mental Health and Substance Abuse Services and receive a large part of their funding from insurance, including Medicaid/Medicare, for providing "medically necessary" treatment services. While these agencies may employ unlicensed clinicians to provide therapy to Medicaid clients, commercial insurers generally require a clinician be licensed.

- **Children's Advocacy Centers and Multidisciplinary Investigative Teams (CACs)** often receive funding from the Pennsylvania Commission on Crime and Delinquency and are guided by standards from the National Children's Alliance, which provides accreditation for CACs.

- There are a variety of other social service agencies that serve children and families in Pennsylvania.

DEFINITIONS

The surveys focused on Counseling and Therapy services. Based on regulations and guidelines used in Pennsylvania, organizations were asked to use the following definitions to differentiate these services.

- **Counseling:** Psychoeducation, supportive listening, feedback, clarification of options and/or assessment of needs, provided in response to the effects of victimization.

- **Mental Health Treatment / Therapy:** Interventions or treatment to address mental health symptoms (including those resulting from a traumatic event), typically provided by a licensed clinician or within a licensed mental health agency.

Individuals responding to the Practitioner Survey were asked to self-identify as providing supportive counseling, mental health treatment, or supervision.

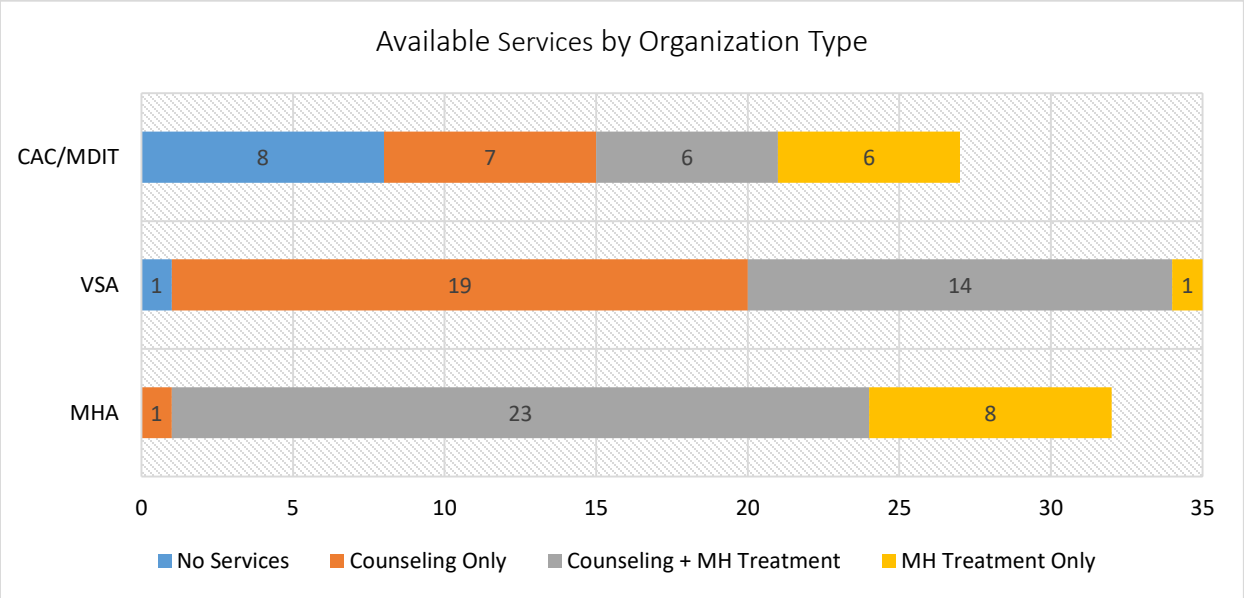
Although the definitions above were provided, our experience suggests that the terms "counseling" and "therapy" are often used interchangeably, even by professionals, which can create confusion about the type of service being offered.

WHAT SERVICES WHERE?

As might be expected, nearly all Mental Health Agencies offer therapy; the majority (75%) offer counseling as well. Therapists (individuals providing mental health treatment) were most likely to report working in Mental Health Agencies or in private practice.

The overwhelming majority of Victims' Services Agencies (94%) provide counseling while almost half (42%) offer therapy as well. Individuals identifying as Counselors were most likely to work in a VSA.

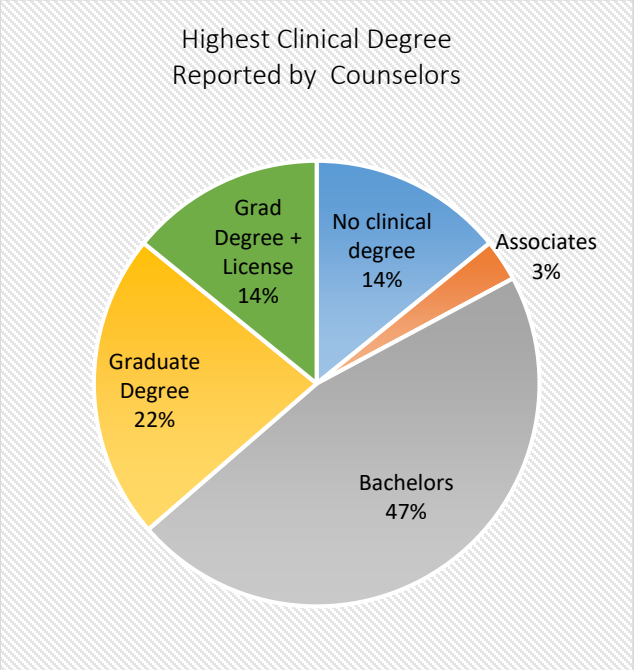
The combination of services is most variable within Children's Advocacy Centers, which are not required to provide counseling or therapy in-house and may instead refer out to other agencies for these services. Only a small number of practitioners participating in the survey identified themselves as working in a CAC.



Practitioners' Primary Place(s) of Employment

	Counselors (n = 37)	Therapists (n = 95)	Supervisors (n = 23)
Children's Advocacy Centers	0%	11%	0%
Victims' Services	84%	12%	22%
Mental Health Agency	8%	62%	52%
Private Practice	3%	17%	13%
School	3%	5%	9%
Other	5%	6%	13%

COUNSELORS

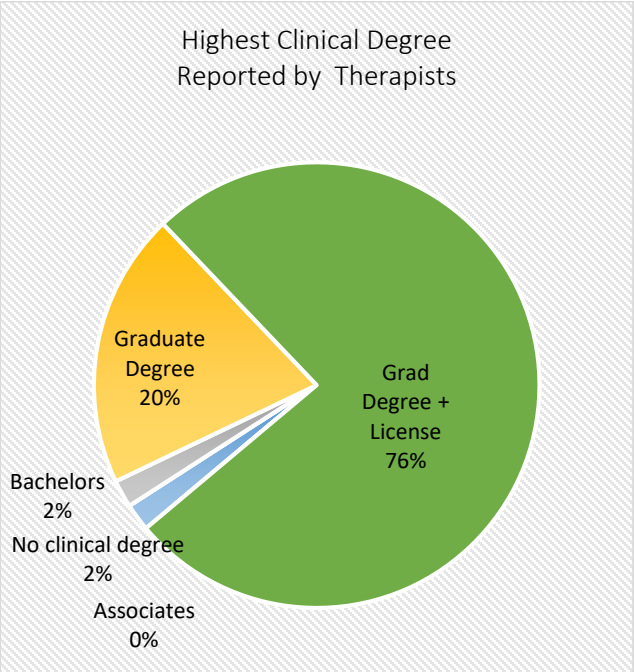


- Most Counselors are full-time employees working in Victim Service Agencies
- Average 7.6 years of experience

Minimum qualifications required of Counselors vary by type of Organization.

- All CACs and MH Agencies require at least a Bachelor's degree; 71% of MH Agencies require a graduate degree in a clinical field and/or licensure.
- Three-fourths (76%) of VSAs require at least a Bachelor's degree; the rest allow individuals with a high school diploma or some college to serve as Counselors.
- VSAs were more likely to report requiring some type of certification, such as those offered by the Pennsylvania Coalition Against Rape.

THERAPISTS



- Nearly all Therapists report having a graduate degree, which is required in most organizations.
- Average 10.5 years of experience

Minimum qualifications were fairly consistent across Organization.

- CACs and VSAs were more likely to require Therapists be licensed (42% and 47%, respectively, compared to 13% of MH Agencies). This is probably because, in MH Agencies, unlicensed therapists can provide billable services under the umbrella of the agency's license.
- A small percent of CACs and MH Agencies (7-8%) indicate allowing Bachelor-level Therapists. All VSAs reported requiring Therapists have a graduate degree or license.

SUPERVISION

FREQUENCY OF SUPERVISION

75% of Counselors and 85% of Therapists reported some type of regular consultation or supervision (either regularly scheduled peer supervision or clinical supervision at least monthly). A minority of practitioners – 25% of Counselors and 15% of Therapists – do not receive regular supervision.

This was comparable to reports from Organizations – 83% reported Counselors receive supervision at least monthly and 95% reported Therapists receive supervision at least monthly. Supervision requirements may vary by department within an organization and also depend on whether staff are licensed to practice independently.

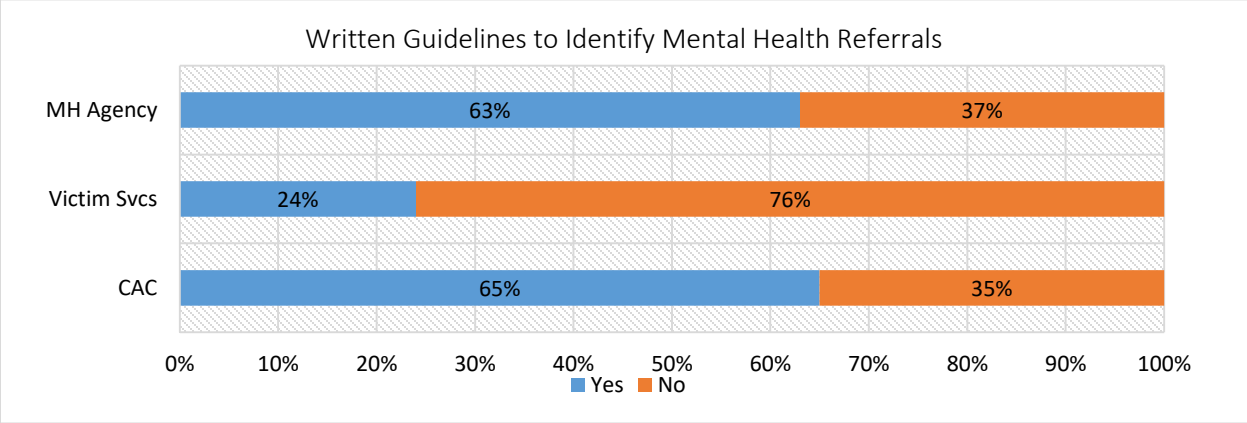
PRACTITIONERS ARE SATISFIED WITH SUPERVISION

- More than 90% of Counselors and Therapists reported that the frequency and quality of supervision was adequate or ideal.
- 100% of Counselors and 91% of Therapists rated their supervisor as moderately or very knowledgeable about trauma treatment.

IDENTIFYING YOUTH FOR THERAPY

USE OF WRITTEN PROTOCOLS OR GUIDELINES

Less than half of the organizations (44%) report having a written protocol or guidelines to identify which youth should be referred for mental health treatment / therapy. Written guidelines were more than twice as likely in CACs and MH Agencies than in Victims' Services Agencies.



METHODS FOR IDENTIFYING YOUTH IN NEED OF MENTAL HEALTH TREATMENT

In CACs and VSAs, the decision to refer a youth for treatment is most often based on family interest and clinical judgment. In MH Agencies, clinical judgment and family interest are also commonly used, but assessment by a licensed clinician is common practice as well.

The use of standardized assessment tools to evaluate need for referral is not routine practice in most organizations. Less than half of the organizations reported using a general symptom measure or PTSD-specific symptom checklist "Often" or "Always" when deciding which cases to refer for therapy. The use of standardized measures is more common in MH Agencies than CACs or VSAs.

Percent reporting method is used "Often" or "Always" to determine need for referral

	CAC	VSA	MHA	All Orgs
MDIT recommendation	81%	56%	57%	62%
Clinical judgment of staff	68%	81%	97%	83%
Family interest / request	77%	84%	93%	83%
General symptom checklist	35%	28%	67%	42%
PTSD-specific checklist	39%	31%	57%	36%
Assessment by licensed clinician	32%	34%	87%	51%

SERVICES TO TRAUMATIZED YOUTH

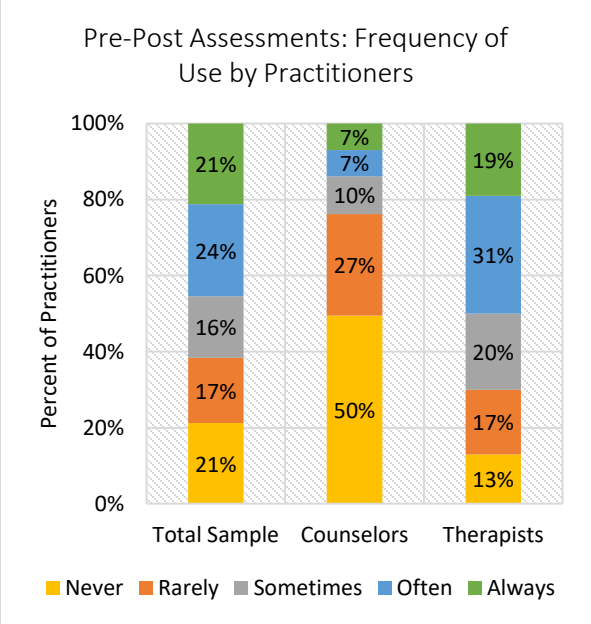
The Scoping Survey looked at the extent to which Counselors and Therapists who work with traumatized youth engage in best practices such as collaborating with caregivers, using objective measures of client progress, and implementing research-informed interventions or evidence-based treatment models.

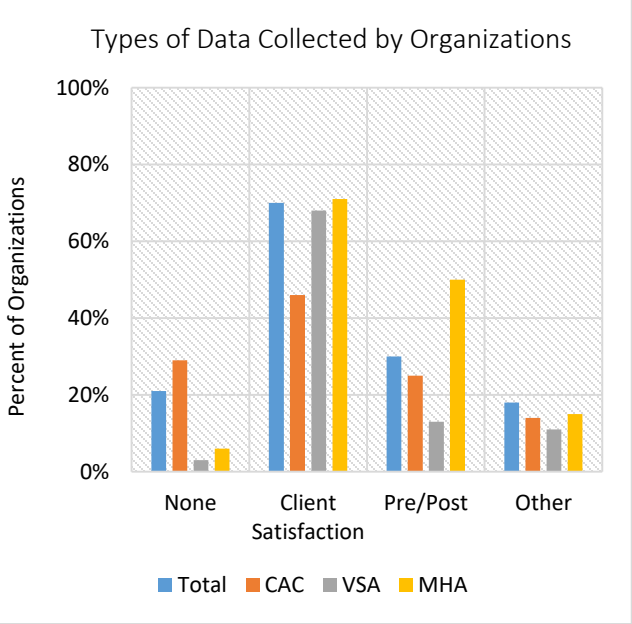
PARENT INVOLVEMENT

About **two-thirds** of Counselors and Therapists reported that parents were involved in the child's counseling or therapy for at least half of the cases they served over the past six months.

MEASURING CLIENT PROGRESS

Overall, less than half (45%) of the participating practitioners use standardized pre- and post-assessment measures "Often" or "Always," to evaluate clients' progress. This is lower for Counselors (14%) than Therapists (50%). At the **organization** level, most organizations collect Client Satisfaction data, but Pre-Post Assessment is less prevalent. Among organizations that collect Satisfaction data, more than half do not collect any other data.





INTERVENTIONS USED

To get a sense of how practitioners work with child victims of trauma, individuals were asked how frequently they use 22 different strategies or techniques when working with these clients. Response options ranged from "Never" to "Always." The percent of respondents indicating they frequently use each intervention ("Often" or "Almost Always") was calculated. Interventions are listed in rank order on the following page, based on frequency of use by the sample as a whole.

The most frequently used interventions were similar across Counselors and Therapists and overlap considerably with interventions included in evidence-based therapy models. For instance, the vast majority of practitioners normalize clients' response to the trauma, teach relaxation and other stress management skills, and educate clients about the relationship between thoughts, feelings, and behaviors.

However, exposure-based interventions, which are common in many evidence-based therapies for trauma, were regularly used by only about half of the practitioners. Exposure involves having clients confront an anxiety-provoking situation, such as discussing their traumatic experience directly or being exposed to trauma triggers, in a safe and supportive environment. This in turn decreases the distress and anxiety the individual experiences in response. About one-third of practitioners wait for clients to bring up the trauma, rather than address it directly

% of Practitioners Using This Intervention "Often" or "Almost Always"	
Normalize the child and family's response to the traumatic event.	91.0%
Teach relaxation skills or other specific ways to manage stress.	91.0%
Teach the child that thoughts can affect feelings and behavior.	87.6%
Reflect back client thoughts and feelings to help client resolve concerns him/herself.	83.4%
Teach safety skills and body safety, to reduce risk of future abuse.	82.1%
Try to help the child gain insight into personal feelings, motives, or conflicts.	81.4%
Help child and/or caregiver to identify, evaluate, and modify maladaptive thoughts.	80.0%
Provide general information about trauma or abuse, such as statistics, dynamics of abuse, and common responses to trauma.	74.5%
Define appropriate family roles and boundaries.	72.4%
Work with family members to change family interaction patterns, improve communication, or reduce conflict.	71.7%
Coach parents to provide supportive responses to child's discussion of traumatic events.	69.7%
Encourage child to gradually describe more details of traumatic experiences.	61.4%
Use games to teach or reinforce new skills.	61.4%
Encourage play to enhance a sense of mastery.	59.3%
Use art, sand play, or toys to help child express emotions and process thoughts and feelings about the traumatic event.	57.2%
Parent training in behavior management.	55.9%
Have joint parent-child sessions to allow the child to directly communicate upsetting feelings, thoughts, or memories to parents.	52.4%
Use the therapeutic relationship to correct for early deprivation or dysfunctional relationships.	52.4%
Help the child to create a trauma narrative…for remembering the traumatic event and sharing his/her thoughts and feelings.	49.7%
Interpret the underlying meaning of the child's words and actions.	46.9%
Use behavior systems, rewards, or contracts.	33.8%
Wait for the client to bring up the traumatic experience him/herself.	35.2%

PRACTITIONER EXPERIENCE WITH EVIDENCE-BASED MODELS

Individual practitioners were asked whether they had received training in any of six specific treatments that have been identified as evidence-based or promising practices for child trauma.

- Trauma-Focused Cognitive Behavioral Therapy was by far the most frequently reported, with 100% of Supervisors, 78% of Therapists and 40% of Counselors having at least some training in TF-CBT.
- The next most common was Eye-Movement Desensitization and Reprocessing Therapy (EMDR); 10% of the overall sample reported training. This was heavily weighted toward Therapists (13%) and Supervisors (16%); no Counselors reported EMDR training.
- Less than 5% of respondents had training in Child & Family Traumatic Stress Intervention (CFTSI); Cognitive Behavioral Intervention for Trauma in Schools (CBITS); Child-Parent Psychotherapy (CPP); and Prolonged Exposure for Adolescents (PE-A).

Respondents also reported using a variety of other models, such as Parent-Child Interaction Therapy, Dialectical Behavior Therapy, SITCAP, and Internal Family Systems, among others.

Although trained, practitioners using evidence-based models did not necessarily do so with fidelity. The very small number using CBITS, CPP, and PE-A all reported incorporating *parts* of these models into their work, rather than implementing the models in their entirety. About half (56%) of 89 TF-CBT-trained clinicians report implementing the model in its entirety, if a client is appropriate for the model. Fidelity was highest for EMDR, with 92% (11 of 12) using the model in its entirety.

ORGANIZATIONAL USE OF EVIDENCE-BASED MODELS

At the organizational level, TF-CBT remains the most commonly available evidence-based model for trauma (although this may be an artifact of the manner in which the survey was distributed), followed by EMDR. Like individual practitioners, organizations reported using a number of other models as well.

Percent of Organizations with Trained Staff Currently Providing Each EBP

	CAC	VSA	MHA	Overall
CBITS Cog. Beh. Intervention in Schools	5%	14%	14%	10%
CFTSI Child & Family Traumatic Stress Intervention	9%	7%	4%	6%
CPP Child-Parent Psychotherapy	5%	7%	21%	10%
EMDR Eye-Movement Desensitization & Reprocess.	14%	21%	17%	17%
PE-A Prolonged Exposure for Adolescents	0%	7%	3%	3%
TF-CBT Trauma-Focused Cog. Beh. Therapy	55%	48%	83%	62%

Respondents from organizations were asked what they see as both strengths and needs of the trauma services field in Pennsylvania. The most frequently mentioned areas are identified below, with the percent of respondents mentioning each strength or need indicated in parentheses.

STRENGTHS

Increasing awareness of trauma (30%): The most frequently mentioned strength was the increased emphasis on trauma-informed care and increased awareness among policy-makers, the public, and in local systems of the impact of childhood trauma.

Networks of support & availability of services (27%): Access to CACs, MDITs, and/or trained trauma therapists were identified by many respondents as a strength. Some also mentioned having strong referral networks or collaboration within their local communities. Others noted accessibility of services, such as being able to offer intervention quickly or at locations convenient to families.

Enhanced standards & emphasis on evidence-based treatment (16%): Respondents specifically mentioned the movement toward evidence-based therapies, trauma certification, and the new NCA accreditation standards for CACs as strengths of the field.

Expertise & skill of staff (16%): The availability of staff who are well-trained, skilled, or experienced in serving children and families impacted by trauma was noted.

NEEDS

Funding (51%): A number of funding-related obstacles were described, including challenges finding licensed therapists who can be credentialed with insurance panels or finding providers that accept funding from VCAP (Victims Compensation Assistance Program); adequate levels of reimbursement to enable manageable therapist caseloads and cover the cost of specialized trainings and certifications; and funding to address transportation barriers and increase the number of therapists in rural areas. Organizations also noted the administrative requirements and time-limited nature of grants as a challenge to ensuring stable funding for services.

Training & supervision (28%): Organizations see a need for more low-cost, high-quality training, including training that provides on-going support to enhance competence (rather than one-time trainings). It is often difficult to find affordable clinical supervision for staff. A need was also noted for better cross-training among service sectors and within Multidisciplinary Investigative Teams, to increase awareness of the role each plays in serving traumatized youth.

Capacity & accessibility of services (27%): There is still a need in many communities for well-trained trauma therapists, so that youth do not have been placed on waitlists for services. Particularly in rural communities, transportation and the distance families must travel to access services are barriers. Some respondents noted that it is important that children with commercial insurance, not just Medical Assistance, have access to effective trauma services.