Staff Survey and Time Log

Trauma-Focused Cognitive Behavioral Therapy Version

INTRODUCTION

To help expand the available information on the costs of services for families and children, the Children's Bureau within the Administration on Children, Youth & Families, U.S. Department of Health and Human Services, contracted with Mathematica Policy Research to design and pilot test instruments to study the costs of implementing Trauma-Specific Evidence-Based Programs (TS-EBPs). Mathematica developed these instruments as part of the Regional Partnership Grants cross-site evaluation.

This survey asks questions about how much time staff members in your agency spend working on one TS-EBP, Trauma-Focused Cognitive Behavioral Therapy (TF-CBT). It also asks about TF-CBT training that staff members might have received. This information is necessary to estimate the costs of providing this program.

Who should complete the survey? All staff members that spend any time delivering or managing and administering TF-CBT should complete this survey, including clinicians or therapists, case managers, supervisors, administrators, or other agency personnel.

How to complete the survey? You can answer most questions in Sections A and B by simply placing a check mark or entering a number or date in the appropriate box. For some questions, you will write in a brief response. In Section C, you will enter the number of minutes you spent on specific activities each day during the data collection period.

If you are unsure how to answer a question, please give the best answer you can rather than leaving it blank. Please write legibly and make sure all responses are clearly indicated.

Voluntary participation. Your participation in this survey is important and will help us better understand the costs of TF-CBT. You may refuse to answer any question.

It will take approximately 10 minutes to complete the time log each day during the data collection period.

Please answer the following question before beginning the survey and time log.

I have read the introduction and agree that the information I provide in this survey and time log may be used in further analyses.

1 ☐ Yes →

0 ☐ No **END SURVEY**

SECTION A: YOUR POSITION AND WORKING HOURS

A1. What is the name of the organization where you work?

_____

AGENCY NAME

A2. What is your current job title? (If you have more than one job title, please indicate the titles for all positions you currently hold.)

_____

JOB TITLE

A3. How would you describe your primary responsibilities?

SELECT ONE ONLY

1 ☐ My primary responsibilities relate to direct service delivery.

2 ☐ My primary responsibilities relate to management and administration.

3 ☐ My primary responsibilities are split between direct service delivery and management and administration.

A4. What is your current employment status?

SELECT ONE ONLY

1 ☐ Permanent full-time

2 ☐ Permanent part-time

3 ☐ Temporary full-time

4 ☐ Temporary part-time

5 ☐ On-call

A5. How many hours are you scheduled to work at your agency in a typical or average week?

|___|___| HOURS PER WEEK

A6. How many hours do you usually work in a typical or average week?

|___|___| HOURS PER WEEK

SECTION B: TRAINING

The next few questions ask about time you spent in professional training for TF-CBT.

B1. Did you receive <u>initial</u> training(s) on TF-CBT? Initial training refers to formal or structured training you received before delivering TF-CBT to clients.

1 ☐ Yes →
0 ☐ No **GO TO B6**

If you answered yes to B1, use the table below to record up to three initial trainings you received before delivering TF-CBT:

	B2. What kind of <u>initial</u> training did you receive? **PLEASE MARK ONE ANSWER**	**B3. Who paid the majority of the costs (if any) of the <u>initial</u> training you received?** **PLEASE MARK ONE ANSWER**	**B4. When did you receive this <u>initial</u> TF-CBT training?**	**B5a. How many hours do you estimate you spent attending <u>initial</u> training?**
Initial training 1	1 ☐ Formal training led by a developer of the program 2 ☐ Online training or access to online resources 3 ☐ Training provided by staff at your agency 4 ☐ Other *(please specify)* _____	1 ☐ My current agency paid the cost 2 ☐ Another agency (not my current agency) paid the cost 3 ☐ I paid the cost 4 ☐ There was no cost for the training	___ ___ / 20 ___ ___ MONTH/YEAR TRAINING BEGAN ___ ___ / 20 ___ ___ MONTH/YEAR TRAINING ENDED	___ ___ HOURS SPENT IN TRAINING **B5b. Were you paid for these hours?** 1 ☐ Yes 2 ☐ No
Initial training 2	1 ☐ Formal training led by a developer of the program 2 ☐ Online training or access to online resources 3 ☐ Training provided by staff at your agency 4 ☐ Other *(please specify)* _____	1 ☐ My current agency paid the cost 2 ☐ Another agency (not my current agency) paid the cost 3 ☐ I paid the cost 4 ☐ There was no cost for the training	___ ___ / 20 ___ ___ MONTH/YEAR TRAINING BEGAN ___ ___ / 20 ___ ___ MONTH/YEAR TRAINING ENDED	___ ___ HOURS SPENT IN TRAINING **B5b. Were you paid for these hours?** 1 ☐ Yes 2 ☐ No
Initial training 3	1 ☐ Formal training led by a developer of the program 2 ☐ Online training or access to online resources 3 ☐ Training provided by staff at your agency 4 ☐ Other *(please specify)* _____	1 ☐ My current agency paid the cost 2 ☐ Another agency (not my current agency) paid the cost 3 ☐ I paid the cost 4 ☐ There was no cost for the training	___ ___ / 20 ___ ___ MONTH/YEAR TRAINING BEGAN ___ ___ / 20 ___ ___ MONTH/YEAR TRAINING ENDED	___ ___ HOURS SPENT IN TRAINING **B5b. Were you paid for these hours?** 1 ☐ Yes 2 ☐ No

B6. Have you received any <u>additional or ongoing</u> training on TF-CBT (not including regular supervision or clinical support) <u>in the past 12 months</u>? Additional or ongoing training refers to formal or structured training you received after you started providing TF-CBT, such as a session to review TF-CBT concepts or methods.

1 ☐ Yes →

0 ☐ No **GO TO SECTION C**

If you answered yes to B6, use the table below to record up to three additional or ongoing trainings you received in the past 12 months:

	B7. What kind of <u>additional or ongoing</u> training did you receive? **PLEASE MARK ONE ANSWER**	**B8. Who paid the majority of the costs (if any) of the <u>additional or ongoing</u> training you received?** **PLEASE MARK ONE ANSWER**	**B9. When did you receive this <u>additional or ongoing</u> TF-CBT training?**	**B10a. How many hours do you estimate you spent attending this <u>additional or ongoing</u> training?**
Additional training 1	1 ☐ Formal training led by a developer of the program 2 ☐ Online training or access to online resources 3 ☐ Training provided by staff at your agency 4 ☐ Other *(please specify)* _____	1 ☐ My current agency paid the cost 2 ☐ Another agency (not my current agency) paid the cost 3 ☐ I paid the cost 4 ☐ There was no cost for the training	___ ___ / 20 ___ ___ MONTH/YEAR TRAINING BEGAN ___ ___ / 20 ___ ___ MONTH/YEAR TRAINING ENDED	___ ___ HOURS SPENT IN TRAINING **B10b. Were you paid for these hours?** 1 ☐ Yes 2 ☐ No
Additional training 2	1 ☐ Formal training led by a developer of the program 2 ☐ Online training or access to online resources 3 ☐ Training provided by staff at your agency 4 ☐ Other *(please specify)* _____	1 ☐ My current agency paid the cost 2 ☐ Another agency (not my current agency) paid the cost 3 ☐ I paid the cost 4 ☐ There was no cost for the training	___ ___ / 20 ___ ___ MONTH/YEAR TRAINING BEGAN ___ ___ / 20 ___ ___ MONTH/YEAR TRAINING ENDED	___ ___ HOURS SPENT IN TRAINING **B10b. Were you paid for these hours?** 1 ☐ Yes 2 ☐ No
Additional training 3	1 ☐ Formal training led by a developer of the program 2 ☐ Online training or access to online resources 3 ☐ Training provided by staff at your agency 4 ☐ Other *(please specify)* _____	1 ☐ My current agency paid the cost 2 ☐ Another agency (not my current agency) paid the cost 3 ☐ I paid the cost 4 ☐ There was no cost for the training	___ ___ / 20 ___ ___ MONTH/YEAR TRAINING BEGAN ___ ___ / 20 ___ ___ MONTH/YEAR TRAINING ENDED	___ ___ HOURS SPENT IN TRAINING **B10b. Were you paid for these hours?** 1 ☐ Yes 2 ☐ No

INSTRUCTIONS FOR COMPLETING THE TIME LOG

We are asking you to track how you spend your time over 4 weeks.

The next page has a table of activity categories related to the delivery of TF-CBT. The table provides examples of specific activities under each category, although the examples might not reflect all the types of work you do. Please refer to this table as you track your time each day.

The time log includes a two-sided sheet that you can copy as many times as needed to cover the data collection period. You should complete one two-sided sheet for each week of the data collection period. After you copy the necessary number of sheets, please indicate the week number on the top of each sheet as well as the staff name and agency name.

Please follow the instructions below when filling out your time log:

1) At the end of each work day during the data collection period, please record how much time, in minutes, that you spent on each of these activities under each category.

   You might find it helpful to use case notes, appointment schedules, or other materials to help you fill in the time log, but remember to indicate the actual time spent on each activity (which might be longer or shorter than a scheduled appointment).

2) If you forget to fill out the time log at the end of the day, please enter the missing information as soon as possible.

3) Start by filling in the appropriate date under the corresponding day of the week (Monday to Friday).

4) For the **Client-Focused Activities** section of the log, first enter the number of clients receiving TF-CBT you served that day. In the context of TF-CBT, the term “client” can refer to the participating child, the parent/caregiver, or both (for example, if you provide a therapy session in which both the child and parent/caregiver participate, you should count this as one client). Please record the time spent on activities conducted with or on behalf of the child, the parent/caregiver, or both.

5) If you report serving one or more clients who receive TF-CBT, enter the number of minutes you spent on each of the client-focused activities listed. For each entry, please list the initials of the client you worked with or for and how many minutes you spent on that activity with or for the client listed. Please make separate entries for each client you worked with or for that day. If you did not spend any time on an activity that day, please enter 0. Finally, enter the percentage of time you spent that day delivering services to clients in a virtual setting. If no services were delivered virtually, please enter 0.

6) For the **Other Activities** section of the log, enter the total amount of time you spent on each activity that day. **Please include only the time you spent on activities that support the delivery of TF-CBT.** If you did not spend any time on an activity that day, please enter 0.

Table 1: Activities for TF-CBT implementation and examples

Client-focused activities for TF-CBT implementation	Examples
1. **Screening, assessment, and enrollment**—activities to screen or assess clients to determine eligibility and inform treatment plans. Activities to enroll clients into services.	• Gathering information from referral sources, meetings, or talking with people one on one • Reading past case documentation and client assessments
2. **Session planning and preparation**—activities to prepare for each session of TF-CBT.	• Reflecting on the client's previous session • Identifying and reviewing worksheets or other materials for clients to use during sessions
3. **Clinical service delivery**—delivery of therapeutic services, usually in treatment sessions.	• Delivering therapy in treatment sessions • Crisis intervention • Communicating with clients outside of sessions if they need support • Completing checklists at the end of each session to indicate which TF-CBT treatment component was implemented
4. **Case documentation**—writing and processing case notes.	• Completing case notes • Completing regular psychological measurements and trauma screenings for grant requirements • Completing treatment plans, mental health assessment, and notes necessary for Medicaid reimbursement • Completing quarterly reports and other documentation of meetings and communication • Processing releases of information to other agencies • Contacting other service professionals who are involved in the client's care
5. **Case management**—activities related to individual case management and interagency coordination or referrals on behalf of a client.	• Advocating for children in other contexts including at school and in foster care placements • Communicating with caregivers to make sure they bring clients to the session • Meeting with other people in your agency who work on the client's case • Communicating with other people involved in the client's case (for example, health care professionals, foster parents, teachers)
6. **Travel and transportation**—activities related to transporting clients or organizing transportation for clients to TF-CBT sessions.	• Arranging transportation for clients • Providing public transportation vouchers or cards to clients as necessary
Other activities	**Examples**
7. **Supervision and clinical support**—providing or receiving ongoing training and clinical supervision, including conducting and reviewing fidelity assessments.	• Intensive trauma-specific individual supervision with clinical supervisors (both supervisors and therapists/clinicians should account for time spent on supervision) • Group meetings for supervision and clinical support
8. **Outreach**—activities to inform referral agencies and potential **new** clients about services.	• Communicating with child welfare agency staff regarding referrals • Communicating with staff at other agencies about referrals
9. **Program administration and management**—activities related to ongoing general management of TF-CBT services.	• Planning, budgeting, and other management activities related to TF-CBT services • Maintenance and upkeep of TF-CBT materials and meeting spaces

WEEK #

_____ **NAME:**_____ **AGENCY:**_____

	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY
DATE:	__ __ / __ __ / 20__ ___	__ __ / __ __ / 20__ ___	__ __ / __ __ / 20__ ___	__ __ / __ __ / 20__ ___	__ __ / __ __ / 20__ ___

CLIENT-FOCUSED ACTIVITIES FOR PCIT IMPLEMENTATION

For how many clients receiving TF-CBT did you provide services today?
(Include clients to whom you provided clinical services, any of the other activities listed below, or both. For this total, please count each client only once.)

	___ ___ CLIENTS	___ ___ CLIENTS	___ ___ CLIENTS	___ ___ CLIENTS	___ ___ CLIENTS

IF YOU WORKED WITH ONE OR MORE CLIENTS:
How many minutes did you spend per client on each activity related to PCIT?

	CLIENT INITIALS	MINUTES	CLIENT INITIALS	MINUTES	CLIENT INITIALS	MINUTES	CLIENT INITIALS	MINUTES	CLIENT INITIALS	MINUTES
1. Screening, assessment, and enrollment *Screening or assessing clients to determine eligibility and inform treatment plans. Enrolling clients into TF-CBT services.*										
2. Session planning and preparation *Activities to prepare for each session of TF-CBT.*										
3. Clinical service delivery *Delivery of therapeutic services, usually in treatment sessions.*										
4. Case documentation *Writing and processing case notes.*										
5. Case management *Activities related to individual case management and inter-agency coordination or referrals on behalf of a client.*										
6. Travel and transportation *Transporting clients or organizing transportation for clients to TF-CBT sessions.*										

Virtual services are those delivered via video, telephone, online, or on another communications platform, and not delivered in-person with face-to-face interaction.

	PERCENT OF TIME	PERCENT OF TIME	PERCENT OF TIME	PERCENT OF TIME	PERCENT OF TIME
7. Virtual Services *Approximately what percentage of time did you spend delivering services to clients in a virtual setting?*					

PLEASE USE THE NEXT PAGE TO RECORD YOUR TIME FOR OTHER ACTIVITIES.

WEEK #

_____ **NAME:**_____ **AGENCY:**_____

OTHER ACTIVITIES					
	MONDAY	**TUESDAY**	**WEDNESDAY**	**THURSDAY**	**FRIDAY**
DATE:	__ __ / __ __/ 20__ ___	__ __ / __ __/ 20__ ___	__ __ / __ __/ 20__ ___	__ __ / __ __/ 20__ ___	__ __ / __ __/ 20__ ___
	How many minutes did you spend on the activities below? Include only the time you spent on activities that support the delivery of TF-CBT.				
	MINUTES	MINUTES	MINUTES	MINUTES	MINUTES
8. Supervision and clinical support *Providing or receiving ongoing training and clinical supervision on TF-CBT, including conducting and reviewing fidelity assessments.*					
9. Outreach *Activities to inform referral agencies and potential **new** clients about TF-CBT services.*					
10. Program administration and management *Activities related to ongoing general management of TF-CBT services.*					

PLEASE CONFIRM THAT THE TOTAL TIME YOU HAVE RECORDED FOR ACTIVITIES 1 THROUGH 10 EACH DAY DOES NOT EXCEED THE TOTAL TIME YOU WORKED THAT DAY.