CBLC Implementation Manual

APPENDICES
APPENDIX A

Community Based Learning Collaborative Participating Agencies

Essential
✓ State-funded mental health service provider agencies
✓ State-contracted mental health service provider agencies
✓ Private nonprofit or for-profit mental health providers and agencies
✓ State child welfare/child protection agencies
✓ State juvenile justice agencies
✓ Children’s Advocacy Centers (CAC)

Should be considered depending on their programs and services delivered
✓ Victim Advocate programs
✓ University or college-based training or service programs
✓ Guardian ad Litem (GAL) programs
✓ Court-Appointed Special Advocate (CASA) programs
✓ Residential Treatment Facilities
✓ Alternative or Appropriate Response programs
✓ Rape Crisis Centers
✓ Domestic violence shelters and programs
✓ School system personnel, e.g. guidance counselors
✓ School support programs
✓ After-school programs
✓ Law enforcement
✓ Prosecutor’s office
✓ Family/juvenile court personnel

Community Based Learning Collaborative Participant Breakdown
• 50 Clinicians/Clinical Supervisors (5 clinical consultation call groups, 2 calls a month)
• 30 Brokers (3 Broker consultation call groups, 1 call each month)
• 10 Senior Leaders (1 Senior Leader consultation call group, 1 call each month)
APPENDIX B

Community Readiness Assessment Workbook
COMMUNITY READINESS ASSESSMENT (CRA) WORKBOOK

INTRODUCTION: As part of Project BEST, we are conducting a Community Readiness Assessment (CRA) with several different communities throughout the state. The purpose of the CRA is to help you, as a community, assess your readiness to participate in a community based learning collaborative designed to increase capacity to provide evidence-based, trauma-focused services to children and families who have experienced abuse or trauma.

How do you know if your community is ‘ready?’
- Strong, committed and enthusiastic leadership
- Professionals in your community are INTERESTED and MOTIVATED to learn about evidence-based, trauma focused services
- Commitment to ongoing sustainability of evidence-based, trauma focused services in your community

This CRA will be comprised of the following 2 components:
1. A community-wide Self-Study led by your community children’s advocacy center (CAC)
2. Interviews by members of the PB Faculty

Who should participate?
In identifying key informants, we encourage you to include representatives from all of the professional disciplines involved in the care of abused/traumatized children in your communities. These should include both clinicians (therapists, clinical supervisors) and brokers (e.g., those professionals involved in identifying, referring, and monitoring children who have experienced abuse/trauma) from agencies such as Department of Social Services, the guardian ad litem program, juvenile justice, mental health, and the school districts. Be sure to include front-line professionals, supervisors, and agency leaders. Our past experience has demonstrated that successful implementation is dependent on active, enthusiastic participation from all levels and that strong committed leadership is critical to ongoing sustainability.

Getting Started: The CRA is designed to begin with the CAC/MDT Self-Study. We recommend that you identify a key person at the CAC who will be designated to collect this information. The information can be obtained through a variety of means, including review of CAC records and relevant documents; phone calls and brief interviews with community professionals; or short, internet-based surveys (such as Survey Monkey). A PB Faculty Liaison will provide individual assistance and guidance to help you complete all components of the CRA, starting with the Self-Study. If you have any questions, please do not hesitate to contact your PB Faculty Liaison.

PART 1: CAC/MDT SELF-STUDY
The purpose of the Self-Study is to increase your awareness regarding the availability and quality of services for abused and traumatized children in your community. This will also help to identify existing gaps and give you a better sense of where your community is regarding the provision of evidence-based, trauma-informed services for children and their families.
A. **CAC Component** – These questions are designed to obtain specific information about the infrastructure of the CAC. Our past experience with Project BEST has demonstrated that the CAC often serves as a leader and coordinating center for service and training activities within a given community. CACs are the point of entry for many abused/traumatized children and their families and further, the existing multidisciplinary team (MDT) includes key community leaders and professionals who can then serve as the foundation for the Project BEST Community Change Team. Thus, questions to assess the CAC infrastructure are important for the CRA.

1. How long have you been a member of the National Children’s Alliance (NCA)?
   - # of Years
   - Year of initial affiliation/membership

2. What is your current level of membership in the NCA?
   - Developing
   - Associate
   - Accredited

3. Please provide the following information about your CAC:
   - # full-time employees
   - # part-time employees

4. Do you have any community partner staff co-located at your CAC?
   - Yes
   - No

4a. If yes, please provide names of these agency partners and the number of co-located staff:

<table>
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<tr>
<th>Agency Name</th>
<th># of staff</th>
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5. What is the organizational structure of your CAC?
   - 501c3
   - Umbrella (e.g., rape crisis center) - Please describe:
     - Hospital-based
     - Government-based
     - Agency-based (e.g., Prosecutor’s office)
     - Other – Please describe: ____________________________

6. Does your CAC have a governing or advisory board?
   - Yes
   - No
7. In the past two years, how many grants have you secured and managed? ____

8. Please list your top three sources of funding:

____________________________
____________________________
____________________________

9. Do you have a staff member designated for financial management of grants?

☐ Yes
☐ No

10. Who are your top 5 referral sources?

11. Which of the following services are provided at your CAC? For each service, please indicate the number of children served over the past 6 months:

<table>
<thead>
<tr>
<th>Type of Service</th>
<th># of children</th>
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<tbody>
<tr>
<td>Forensic interview</td>
<td></td>
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<tr>
<td>Treatment assessment</td>
<td></td>
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<tr>
<td>Mental health treatment</td>
<td></td>
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<tr>
<td>Medical Exam</td>
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<tr>
<td>Other – please specify: ________</td>
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</table>

12. If you do provide mental health treatment in-house, which practices do you provide?

☐ TF-CBT
☐ PCIT
☐ MST
☐ AF-CBT
☐ Other – please specify:

13. If you do not provide mental health treatment in house, to whom do you refer? (Please estimate percentage of each)

___% community mental health
___% private practitioners
___% hospital/university-based practice
___% other

14. How do you decide which practitioners in the community to refer your clients? (i.e., do you have any specific criteria or procedures for selecting mental health treatment providers?). Please describe: (Attach additional sheets if needed)

15. Does your CAC routinely utilize standardized assessments to assist in the development of treatment plans or to make referrals to community providers?

☐ Yes
☐ No
☐ Not sure

5/5/2016
15a. If yes – which standardized assessment measures do you utilize?
- UCLA PTSD RI
- Trauma Symptom Checklist for Children (TSCC)
- Achenbach Child Behavior Checklist
- Eyberg Child Behavior Inventory
- Other – please specify

16. Does your CAC track clients who are referred out for mental health treatment?
- Yes
- No
- Not sure

16a. If yes, please describe this process (i.e., do you have any formal process for tracking the number of children that are referred for mental health treatment; the number of children that follow through with this referral; the number that engage in treatment; and/or the number that actually complete treatment?)

16b. If your CAC has a tracking process, please provide the number or % of clients for the following:

<table>
<thead>
<tr>
<th></th>
<th>#</th>
<th>%</th>
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<tbody>
<tr>
<td>Recommended for mental health treatment</td>
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</tr>
<tr>
<td>Seen in house for mental health treatment</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Referred out for mental health treatment</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Engaged in mental health treatment (seen for at least 1 session)</td>
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<tr>
<td>Completed mental health treatment</td>
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<td></td>
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</tbody>
</table>

16c. Who is responsible for collecting this tracking information? __________

16d. Does your CAC have any funder(s) that requires tracking of cases and reporting on outcomes? Please describe: (Attach additional sheets if needed).

16e. If you do NOT currently track mental health referral and treatment outcomes, please describe the reasons (Attach additional sheets if needed).

17. Does your CAC have a mechanism for the following: (Check all that apply)
- Identifying and solving community coordination problems?
- Identifying and filling gaps in service for children and families being served?
- Bringing new programs to the community?
- Evaluating the functioning of current and new programs?

18. Please describe one new community or agency program or service implemented through the CAC or another agency over the past 2 years. (Attach additional sheets if needed.)
B. Clinical Component

B1. Please provide numbers for the following: (if this information is unknown/not available, please write ‘N/A’).

<table>
<thead>
<tr>
<th>Therapists/supervisors currently seeing abused and traumatized children in your community</th>
<th>#</th>
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<tbody>
<tr>
<td>Part-time clinicians (therapists/supervisors) at the community mental health center’s child/adolescent unit</td>
<td></td>
</tr>
<tr>
<td>Full-time clinicians (therapists/supervisors) at the community mental health center child/adolescent unit</td>
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<tr>
<td>Clinicians (therapists/supervisors) in your community who are interested in providing services to abused and traumatized children, but are not currently doing so</td>
<td></td>
</tr>
<tr>
<td>Clinicians in your community who would be interested in participating in a CBLC designed to learn, implement and use TF-CBT</td>
<td></td>
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</table>

B2. Have there been other evidence-supported treatments (EST) implemented by therapists in your community?
- [ ] Yes
- [ ] No - skip to B3
- [ ] Not sure

B2a. If yes, please list:

B2b. How satisfied were you with this experience?
- [ ] Completely unsatisfied
- [ ] Somewhat unsatisfied
- [ ] Neither satisfied nor unsatisfied
- [ ] Somewhat satisfied
- [ ] Very satisfied

B3. Are any ESTs still currently being implemented in their original form (with fidelity) in your community?
- [ ] Yes
- [ ] No
- [ ] Not sure

C. Broker Component: Brokers are defined as those professionals whose primary responsibilities are to i) identify abused/traumatized children or adolescents; ii) develop treatment plans for these children and their families; iii) determine whether they are likely to need mental health services; iv) make referrals for mental health and/or other treatment services; and v) monitor progress.

C1. Please provide the number of current employees (e.g., case managers and supervisors) in each of the following broker agencies who would be interested and appropriate to participate in a community based learning collaborative designed to implement TF-CBT in your community:
<table>
<thead>
<tr>
<th>Agency</th>
<th>Counties Served</th>
<th># Appropriate</th>
<th># Interested</th>
</tr>
</thead>
<tbody>
<tr>
<td>Department of Social Services</td>
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<td></td>
<td></td>
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<tr>
<td>GALs</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Department of Juvenile Justice (# of Probation Officers)</td>
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<td></td>
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<tr>
<td>Other (please list) (e.g., schools, victim advocates)</td>
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</tbody>
</table>

C2. Have brokers in your area participated in any other projects that sought to implement an evidence supported treatment in your area?

- [ ] Yes
- [ ] No
- [ ] Not sure

C2a. If so, what was the success of that effort? What problems were encountered?

C3. How would you rate the working knowledge of brokers in your community concerning the following:

1. Virtually no knowledge
2. Very little knowledge
3. Some knowledge
4. Adequate knowledge
5. A good fund of knowledge
6. Excellent knowledge
7. Outstanding knowledge
C4. Do brokers in your community typically assess children for their lifetime histories of exposure to violence and other potentially traumatic events, other than the emergent incident that is the subject of the report?

☐ Yes – proceed to C4a
☐ No – skip to C5
☐ Not sure

C4a. What methods and assessment tools do brokers in your community use to assess a child’s trauma history?

C4b. What methods and assessment tools do brokers in your community use to assess a child’s mental health problems and possible need for mental health treatment?

C5. Do brokers in your community coordinate the development of service and treatment plans with other professionals involved in the cases, particularly therapists?

☐ Yes
☐ No
☐ Not sure

C6. Do brokers in your community usually incorporate specific evidence supported treatments into their service and treatment plans?

☐ Yes
☐ No
☐ Not sure

C7. Do brokers in your community regularly check on the clinical progress of children in treatment?

☐ Yes
☐ No
☐ Not sure

C8. Do brokers in your community coordinate and work with therapists to promote successful treatment outcome for children in treatment?

☐ Yes
☐ No
☐ Not sure
D. Consumer Component

D1. Does your CAC have any type of consumer advisory board?
   - Yes
   - No
   - Not sure

D2. Are consumers a part of any existing advisory boards?
   - Yes
   - No
   - Not sure

D3. Does your CAC regularly administer any type of client satisfaction questionnaire?
   - Yes (proceed to D3a)
   - No
   - Not sure

D3a. Do you have any available summaries of these results?
   - Yes (proceed to D3b)
   - No
   - Not sure

D3b. Do you use these results to revise policies and practice?
   - Yes
   - No
   - Not sure

Community Collaboration Component

E1. Does your CAC have a Multidisciplinary Team (MDT):
   - Yes – proceed to E1a
   - No – Skip to E2
   - Not sure

E1a. List the professional disciplines consistently represented on your MDT:

<table>
<thead>
<tr>
<th>Agency</th>
<th>Position/Title</th>
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<tbody>
<tr>
<td>Department of Social Services</td>
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<tr>
<td>Mental Health</td>
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<tr>
<td>Law Enforcement</td>
<td></td>
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<tr>
<td>Solicitor’s Office</td>
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<tr>
<td>Others – Please List Below</td>
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5/5/2016
E1b. Do you have signed Memorandums of Agreement/Understanding with each member of your MDT?
- Yes
- No
- Not sure

E1c. How many MOAs do you have? One with each county

E1d. Does the CAC have MDT staffings?
- Yes
- No

If so, how frequently do these occur?
- Weekly
- Monthly
- Quarterly
- Other - specify

How long does a case staffing typically last?

E1e. Is your MDT involved in mental health treatment planning?
- Yes
- No
- Not sure

E1f. Does the MDT monitor treatment progress?
- Yes
- No
- Not sure

If so, how is this progress monitored?

E2. Do you have a community response protocol that describes the collaborative process for responding to allegations of child abuse?
- Yes (please attach a copy)
- No
- Not Sure

E3. Aside from MOAs and MOUs previously discussed, what kind of linkage agreements exist in the community between the CAC and other community service organization (e.g., between the CAC and mental health providers, medical professionals, DSS, and/or DJJ)?

E4. Please provide some examples of collaborative projects with other community youth serving agencies (e.g., training, developing treatment protocols, providing services, shared protocols).
E5. Please describe any co-sponsored trainings/activities for the community? Who was involved? When was the last one? *(Attach additional sheets if needed)*

E6. Do you have shared supervision among different agencies?  

- Yes  
- No  
- Not sure

E6a. If yes, how often do they meet?  

- Weekly  
- Monthly  
- Quarterly  
- Other - specify

E7. Do any agencies within this community provide space for co-location (e.g., school-based, mental health therapists at DSS)?  

- Yes  
- No  
- Not sure

E7a. If yes, please list host agency *(where the providers are located)*; name of partnering agency *(who supplies the providers)* and number of providers that are involved:

<table>
<thead>
<tr>
<th>Name of Host Agency</th>
<th>Partnering Agency</th>
<th># Co-located Providers</th>
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E8. Have there been other types of issues *(quality improvement initiatives, systematic changes, etc…)* around which the community has been able to collaborate? Please describe these efforts, including whether they were successful and the level of buy-in from community partners and agency staff.

**Almost done…. just a few additional questions:**  
How long did it take you to complete this self-study?

Please provide us with any feedback regarding this process:
Please indicate who participated in this self-study and provide a phone number and email so that we may contact them to participate in the remaining components of the CRA – the PB Faculty Interview and/or an on-line survey.

**CRA Self-Study Participants:**

<table>
<thead>
<tr>
<th>Name</th>
<th>Agency</th>
<th>Position/Title</th>
<th>Contact phone #</th>
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**Thank you for taking the time to complete this Self-Study! What happens next??**
Your liaison will review this information along with the other PB Faculty and share our feedback with you. This information will guide the Phase 2 component of the CRA - the interviews that we will conduct with key informants in your community.
Can you help us to identify individuals to contact for the interviews? In addition to the names listed above, please provide the names and contact information for any other individuals in your community who would be important and informative to include in this project:

**Suggestions for Interviews:**

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<tr>
<th>Name</th>
<th>Agency</th>
<th>Position/Title</th>
<th>Contact phone #</th>
<th>Contact email</th>
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5/5/2016
CRA Part II: Project BEST Faculty Liaison Interview

OVERVIEW: The purpose of this component of the CRA is two-fold: (1) to follow-up on material gathered from the Part I CAC/MDT self-study and (2) to obtain more in-depth information that will help to guide our assessment of a community’s readiness. The Interview will be conducted primarily by the Faculty Liaison, with input from the other PB Planning Committee members. Interviews will be conducted with a key informant sample that includes senior leaders from a variety of community agencies [e.g., Child Advocacy Centers, Department of Social Services (DSS), community mental health centers, Guardians ad litem; Department of Juvenile Justice, private practitioners].

Step 1: In consultation with the CAC, the PB faculty liaison will finalize list of key informants for the interviews, ensuring that there is adequate representation across agencies within the given community.

Step 2: PB Faculty Liaison will contact key informants to set a date/time for phone or in-person interviews.

Step 3: PB Faculty Liaison will conduct interviews (phone or in-person). Other PB Planning Committee members may assist, as needed. The Interviewer should aim to take detailed notes and ask any additional questions to elaborate on responses and gain more information in helping us to determine the level of community readiness and barriers to implementation of a CBLC.

INSTRUCTIONS FOR INTERVIEWERS

1. At the start of the interview, ensure that there is adequate time to complete the interview and that the interviewee is in a place where they can answer questions openly and honestly.
2. Obtain a follow-up phone number and email address in case additional information is needed.
3. For each interview conducted, please note the following:
   a. Interviewee’s name, agency, and title/position
   b. Date of the interview
   c. Start/stop time to provide information on length of the interviews
4. Try to take detailed notes and indicate if respondent replies ‘not sure’ or ‘don’t know’ for each item (when appropriate).
5. Provide any information regarding your observations of the interviewee (i.e., level of engagement; detail of responses; apparent interest or disinterest in the interview process, and of Project BEST in general)
Interviewer Name:
Date of Interview:
Start/Stop Time:

Interviewee Name:
Agency:
Title/Position:
Email:
Phone #:

ASKED OF EVERYONE:

1. Please provide a brief description of your position and responsibilities:

2. Are you aware of any available evidence-based trauma-focused treatment services in your community? If Yes – Please elaborate:

3. Have there been any specific trainings/implementation projects focused on evidence-support treatments (ESTs) in your community? (PROBE FOR TRAUMA-FOCUSED INITIATIVES)
   - If so, which ones?
   - How well did this experience go?

4. Do you have a CAC in your community?
   - If yes – what has been your involvement with the CAC? Please describe:
   - Does your agency refer children and families to your local CAC? If not – what are the reasons?

5. Aside from the CAC, what community agencies/programs do you/your organization systematically work with in meeting the needs of your clients? (DSS, GAL, Victim Advocate/Solicitor’s Office, community mental health, private practitioners, other)
6. Within the community, are there agencies that work together consistently?
   o If yes – please describe:
   o If no – what barriers stand in the way of consistent collaborative across agencies?

7. Please describe any Inter-organizational Agreements that exist in your community.
   o What kinds of shared protocols and projects exist?
   o What kinds of programs are co-sponsored in this community?
   o Do these Inter-organizational Agreements function, as they are intended to? If no, why not and what needs to improve?

8. How often do agencies co-sponsor trainings/activities for the community?

9. Do you have shared supervision among different agencies; if so, how often do they meet? If not, do you think there is a need for this? What barriers would make it difficult for this to occur?

10. Do any agencies within this community provide space for co-location; if so, please describe:

11. How would you rate the level of the relationship/collaboration between agencies/agency directors (i.e., agencies that provide services to abused/traumatized children and their families)?

12. Describe the history behind the interagency collaborations in this community (i.e., were they a result of an identified need in the community? How did these collaborations form? Are any particular agencies not involved – if so, why is that?)
What was the level of buy-in around collaboration with other agencies?

13. Have there been other types of issues (quality improvement initiatives, systematic changes, etc.) around which the community has been able to collaborate?
   - What were they, and were these initiatives successful?
   - What was the level of buy-in from community partners and agency staff?

14. Who are the naysayers in the community? (i.e., those who seem resistant or opposed to community/interagency collaboration and shared efforts for abused/traumatized children and their families)
   - What is their impact on agency coordination and improvement initiatives?

15. Describe the “turf” issues in your community.
   - Have these issues been resolved? How?
   - What is the biggest barrier to moving past these issues?
CLINICAL SENIOR LEADERS ONLY

16. Do brokers (NOTE: define ‘brokers’ if needed – ‘professionals whose responsibilities involve the identification of children who experienced trauma/abuse and referral for trauma-focused services’) in your community typically assess children for their lifetime histories of exposure to violence and other potentially traumatic events, other than the emergent incident that is the subject of the report?

   o Yes - Please describe:

   o No – Please describe why not

17. Do brokers in your community coordinate the development of service and treatment plans with other professionals involved in the cases, particularly therapists?

   o Yes - Please describe:

   o No – Please describe why not

18. Do brokers in your community usually incorporate specific evidence supported treatments into their service and treatment plans?

   o Yes - Please describe:

   o No – Please describe why not
19. Do brokers in your community regularly check on the clinical progress of children in treatment?
   - Yes - Please describe:
   - No – Please describe why not

20. Do brokers in your community coordinate and work with therapists to promote successful treatment outcome for children in treatment?
   - Yes - Please describe:
   - No – Please describe why not

21. What do you see as particular challenges or problems that brokers face in being able to work with therapists to promote successful treatment outcome for children in treatment?

**FOR BROKER SENIOR LEADERS ONLY:**
1. How does your agency determine criteria for referral to community mental health providers?

2. Does your agency access these mental health services for your clients? If yes, please describe this process:

3. Does your agency monitor cases to determine if they have followed recommendations for treatment and/or other services? If yes, please describe
EVERYONE:

Any other information about your community’s readiness to participate in a CBLC focused on trauma-focused interventions/practice?

(If applicable): how likely are you to participate? Will you send your staff/will your staff/agency participate?

TO INTERVIEWERS:
Please note any additional information regarding the interview (i.e., your impressions of this community’s readiness to participate in the CBLC). What specific challenges have been identified?

On a scale of 1(not at all ready) – 10 (let’s get this party started NOW), how ‘ready’ is this community to begin the CBLC? _____
APPENDIX C

FACILITY LOGISTICS FOR CBLC LEARNING SESSIONS

- Facility with one large room, accommodating 60-80 at tables, and two smaller rooms accommodating 20-25. Movable furniture in both areas
- Plan sufficient space for each person to avoid feeling cramped.
- Provide for easy access to seating with adequate number and width of aisles.
- Check for adequate air and comfortable air temperature.
- Check room for exterior noise
- Find out who to contact when problems occur
- Place entrance at rear of room to minimize coming and going distractions.
- Large room equipped with microphone, preferably one at front of room and a mobile microphone for moving around the room; internet access if available
- Screen in large room; if available, screen or blank wall in small rooms
- Flip chart stand (3); need one in large room and one in each breakout room
- **Round tables (6-8 to a table) are preferred for large room.** Please see examples below
- Other tables needed (these should be rectangular):
  - Large room – Registration table (2) with four chairs
    1. Tables for Storyboards, resource materials, coffee/water (at least 4)
    2. Small table for A/V equipment
    3. Extra chairs (8)
- Small rooms – Tables Chairs to accommodate 25; small table for AV Equipment

**Time Schedule and Flexibility** – If at all possible, set-up for the Learning Session to take place the afternoon/evening before Day 1. The Planning Team assists the Site Coordinator/participating partners with the set-up. The room set-up stays in place until breakdown at the end of Day 2.

1. **Day 1:** 8:30 am to 4:30 pm for participants. If possible, faculty and planning team like to meet in the same location from 4:30 to 5:00 pm.
2. **Day 2:** 8:30 am – 4:30 pm for participants. Allow 30-45 minutes for breakdown and removal of all training materials.
APPENDIX C (cont.)

- See Examples of preferred seating arrangement below.

<table>
<thead>
<tr>
<th>Cluster style</th>
</tr>
</thead>
<tbody>
<tr>
<td>![Cluster Style Diagram]</td>
</tr>
</tbody>
</table>

- Good for presentations with breakout groups.
- Clusters easily return to being a single group.
- Quick and easy to follow with a meal.
- Tables can be either round or small rectangles.

This setup style promotes team and small group interaction. Also allows participants to move easily when necessary between tables.

Appendix D
Materials Checklist

- Name Tags (prefer hanging name tags with white tag insert)
- Signage to direct participants to meeting space
- Sign In/Out for both days *(Required if offering CEUs; Appendix F)*
- Markers (6-8)
- LCD, Laptop, screen
- Sound Equipment
- Extra batteries (9 volt, AA, AAA)
- 25-50 ft. heavy duty extension cord
- Duct tape
- Index Cards, 3x5
- Index card holder for each table with pens
- Small basket or box for “Parking Lot” questions
- Microphones (stand, lapel, hand-held)
- Flipchart Paper with adhesive
- Flipchart stands
- Collapsible rolling cart (optional)
- Camera (optional)
- Prizes and Books (Appendix L)
- Presentations on laptop
- Food and beverages (continental breakfast and breaks)
- Lunch (or lunch can be on their own)
- The following items suggested for the packets/notebooks:
  1. Handouts & Other related materials
  2. Agenda *(Appendices G,H)*
  3. Participant List
  4. Local Dining options
  5. Donor Acknowledgement
- Evaluations (not to be included in packets/notebooks; Appendices I,J)
- Certificates of Completion (Appendix K) on last day of final Learning Session
- Miscellaneous materials:
  1. raffle tickets, fish bowl
  2. table baskets (optional)
  3. table toys (optional)
  4. tape, scissors, small post-it pads
  5. Pens
  6. Anything else that may be needed by the faculty

*To help keep track of responsibilities, indicate the person responsible for each of the above items. It is also helpful to use large clear storage bins for storing and transporting the above materials.*

Appendix E

Tips for Soliciting Food and Beverage Donors

“It never hurts to ask!”

Make the right contacts
Determine potential donors in your service area, who may be willing to donate food and/or a gift card. A meal can be provided for participants using a variety of different donors (i.e. lunch choices may include 20 servings of pizza, 20 sandwiches, 20 salads, and drinks from the grocery store). Sometimes organizations are more willing to donate a smaller quantity of food. Gift cards can be used to cover drinks and paper products. Potential donors may include:

- Local food manufacturers/processors
- Local food packagers
- Wholesale distributors (Sam’s; Costco)
- Bakeries
- Grocery chain stores
- Dairies
- Growers
- Local food sales people
- Caterers and restaurants, including fast food restaurants

Use personal contacts (yours and your agency/team) to your advantage. If you don’t have a referral, begin with the person in the company with the most authority (owner, president, CEO, COO).

Seek Board Member Assistance – If your agency has a board of directors or a board of advisors, employ their help in soliciting food donations. Many of these individuals sit on local business boards and are involved in chambers of commerce and rotary clubs, which make them well-connected. Ask for their help in approaching smaller businesses they have ties to when asking for contributions. Again, be specific in what your needs are, and whether the donation is something you are trying to secure as a one-time event or ongoing support.

Write a brief letter or e-mail to your potential donor contact, including information about your agency and your request. Follow up your letter/e-mail with a phone call after one week.

Remember: (1) Identify yourself and mention that you are following up on a letter/e-mail (2) Ask for an appointment to discuss further.

Know the benefits of donating
- The donor may receive tax advantages.
- The donor is protected from liability (Good Samaritan Law).
- Donations are a highly visible sign of good corporate community citizenship and often boost morale among the donor’s employees.

Thank them. Send a thank you letter to your donors and thank you notes to those who helped secure the donations, and include an Acknowledgement List of donors in the Learning Session Packet.
Appendix F

### LEARNING SESSION SIGN-IN SHEET – DAY 1; DAY 2 - EXAMPLE

| Project: Name of Collaborative – Session #1, #2 | Learning Session Date: |
| Facilitators: Name of presenters/faculty | Place: Name of place and address |

<table>
<thead>
<tr>
<th>Name</th>
<th>Time In</th>
<th>Signature</th>
<th>Time Out</th>
<th>Signature</th>
</tr>
</thead>
<tbody>
<tr>
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</tbody>
</table>

Participants must sign in and out each day to be eligible for CEUS

*It is helpful if the participant names are typed in alphabetical order on sheet before the sessions*
### APPENDIX G

Community Based Learning Collaborative
Learning Session 1
Agenda - Example

#### DAY 1:

<table>
<thead>
<tr>
<th>Time</th>
<th>Activity</th>
</tr>
</thead>
</table>
| 8:30 – 9:00 am     | Registration
                  Continental breakfast
                  Distribute raffle tickets (until 9:00) |
| 9:00 – 9:15 am     | Welcome and Introductions
                  Overview of the Learning Session |
| 9:15 – 9:30 am     | Ice Breaker Activity (e.g., Bingo; Scavenger Hunt)                        |
| 9:30 – 10:00 am    | Agency/CCT Introductions
                  Summary of Pre-CBLC Assessment                                      |
| 10:00 – 10:30 am   | EBTP Overview                                                            |
| 10:30 – 10:45 am   | BREAK                                                                    |
| 10:45 – 11:15 am   | TF-CBT Overview
                  • Why TF-CBT?
                  • CRAFTS Overview
                  • PRACTICE Overview
                  • TF-CBT Referral Criteria                                        |
| 11:15 – 12:00 am   | Is TF-CBT the right treatment?                                           |
| 12:00 – 1:00 pm    | LUNCH
                  Raffle                                                                |
| 1:00 – 2:30 pm     | Overview of PRAC                                                         |
| 2:30 – 2:45 pm     | BREAK                                                                   |
| 2:45 – 4:15 pm     | Track Break-Outs
                  ➢ Clinicians
                  ➢ Brokers
                  ➢ Senior Leaders                                                        |
| 4:15 – 4:30 pm     | Parking Lot
                  Raffle; Evaluations; Sign-Out                                          |
## Community Based Learning Collaborative
### Learning Session 1
### Agenda - Example

#### DAY 2:

<table>
<thead>
<tr>
<th>Time</th>
<th>Activity</th>
</tr>
</thead>
</table>
| 8:30 – 9:00 am  | Sign-In  
Continental breakfast.  
Distribute raffle tickets (until 9:00) |
| 9:00 – 9:30 am  | Metrics & Fidelity Measures                                             |
| 9:30 - 10:30 am | Initiating the Trauma Narrative                                         |
| 10:30 – 10:45   | BREAK                                                                   |
| 10:45 – 11:30 am| Cognitive Processing                                                   |
| 11:30 – 12:30 pm| Finishing the model – In vivo, Conjoint & Enhancing Safety              |
| 12:30 – 1:30 pm | LUNCH  
Raffle                                                             |
| 1:30 – 3:00 pm  | Track Break-Outs  
Clinical/Supervisor; Broker/Senior Leader                             |
| 3:00 – 3:30 pm  | Parking Lot  
Raffle  
Evaluations/Sign-out                                                   |
## Appendix H
### Community Based Learning Collaborative
#### Learning Session 2
##### Day 1 Agenda - Example

<table>
<thead>
<tr>
<th>Time</th>
<th>Activity</th>
</tr>
</thead>
</table>
| 8:30 – 9:00 am| Registration  
Continental breakfast  
Distribute raffle tickets (until 9:00) |
| 9:00 – 9:15 am| Welcome and Introductions  
Overview of the Learning Session |
| 9:15 – 9:45 am| News You Can Use  
CBLC Metrics Update |
| 9:45 – 10:15 am| Group Activity: Treatment Completion |
| 10:15 – 10:30 am| BREAK |
| 10:30 – 12:00 pm| Big vs. Small Tests of Change  
Obstacles to Children Receiving TF-CBT  
Family Engagement/Crises of the Week |
| 12:00 – 1:00 pm| LUNCH (Provided)  
Raffle (Must be Present to Win) |
| 1:00 – 2:30 pm| Track Break-Outs  
- Clinicians  
- Brokers  
- Senior Leaders |
| 2:30 – 2:45 pm| BREAK |
| 2:45 – 4:00 pm| Track Break-Outs  
- Clinicians  
- Brokers  
- Senior Leaders |
| 4:00 – 4:30 pm| Popcorn  
Parking Lot Evaluations  
Raffle/Sign-Out |
| 4:30 – 5:00 pm| FACULTY MEETING |
# Community Based Learning Collaborative

**Learning Session 2 Agenda - Example**

**Day 2:**

<table>
<thead>
<tr>
<th>Time</th>
<th>Activity</th>
</tr>
</thead>
<tbody>
<tr>
<td>8:30 – 9:00 am</td>
<td>Sign-In&lt;br&gt;Continental breakfast.&lt;br&gt;Distribute raffle tickets (until 9:00)</td>
</tr>
<tr>
<td>9:00 – 9:15 am</td>
<td>Welcome&lt;br&gt;Review of Day 2 Agenda</td>
</tr>
<tr>
<td>9:15 - 10:15 am</td>
<td>Traumatic Grief&lt;br&gt;Cultural Considerations</td>
</tr>
<tr>
<td>10:15 – 10:30</td>
<td>BREAK</td>
</tr>
<tr>
<td>10:30 – 12:00 pm</td>
<td>Track Break-Outs&lt;br&gt;- Clinicians&lt;br&gt;- Brokers&lt;br&gt;- Senior Leaders</td>
</tr>
<tr>
<td>12:00 – 1:00 pm</td>
<td>LUNCH (On Your Own)&lt;br&gt;Raffle (Must be Present to Win)</td>
</tr>
<tr>
<td>1:00 – 2:00 pm</td>
<td>Track Break-Outs&lt;br&gt;- Clinicians&lt;br&gt;- Brokers&lt;br&gt;- Senior Leaders</td>
</tr>
<tr>
<td>2:00 – 2:30 pm</td>
<td>Collaborative Case Monitoring&lt;br&gt;PEAPO</td>
</tr>
<tr>
<td>2:30 – 2:45 pm</td>
<td>BREAK</td>
</tr>
<tr>
<td>2:45 – 4:15</td>
<td>Plans for Sustainability&lt;br&gt;Vicarious Trauma</td>
</tr>
<tr>
<td>4:15 – 4:30</td>
<td>Parking Lot&lt;br&gt;Raffle&lt;br&gt;Evaluations/Sign-out</td>
</tr>
</tbody>
</table>
Appendix I

CBLC Learning Session 1 Clinician Evaluation
Day 1 - Example

1. What track are you in? (please check one)
   _____ Therapist  _____ Supervisor

2. Please check your years of professional experience working with children and families.
   _____ Less than 1  _____ 1-3  _____ 4-10  _____ 11-20  _____ more than 20

<table>
<thead>
<tr>
<th>As a result of the Pre-Work and the first Learning Session... (circle your answer)</th>
<th>Strongly Disagree</th>
<th>Disagree</th>
<th>Neutral</th>
<th>Agree</th>
<th>Strongly Agree</th>
</tr>
</thead>
<tbody>
<tr>
<td>3. I believe the Pre-Work prepared me for Learning Session 1.</td>
<td>1</td>
<td>2</td>
<td>3</td>
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</tr>
<tr>
<td>4. I know what evidence-based treatments are.</td>
<td>1</td>
<td>2</td>
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<tr>
<td>5. I understand how a learning collaborative differs</td>
<td>1</td>
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<tr>
<td>from traditional training workshops.</td>
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<tr>
<td>6. I feel knowledgeable about psychological trauma and how it</td>
<td>1</td>
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<tr>
<td>affects abused children and their families.</td>
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<tr>
<td>7. I understand what Posttraumatic Stress Disorder (PTSD) is.</td>
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<tr>
<td>8. I feel confident about how to screen children for a</td>
<td>1</td>
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<tr>
<td>history of traumatic events using the UCLA PTSD-RI.</td>
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<tr>
<td>9. I understand how to score and interpret the UCLA PTSD RI</td>
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<tr>
<td>10. I understand the importance of conducting an assessment</td>
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<tr>
<td>of trauma-related symptoms.</td>
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<tr>
<td>11. I can use the results of assessment with abused children</td>
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<td>and their families to help me plan treatment.</td>
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<tr>
<td>12. I feel confident in sharing assessment results with</td>
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<tr>
<td>children and their caregivers.</td>
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<tr>
<td>13. I understand the types of cases for which TF-CBT</td>
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<td>should be used.</td>
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<td>14. I understand the importance of implementing TF-CBT in the</td>
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<td>way it was developed and structured.</td>
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<td>15. I am confident in my ability to engage families in the</td>
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<td>treatment process.</td>
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<tr>
<td>16.</td>
<td>I understand how to conduct the neutral and baseline narratives with children to initiate treatment.</td>
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<tr>
<td>17.</td>
<td>I am ready to use Psychoeducation with children.</td>
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<tr>
<td>18.</td>
<td>I am ready to use Relaxation procedures with children.</td>
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<tr>
<td>19.</td>
<td>This Learning Session was well-organized.</td>
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<tr>
<td>20.</td>
<td>The meeting facilities met our needs.</td>
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<tr>
<td>21.</td>
<td>The material covered in today's session was a reasonable amount.</td>
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<tr>
<td>22.</td>
<td>This Learning Session was active and interactive in its learning approach.</td>
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<tr>
<td>23.</td>
<td>This Learning Session was fun.</td>
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<tr>
<td>24.</td>
<td>This Learning Session supported the building of a learning community.</td>
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<tr>
<td>25.</td>
<td>The presenters communicated the information in a way that was easy to understand.</td>
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<td>26.</td>
<td>I feel comfortable incorporating TF-CBT into my work.</td>
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</table>

**Please indicate if you believe each of the following training approaches were effective:**

<table>
<thead>
<tr>
<th>Training Approach</th>
<th>Strongly Disagree</th>
<th>Disagree</th>
<th>Neutral</th>
<th>Agree</th>
<th>Strongly Agree</th>
</tr>
</thead>
<tbody>
<tr>
<td>27. Presentations by faculty.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>28. Questions, answers and discussions with the full group.</td>
<td>1</td>
<td>2</td>
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<td>4</td>
<td>5</td>
</tr>
<tr>
<td>29. Small group discussions and activities.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>30. Powerpoint slides used in presentations.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>31. Role plays.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>32. Track breakout sessions.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
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</tbody>
</table>

Please provide any suggestions or feedback that would improve the quality of this Learning Session.
# CBLC Learning Session 1
## Clinician Evaluation
### Day 2 - Example

1. **What track are you in?** (please check one)
   - _____ Therapist
   - _____ Supervisor

2. **Please check your years of professional experience working with children and families.**
   - _____ Less than 1
   - _____ 1-3
   - _____ 4-10
   - _____ 11-20
   - _____ more than 20

### As a result of first Learning Session...

<table>
<thead>
<tr>
<th>As a result of first Learning Session... (circle your answer)</th>
<th>Strongly Disagree</th>
<th>Disagree</th>
<th>Neutral</th>
<th>Agree</th>
<th>Strongly Agree</th>
</tr>
</thead>
<tbody>
<tr>
<td>3. I understand the importance of collecting metrics to help us implement TF-CBT in our organization and community.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>4. I can identify cognitive distortions in caregivers</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>5. I am ready to challenge and reframe cognitive distortions in caregivers (i.e., I am ready to use the Cognitive Processing component with caregivers).</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>6. I am ready to use Affective Processing with children.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>7. I am ready to use Cognitive Coping with children</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>8. I am ready to present the rationale for creating a Trauma Narrative with caregivers and children.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>9. I am ready to create a Trauma Narrative with children.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>10. I am ready to use cognitive processing of the trauma narrative with children.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>11. I am ready to use in vivo exposure with children and caregivers</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>12. I feel confident in determining when a child and caregiver are ready to participate in a conjoint session to share the trauma narrative</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
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Please indicate if you believe each of the following training approaches were effective:

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<th></th>
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<td>30.</td>
<td>Track breakout sessions</td>
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**What is your overall evaluation of this training?** (Please circle.)

1. Outstanding, one of the very best trainings I have ever attended.
2. Excellent, would highly recommend to others.
3. Good, better than most trainings I attend.
4. Useful, average, typical of most trainings I attend.
5. Below average, learned some things, but less than expected.
6. Poor, learned very little.
7. Of little or no value, a waste of my time.

**Please provide any suggestions or feedback that would improve the quality of this Learning Session.**
Appendix J
CBLC Learning Session 1
Broker/Senior Leader Evaluation
Day 1 - Example

1. What track are you in? (please check one)
   _____ Broker  _____ Senior Leader

2. Please check your years of professional experience working with children and families.
   _____ Less than 1  _____ 1-3  _____ 4-10  _____ 11-20  _____ more than 20

<table>
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<tr>
<th>As a result of the Pre-Work and the first Learning Session... (circle your answer)</th>
<th>Strongly Disagree</th>
<th>Disagree</th>
<th>Neutral</th>
<th>Agree</th>
<th>Strongly Agree</th>
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<tbody>
<tr>
<td>1. I believe the Pre-Work prepared me for Learning Session 1.</td>
<td>1</td>
<td>2</td>
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<tr>
<td>2. I know what Evidence Supported Treatments are.</td>
<td>1</td>
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<tr>
<td>3. I understand how a learning collaborative differs from traditional training workshops.</td>
<td>1</td>
<td>2</td>
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<td>4</td>
<td>5</td>
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<tr>
<td>4. I feel knowledgeable about psychological trauma and how it affects abused children and their families.</td>
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<td>2</td>
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<td>5. I understand what Posttraumatic Stress Disorder (PTSD) is.</td>
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<td>6. I understand the importance of conducting an assessment of a child’s complete victimization and trauma history and not just focusing on the emergent report.</td>
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<td>7. I understand the importance of conducting an assessment of trauma-related symptoms.</td>
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<td>8. I can use the results of assessment with abused children and their families to help me develop a treatment plan.</td>
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<td>2</td>
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<td>9. I understand the types of cases for which TF-CBT should be used.</td>
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<td>10. I understand of the importance of implementing TF-CBT in the way it was developed and structured.</td>
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<td>11. I have a basic understanding the treatment components of TF-CBT (PRACTICE).</td>
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<td>12. I understand the rationale behind and the importance of the child completing a Trauma Narrative.</td>
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<td>13. I understand the importance of parent or caregiver involvement in the child’s treatment.</td>
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<td>2</td>
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<td></td>
<td>I am well prepared to incorporate TF-CBT into my treatment plans for appropriate families.</td>
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<td>15.</td>
<td>I am ready to talk knowledgeably with therapists about using TF-CBT with children and families.</td>
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<td>16.</td>
<td>I am confident in my ability to help engage and maintain families in the TF-CBT treatment process.</td>
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<td>17.</td>
<td>I am well prepared to discuss with therapists the progress of my clients in TF-CBT treatment.</td>
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<td>18.</td>
<td>I understand what Evidence-Based Treatment Planning is.</td>
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<td>19.</td>
<td>I understand how to identify barriers to implementing TF-CBT in my community.</td>
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<td>20.</td>
<td>This Learning Session was well-organized.</td>
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<td>Small group discussions and activities.</td>
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<td>31.</td>
<td>Powerpoint slides used in presentations.</td>
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<td>32.</td>
<td>Role play demonstrations.</td>
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<td>33.</td>
<td>Track breakout sessions.</td>
<td>1 2 3 4 5</td>
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</table>
34. What was your favorite thing about the Learning Session?
____________________________________________________________________________________

35. What was the thing you liked least about the Learning Session?
____________________________________________________________________________________
____________________________________________________________________________________

36. Please provide any suggestions or feedback that would improve the quality of this Learning Session.
____________________________________________________________________________________
____________________________________________________________________________________
Appendix J
CBLC Learning Session 1
Broker/Senior Leader Evaluation
Day 2 - Example

1. What track are you in? (please check one)
   _____ Broker  _____ Senior Leader

2. Please check your years of professional experience working with children and families.
   _____ Less than 1  _____ 1-3  _____ 4-10  _____ 11-20  _____ more than 20

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<tr>
<th>As a result of first Learning Session... (circle your answer)</th>
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<tr>
<td>3. I understand the importance of collecting metrics to help us implement TF-CBT in our organization and community.</td>
<td>1</td>
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<td>4. I can identify cognitive distortions in caregivers</td>
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<tr>
<td>5. I am ready to challenge and reframe cognitive distortions in caregivers (i.e., I am ready to use the Cognitive Processing component with caregivers).</td>
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<td>6. I understand the use of Affective Processing with children</td>
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<td>7. I understand the use of Cognitive Coping with children</td>
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<td>8. I understand the rationale for creating a Trauma Narrative with caregivers and children.</td>
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<tr>
<td>9. I understand the use of in vivo exposure with children and caregivers</td>
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What is your overall evaluation of this training? (Please circle.)

1. Outstanding, one of the very best trainings I have ever attended.
2. Excellent, would highly recommend to others.
3. Good, better than most trainings I attend.
4. Useful, average, typical of most trainings I attend.
5. Below average, learned some things, but less than expected.
6. Poor, learned very little.
7. Of little or no value, a waste of my time.

Please provide any suggestions or feedback that would improve the quality of this Learning Session.
Appendix K
Certificate of completion

First Last

participated in

Project BEST
Community-Based Learning Collaborative Learning Sessions

and awarded

30 continuing education contact hours

Granted: Month – Day - Year

Course Co-Directors: **Rochelle Hanson, Ph.D. & Ben Saunders, Ph.D.**

Approved: The Medical University of South Carolina (MUSC) awards 10 continuing education credits for this training. MUSC is an approved provider of continuing education by all mental health licensing boards in South Carolina (SC Board of Psychology; SC Board of Social Work; SC Board of License Professional Counselors, Marriage and Family Therapists, & Psycho-Educational Specialists); This training is approved by The National Association of Social Workers (NASW) (Approval 886453433-1442) for Clinical Continuing Education Contact Hours. The National Crime Victims Research and Treatment Center is an NBCC-Approved Continuing Education Provider (ACEP) and may offer NBCC-approved clock hours for events that meet NBCC requirement. The ACEP is solely responsible for all aspects of the Program (Approval 6512).
Appendix L
CBLC Books and Games

The following are suggestions for books and games that can be used as prizes and gifts at the Learning Sessions. Unless otherwise noted, all can be purchased from Amazon and Barnes & Noble. These books and games can assist therapists in using Trauma-Focused Cognitive Behavioral Therapy (TF-CBT).

Please Tell! A Child’s Story about Sexual Abuse
Peaceful Piggy Meditation
A Very Touching Book...For Little People and for Big People
Off Road Parenting: Practical Solutions for Difficult Behaviors w/DVD
How to take GrrrRR Out of Anger
Giraffes Can’t Dance
Kids Need to be Safe: A Book for Children in Foster Care (Kids are Important)
Mad Isn’t Bad: A Child’s Book About Anger
When I feel Sad (The Way I Feel Books)
A Terrible Thing Happened
The Star: A Story to Help Young Children Understand Foster Care
Finding the Right Spot
What’s the Big Secret?
Girlology
Girlology: Hang-ups, Hook-ups and Holding Off
Girlology’s There’s something new about you
The Brightest Star (Hemery)
Updated 2009 – Understanding Children’s Sexual Behaviors – Booklets (http://www.tcavjohn.com/orderform.htm)
Taking Care of ME! (Workbook) (http://www.hope4families.com/)
Let’s Talk About Taking Care of You! – Educational Book about Body Safety (http://www.hope4families.com/)
When I feel Afraid
Sometimes I get Sad
When I am Sad
The Words Hurt: Helping Children Cope with Verbal Abuse (Loftis)
Coping Skills Workbook
Dr. Playwell’s Positive Thinking Game
Double Dip Feelings Stories
Today I Feel Silly & Other Moods that Make My Day
The Way I Feel
What Do You Know Cards (CARES Institute, UMDNJ-SOM, 42 E Laurel Road, Suite 1100, Stratford, NJ 08084; or by email carestraining@umdnj.edu)
Strong At the Heart
Treating Trauma and Traumatic Grief in Children and Adolescents
Trauma-Focused CBT for Children and Adolescents, Treatment Applications
Tell Me Again about the Night I was Born
Murphy’s Three Homes
It’s My Body
I Said No!
More Creative Interventions for Troubled Children and Youth
My Many Colored Days
The Hyena Who Lost her Laugh
Words are Not for Hurting
Zachary’s New Home, A Story for Foster and Adopted Children
When Dinosaurs Die, A Guide to Understanding Death
APPENDIX M

CLINICAL CONSULTATION CALL AGENDA

Call #1

- Introductions and acclimate clinicians to call logistics
  - Expectations and suggestions for calls
  - Consultation call goals:
    - to identify and overcome barriers to implementing TF-CBT with fidelity;
    - to promote group sharing of creative strategies to implementing TF-CBT;
    - to promote completion of TF-CBT cases in a timely fashion

- Identifying and Registering cases
  - Checking in to ensure each participant is identifying cases: Have people been able to identify cases? If not, what barriers are present?
  - Any issues in registering cases? Ensure everyone understands the procedure for registering cases
  - Criteria to determine whether case is appropriate for TF-CBT (provide “Target Criteria for TF-CBT” handout):
    - Child is between ages 3-18
    - there is an identified trauma that the child recalls;
    - child is endorsing symptoms related to the traumatic event(s);
    - there’s an identified supportive caregiver who will be participating in the therapy
    - there can be more than one identified trauma;
    - child is ‘relatively’ stable
  - Contraindications
    - No identified trauma history OR child does not remember the trauma
    - No significant trauma-related symptoms
    - Severe cognitive disabilities
    - Problems to be addressed prior to trauma-focused therapy (safety, extremely poor caregiver system, severe disruptive behavior problems, self-harm behaviors, substance abuse)

- Conducting Assessments
  - Do clinicians understand how to access assessments?
  - Questions around administering assessments to families?
  - Psychoeducation about scores

- Introduction to case presentation template (share handout)

**TF-CBT Case Presentation Template**

1. Demographic Information (child's age, gender, grade)
2. Relevant Family Information, including the identified caregiver to participate in TF-CBT
3. Brief Treatment History
4. Reason for Referral for TF-CBT, including brief trauma history
5. Assessment Results (UCLA PTSD Reaction Index, etc.)
6. Diagnosis and Medications
7. Current symptoms, including any behavior problems
8. Use of TF-CBT
   a. PRACTICE Components completed
   b. Successes
   c. Challenges
Call #2

• Identifying and registering cases
  o Review criteria to determine whether case is appropriate for TF-CBT
  o Problems with getting cases? Discuss barriers
• Assessments
  o Rationale/goals of assessment
  o Review of administering assessments and psychoeducation of scores
  o Questions about assessments?
  o Getting information from both child and caregiver
    ▪ If child and parent give differing reports, discuss these discrepancies openly in session – discuss with child and caregiver what you learned on the assessments and probe their explanations for why this has occurred.
    ▪ Importance of getting child’s perspective on the most traumatic event
• Case presentations
• Overview and plan for next call; identify case presenters for next call

Call #3

• Case presentations (either beginning or end)
• Review of conducting assessments
• Importance of providing feedback to the child and caregiver about the assessment results
• Review any difficulties with identifying cases
• Getting started with TF-CBT and rationale for this particular treatment model
• Discussion of Psychoeducation component
  o Emphasize that psychoeducation begins during 1st session and continues throughout treatment
  o Explain trauma-related symptoms/ diagnosis
  o Provide overview of treatment (include theoretical rationale, treatment length, importance of including caregiver)
  o Other possible topics to address:
    ▪ Offender motives
    ▪ Abuse disclosure
    ▪ Forensic interview process
    ▪ Healthy sexuality
  o Emphasize need to be sensitive to child’s age/developmental level
  o Safety if there are current, ongoing safety concerns
  o Creative ideas for implementing psychoeducation
  o Barriers/challenges during psychoeducation
• Review facts sheets with parents and children
• Review summary sheets for Relaxation (and send to clinicians)
Overview and plan for next call; identify case presenters for next call

Call #4

• Case presentations (either beginning or end)
• Review of Psychoeducation component and additional questions/difficulties
• Touch base regarding registering of cases; identify any barriers for clinicians that have not yet identified a case
Discussion of Parenting component
- Emphasize that parenting will be a key component throughout treatment
- Several parenting components that can be addressed based on needs of the parent and family
  - Address and teach about effective parenting skills
  - Increase parental support of the child
  - Teach stress management skills
  - Reduce inappropriate parenting practices
  - Improve personal safety skills that parents can assist with
  - Enhance ability to manage trauma reminder and future stressors that children are faced with
- Review handouts on child behavior management with parents
- Discuss cases in which there isn’t an involved parent, including ways to involve other caregivers or adults who manage child behavior
- Overview and plan for next call; identify case presenters for next call

Call #5
- Case presentations (either beginning or end)
- Review of Parenting component and additional questions/difficulties
- Touch base regarding registering of cases; identify any barriers for clinicians that have not yet identified a case
- Managing multiple traumas
  - Identify common underlying themes across multiple traumas (e.g., common emotional and behavioral responses; common thinking patterns)
  - Good rule of thumb is to identify and process the first event, most recent, and worst, as well as any other particular event causing significant emotional distress
- Discussion of Relaxation component
  - Review rationale/component goals
  - Creative ways to implement relaxation
  - When to use breathing, muscle relaxation, and imagery
  - Relaxation with older children/adolescents
  - Ways to incorporate relaxation with unique cases
  - Barriers/challenges in engaging children in relaxation
- Reminder of importance of including caregivers
- Discuss possibility of conjoint session (e.g., child can ‘teach’ caregiver relaxation strategy learned in session)
- Review summary sheets for Relaxation (and send to clinicians)
- Reminder about assigning homework and following up to see if it was completed
- Overview for next call; identify case presenters for next call

Call #6
- Case presentations (either beginning or end)
- Introduce the Affect Modulation component
  - Review rationale/component goals
  - Creative ways to teach children feelings (games, feeling lists, songs, books)
  - Problems in getting children to talk about feelings
  - Strategies for different age groups (younger children/adolescents)
  - Involving parents in feelings identification
• Review summary sheets for Affect Modulation (and send to clinicians)
• Discuss any topics (from below) that pertain to cases presented by the call group
• Reminder about assigning homework and following up to see if it was completed
• Overview for next call; identify case presenters for next call

Call #7
• Case presentations (either beginning or end)
• Introduce **Cognitive Coping** component
  o Review rationale/component goals
  o Discuss creativity to get kids to understand how to identify and restructure thoughts
  o Helpful suggestions for getting kids engaged in cognitive coping using the triangle
  o Discussions about barriers in using the triangle – what to do when children do not understand
  o Methods for use of this component with very young or developmentally delayed children
  o Importance of reinforcing positive coping strategies
  o Use of motivational interviewing to help kids problem solve and connect thoughts and feelings
• Explain importance of keeping track of cognitions outside of session, and unique ways to do this with children
• Review summary sheets
• Reminder about assigning homework and following up to see if it was completed
• Discuss any topics (from below) that pertain to cases presented by the call group
• Overview for next call; identify case presenters for next call

Call #8
• Case presentations (either beginning or end)
• Introduce **Trauma Narrative** component
• Review rationale/component goals
  o Introducing and explaining the trauma narrative to families
  o Importance of giving the child options for how he/she would like to complete the narrative
  o Other ways to get kids to start talking about the trauma (other than the book)
  o Unique ways to complete the trauma narrative – elicit examples of ways that clinicians have done the trauma narrative
  o Multiple traumas
    ▪ Use of a timeline to identify specific traumatic events for processing
    ▪ How to incorporate multiple traumatic events in the TN
    ▪ Identifying positive events that co-occurred during the time of the abuse
  o Help in managing adolescents who do not want to discuss the trauma
  o Discuss any apprehension of the clinician in completing the trauma narrative
• Importance of beginning to prepare the caregiver for conjoint sessions early
• Discuss any topics (from below) that pertain to cases presented by the call group
• Discussion regarding fact that homework is unlikely to be appropriate for this component
• Overview for next call; identify case presenters for next call
Call #9

- Case presentations (either at beginning or end)
- Review Trauma Narrative component
  - Elicit additional creative ideas from families, and progress on completing narrative
  - Discuss barriers in completing the trauma narrative
- Introduce Cognitive Processing of the TN
  - Review rationale/component goals
  - Review Cognitive Triangle and how to incorporate thoughts and feelings into the trauma narrative
  - Identify maladaptive and/ unhelpful cognitions
  - Review how to challenge/restructure maladaptive cognitions
  - Role play Socratic questioning
- Introduce In Vivo component
  - Review rationale/component goals
  - May not be necessary in every case, but it is important to assess for any potential real world triggers and then to develop a plan if indicated
  - Important to include caregiver, who might have their own triggers that could benefit from discussion/processing. Also – important for caregiver to have input on the in vivo plan to facilitate its successful completion
  - Walk through a sample in vivo plan (try to get a clinician to present a case that includes this, but if none available, have one for discussion)
- Discuss any topics (from below) that pertain to cases presented by the call group
- Overview for next call; identify case presenters for next call

Call #10

- Case presentations (either at beginning or end)
- Introduce Conjoint Parent-Child component
  - Review rationale/component goals
  - Importance of making sure caregiver is prepared to hear the TN
  - Ways to know that caregiver is ready for conjoint session
  - Situations when conjoint sessions may not be possible, or appropriate
  - Discuss barriers to the conjoint session
- Try to role play a conjoint session and/or preparation of the caregiver
- Use case example to highlight challenges to this component
- Specific focus on topics (from below) that have not been discussed in previous sessions, or that need review based upon cases presented by the call group
- Overview for next call; identify case presenters for next call

Call #11

- Case presentations (either at beginning or end)
- Introduce Enhancing Safety component
  - Review rationale/component goals
  - Ending Treatment: How do you know that treatment is finished?
  - Planning for booster sessions
  - Reminder that new issues can emerge later in development
  - Assessing need for further intervention
• Specific focus on topics (from below) that have not been discussed in previous sessions, or that need review based upon cases presented by the call group
• Overview for next call; identify case presenters for next call

**Call #12**
• Case presentations (either at beginning or end)
• Specific focus on topics (from below) that have not been discussed in previous sessions, or that need review based upon cases presented by the call group
• Overview and last comments

**Topics to be covered when appropriate throughout calls:**

**Crisis of the Week**

• Foster parents and child changing homes
  o Deciding how much the “new” foster parents should be involved in treatment
  o Dealing with temporary placements
  o Family reunification

• Special Populations
  o Children in residential treatment centers
  o Incarcerated youth
  o Modifications for very young children
  o Modifications for adolescents
  o Cultural considerations

• Avoidance and/or not remembering all aspects
  o Ways to deal with reluctance to discuss details of the trauma
  o Strategies/ways to manage avoidance
  o How to deal with a case when the abuse happened at a very young age and the child has no memory

• Child engagement
  o Responding when child jumps from one topic to another
    ▪ Best way to manage this is to gently bring the child back and ‘check-in’ to see what prompted the switch in topic

• Caregiver engagement
  o Can use phone to keep parent in the loop
  o Involvement of supportive and unsupportive caregivers

• Other services family is involved in
  o Family is seeing more than one therapist

• Unique considerations with adolescents
  o Ways to approach sex education, especially when adolescents are uncomfortable discussing the topic
  o Discussing sex education/health sexuality with children at different developmental levels
  o Addressing early trauma with adolescents who are currently exhibiting oppositional behaviors, high risk behaviors, and emotion dysregulation
  o How to manage when adolescents don’t want caregiver involved in treatment
  o Addressing high-risk and self-harm behaviors in the context of TF-CBT
  o Materials for discussing unique adolescent behaviors/risks (SAHMSA website, Girlology Books)

• Trauma-related child symptoms
o Sleep problems: discuss sleep hygiene and things parents can do to improve child’s sleep
o Serious behavior problems: introduce parent training
CBLC Broker Curriculum Topics

1. **Knowledge of evidence-based, trauma-informed child welfare practice**
   a. Principles of Evidence-Based Practice (EBP)
   b. Principles of Trauma-Informed Practice
   c. Critical importance of community collaboration and coordination

2. **Knowledge of traumatic stress**
   a. What is trauma?
   b. Stress Continuum: Stress – Distress – Traumatic Stress
   c. What is a potentially traumatic event (PTE)?
   d. What is an Adverse Childhood Experience (ACE)?
   e. How prevalent are PTEs among children and youth?
   f. How does exposure to PTEs impact children and youth?
   g. How does traumatic stress affect the developing brain?
   h. How prevalent are trauma-related problems among youth in the child welfare system?
   i. Diagnostic criteria for posttraumatic stress disorder (PTSD)
   j. Traumatic stress and emotional and behavior problems among youth in the child welfare system
   k. Traumatic stress and child welfare practice activities

3. **Knowledge of Evidence Supported Interventions**
   a. Common errors concerning program effectiveness
   b. Clinical science process
   c. What is an Evidence Supported Intervention (ESI)?
   d. Why use ESIs compared to treatment as usual
   e. Common ESIs used with children in the child welfare system
   f. Resources for learning about specific ESIs
   g. Responsibilities of brokers to children and families for obtaining effective mental health services

4. **Knowledge of Evidence-Based Service/Treatment Planning for children and families in the child welfare system**
   a. Assessment
   b. Integrate information from all relevant sources
   c. Strengths-Needs-Problems matrix
   d. Measurable intervention goals with metrics and thresholds for successful outcomes
   e. Match goals to evidence-based interventions with feasible staging
   f. Identify and solve barriers to intervention engagement and completion
   g. Monitor goal-related metrics of progress and outcomes

5. **Knowledge of TF-CBT**
   a. Referral criteria for TF-CBT
   b. Treatment components of TF-CBT
   c. Parent/caregiver involvement
d. Duration of treatment
e. Frequency and length of treatment sessions
f. Pacing of treatment components
g. Qualifications of TF-CBT therapists

6. Case Management Skills for Treatment Success
   a. Systematic screening of children and youth for their history of potentially traumatic events
   b. Systematic screening of children and youth for PTSD symptoms and other trauma-related problems
   c. Constructing an evidence-based, trauma-informed service plan
   d. Identifying a trained TF-CBT therapist
   e. Making an effective TF-CBT referral
   f. Encouraging youth and caregiver engagement in and completion of treatment
   g. Building successful collaborations with therapists
   h. Monitoring treatment progress and outcomes