



## Network Performance

April – June 2003

[www,NCTSNet.org](http://www.NCTSNet.org)

**The mission of the National Child Traumatic Stress Network is to raise the standard of care and improve access to services for traumatized children, their families, and communities throughout the United States.**

**The NCTSN is funded by the Substance Abuse and Mental Health Services Administration,  
U.S. Department of Health and Human Services**

# CONTENTS

<b>Executive Summary</b> .....	1
<b>Clinical and Behavioral Outcomes</b> .....	2
I. Pilot Data Collection	
II. Regulatory Requirements (HIPPA, IRB)	
III. Implementation Timeline	
<b>Development and Adoption of Assessments and Treatments</b> .....	3
I. Developing Assessments	
II. Developing and Testing New Interventions	
III. Adopting and Adapting Treatment	
<b>Availability of and Access to Services</b> .....	7
I. Demographic Characteristics of Children Served by NCTSN Centers	
II. Direct Clinical Services	
III. Client-Related Services for Children	
IV. Family-Related Services	
V. Change in Capacity to Provide Services	
VI. Progress Improving the Availability of Services	
<b>Collaboration and Accomplishments</b> .....	13
I. Collaborative Group Status	
II. Collaborative Group Accomplishments	
<b>Training</b> .....	18
I. Training Activities	
II. Progress in Training Activities	
<b>Dissemination of Information and Public Awareness</b> .....	21
I. Web Site Activity	
II. Public Awareness Events	
III. Outreach Activities	
IV. Media Activity	
V. Progress Increasing Public Awareness	
<b>NCTSN Operations</b> .....	27
I. National Resource Center	
II. Media Activity	
III. Public Policy	
IV. Monitoring and Evaluation	
<b>APPENDIX A – Background</b> .....	28
<b>APPENDIX B – NCTSN Members</b> .....	31

Page left blank for double-sided printing.

## EXECUTIVE SUMMARY

The National Child Traumatic Stress Network (NCTSN) was established through a cooperative agreement with the U.S. Department of Health and Human Services (DHHS) through the Substance Abuse and Mental Health Services Administration (SAMHSA) under the auspices of the Center for Mental Health Services (CMHS), to make high quality, effective services available to children who have suffered trauma. Without effective treatment, children who have been traumatized suffer emotionally, feel isolated and cut off from others, and develop mental health problems. The emotional pain of trauma can cause children to perform poorly in school, have difficulties with their families and friends, and engage in reckless and dangerous behavior. These behaviors, which begin in reaction to trauma, can lead to trouble with the legal system or long-term development problems that carry over into adulthood.

The NCTSN was created with the goal of bringing together the academic excellence of the clinical research community and the wisdom of front-line community service providers to develop and deliver highly effective services to help children who have suffered traumatic experiences. As this report shows, the Network is making it possible for leaders in the field of child traumatic stress to work collectively and individually across disciplines and service settings to make a positive difference in the lives of children. Some of the accomplishments of the Network in this reporting period (April through June 2003) include:

- Network Centers providing **direct clinical services to more than 11,000 children** who were traumatized by physical abuse, sexual abuse, domestic violence, community violence, traumatic loss, refugee trauma, school trauma, or medical trauma. These direct clinical services were made available in mental health clinics, communities, schools, and other settings.
- **Training approximately 17,000** mental health professionals, teachers, primary care providers, and other professionals to treat or assess child traumatic stress.
- **Educating well over 15,000** professionals in child-serving systems, judges and law enforcement officials, members of faith-based groups, public health officials, policy makers, government officials, members of the general public, and the media about the causes and consequences of traumatic stress, how to recognize when children need help, and where to find that help.
- **Ensuring effective mental health services were available to children and their communities** following traumatic events such as fires, tornadoes, and shootings.
- **Introducing new and innovative services** for children with developmental disabilities, children who are refugees from West Africa, and children in the Asian, Native American, and Latino communities.

# CLINICAL AND BEHAVIORAL OUTCOMES

A major effort is underway to develop and implement a system throughout the NCTSN for collecting data on the clinical and behavioral outcomes of the thousands of children who receive services each quarter from Network centers. This system and the data it will yield have come to be known as the *core data set*.

## I. Pilot Data Collection

During the period April through June, 2003, the Data Core pilot-tested data collection procedures for the core data set. Four centers that are actively involved in the selection of measures for the core data set volunteered to collect data on 20 youth at each of their centers. Completion rates varied considerably – from 10 percent to 80 percent. The variability in completion rates provided valuable feedback regarding challenges that need to be addressed in implementing data collection procedures Network-wide.

Questions at the end of each interview were used to elicit feedback from the clinicians and staff members who completed the measures. There was a high level of acceptance and enthusiasm for the questions and measures, and respondents and administrators felt the questions were reasonable and provided useful information. At the suggestion of respondents, one instrument was replaced due to concerns that it was inappropriate for younger children. Other comments and questions concerned the logistics of implementing core data set measures. These are being addressed as the design of the core data set and associated data collection procedures are finalized.

## II. Regulatory Requirements (HIPAA, IRB)

The Data Core has been working closely with the Duke University Institutional Review Board (IRB) and HIPAA personnel to ensure that client rights and confidentiality are safeguarded. An application to the Duke IRB is being prepared to establish officially that the collection of data for the Core Data set is categorized as Program Evaluation/Quality Improvement rather than as Scientific Research.

## III. Implementation Timeline

The core data set was initially slated for implementation in October 2003. The original plan was to collect data using paper versions of core data set instruments until the programming of a Web-based data collection tool – the Electronic Data Capture (EDC) system – could be completed. It became clear that this strategy would create more problems than it solved by diverting resources toward a temporary approach and away from the efficient completion of the fully operational EDC. Therefore, implementation of the core data set via the EDC is slated for January 2004.

# DEVELOPMENT AND ADOPTION OF ASSESSMENTS AND TREATMENTS

The NCTSN is, in part, a learning network in which researchers and service providers work together to develop and test assessments and measure the effectiveness of services for traumatized children and their families. The ultimate goal is to make developmentally appropriate, trauma-focused, evidence-based practices available to children in all care settings. Work is underway to develop a wide range of projects and effective services. Some of these projects are conducted under the auspices of Network collaborative groups operating under the Network's Learning from Research and Clinical Practice Core and the Data Core; others are being carried out by individual Network centers. This report provides examples of these activities during the present quarter.

## I. Developing Assessments

An important part of improving the standard of care is improving the assessment of child trauma. Assessments must accurately assess trauma and the effects of trauma in order to help providers determine the needs of children and their families. Such instruments must be meaningful and valid when used with children and families from diverse ethnic and cultural backgrounds.

### Progress Developing Assessments

- **Children's Hospital of Philadelphia** is in the process of developing two assessments of risk for acute and posttraumatic stress for children seen in the hospital's Pediatric Intensive Care Unit and their families.
- **The Early Trauma Treatment Network** is made up of four organizations working together as one Network center. Each participating organization has begun using a standardized assessment protocol. Work on a database to collect data from these assessments is 90 percent complete; the database is expected to be completed, tested, and disseminated in the next quarter. This database can code, score, and print out clinical information from multiple measures on child and parent trauma history as well as their current functional status.
- **Project TAMAA** staff of the **Children's Crisis Treatment Center** in **Philadelphia** have been developing and implementing culturally sensitive trauma-related services for West African refugee children at the Tilden Middle School in Philadelphia. Part of their work has involved developing a culturally appropriate screening instrument.

## II. Developing and Testing New Interventions

There are times when there is very little research to guide decisions about the most effective treatment to use with a particular group of children. In such cases, it is important for researchers to learn more about the cause or nature of the problems children experience so that such information can be used to develop best practices for specific situations or populations. Assessment of the effectiveness of these best practices leads to the development of a base of knowledge that future practitioners can use in selecting treatments.

### Progress Developing and Testing New Interventions

- **Aurora Mental Health Center**, Aurora, CO, has designed a study to better understand the relationship between trauma exposure, psychological intervention, and psychiatric distress in children and adolescents. This project aims to understand variables influencing the development of PTSD symptoms in children. IRB approval is pending.

- **Cullen Center for Children, Adolescents and Families**, Toledo, OH, is collaborating with the local juvenile court to initiate data collection to explore linkages between mental health problems and the trauma history of children admitted into the Juvenile Detention Center. A key needs assessment is near completion. This assessment will serve as a foundation for developing a model treatment program for youth entering the juvenile justice system.
- **Harborview Medical Center**, Seattle, WA, is in the process of implementing a study to examine the effect the violent death of a parent has on children as well as on family help seeking behavior. This study, which is being planned in collaboration with the medical examiner's office, will recruit children whose parent has died as a result of homicide, suicide, or accident. The IRB application approval is in the final stages.
- **New York University**, NYC, the **William Wendt Center for Loss and Healing**, Washington, DC, and the **National Center for Child Traumatic Stress** are working together through the Child Traumatic Grief Task Force to design a study of the etiology of child traumatic grief. Study questionnaires have been developed and IRB applications have been submitted at the three centers participating in this study.
- Four Network centers, **Allegheny General Hospital Center for Child Abuse and Traumatic Loss**, Pittsburgh, PA, **North Shore University Hospital Adolescent Trauma Treatment Development Center**, Manhasset, NY, **Jewish Board of Family and Children's Services**, NYC, and **Safe Horizon-Saint Vincent's Child Trauma Care Continuum**, NYC, are working together to develop a curriculum for a peer education trauma intervention.
- **Directions for Mental Health**, Clearwater, FL, wrote protocols for treatments for bereavement and child sexual abuse that are being used by their local partners, the Hospice of the Florida Suncoast and Family Services Centers' S.A.F.E. program. These protocols will be used in a forthcoming study of the effectiveness of these treatment approaches. Copies of the protocols are being reviewed by National Network centers and the local partners. Adherence measures and procedures to ensure fidelity to the protocols are being developed.
- **Jewish Board of Family and Children's Services**, NYC, is developing the Sanctuary model, an intensive milieu-based treatment model for individuals with a trauma history that involves the active creation and maintenance of a nonviolent, democratic, therapeutic community in residential programs for youth. Alternative Learning School personnel have been trained to implement this model and the school superintendent has agreed that all teachers will be trained in the Sanctuary model in fall 2003. In addition to the sites originally participating in this evaluation study, the Sanctuary model is also being implemented at Hawthorne Cedar Knolls Residential Treatment Center, the Goldsmith Center for Adolescent Treatment, and the Mt. Vernon Girls Residence.
- **North Shore University Hospital Adolescent Trauma Treatment Development Center**, Manhasset, NY, is initiating a pilot treatment project for traumatized adolescent girls in a school program for teen parents. The initial response to this project has been very positive as illustrated by the fact that the girls, independent of any adult input, recently arranged a meeting with the school principal to request that these groups be continued and expanded next year.
- A goal of the **Center for Medical and Refugee Trauma (CMRT)** at Boston University Medical Center is to develop innovative treatments for childhood medical and refugee trauma. In this quarter, CMRT submitted a grant application to the National Institute of Drug Abuse entitled, "PTSD and Substance Abuse in Adolescents" in partnership with University of Massachusetts and another application in response to an RFA on children and violence in partnership with the Grow Clinic at Boston Medical Center. It also submitted a grant to the National Institute of Mental Health entitled "The Developmental Epidemiology of PTSD" and another to the National Institute of Child Health and Human Development (NICHD).
- Staff at **International C.H.I.L.D. Center for Multicultural Human Services**, Falls Church, VA, interviewed and conducted a pre-intervention assessment battery with 37 children who will attend the center's

summer program. A new intervention evaluation design was developed that uses weekly counselor focus groups to rate children's progress vis-à-vis program goals.

- **Allegheny General Hospital Center for Child Abuse and Traumatic Loss**, Pittsburgh, PA, is conducting a study of the effectiveness of a treatment for child traumatic grief. To date, 38 children have been enrolled in the study and eight have completed treatment.
- **Children's Institute International, Central LA Child Trauma Treatment Center**, has completed data collection and analysis on the first nine months of domestic violence group treatment for children and their mothers.
- The **Child and Adolescent Treatment Services Consortium** at **New York University** has recruited children and adolescents with PTSD related to 9-11 to be treated with trauma-focused cognitive-behavioral therapy. Project Liberty Phase Down will be making referrals to this study.

### III. Adopting and Adapting Treatments

There are some treatments for child trauma that research has shown to be effective. When a service provider uses these treatments as they were originally designed, the provider is *adopting* the intervention. However, sometimes there may be differences in the characteristics of the children with whom the intervention was originally tested and the group for which the treatment is being adopted. When providers modify a treatment to accommodate these differences, they are *adapting* the treatment. Careful evaluation is needed to assess the effectiveness of either an adopted or adapted treatment. Each new study either helps to confirm the effectiveness of the treatment or points to areas where changes or improvements may be needed.

#### Progress Adopting and Adapting Treatments

- **Harborview Medical Center**, Seattle, WA, is collaborating with the Asian Counseling and Referral Service and a Seattle School District middle school to replicate an intervention to address exposure to community violence that was tested by the **Los Angeles Unified School District**. Planning is under way to pilot this intervention during the current school year.
- **Jewish Board of Family and Children's Services (JBFCs)**, NYC, is planning for the implementation and evaluation of the STAIR treatment model. This model, developed by the New York University Child Study Center will be tested at the JBFCs adolescent girls' Montague day treatment program. The model has been presented to the day treatment director and clinicians. Clients have been identified for whom the intervention may be appropriate. Training has been scheduled for JBFCs clinicians.
- **Cullen Center for Children, Adolescents and Families**, Toledo, OH, is receiving clinical case consultation and support to implement a treatment for traumatic bereavement developed by **Allegheny General Hospital Center for Child Abuse and Traumatic Loss** in Pittsburgh.
- Staff at **Aurora Mental Health Center**, CO, are working with the Intercept Program for children with developmental disabilities on a project to implement a behavioral treatment program to assist children in developing self-control and reducing aggressive behavior. This requires adapting interventions to take into account both the lower ages and cognitive disabilities of these young people. Evaluation to date shows a reduction in incidents of aggression. This center is also adopting a treatment for sexually abused children developed by **Allegheny General Hospital Center for Child Abuse and Traumatic Loss** in Pittsburgh. Center staff have received initial training in this model.
- In conjunction with the Women's Center Shelter of Greater Pittsburgh, **Allegheny General Hospital Center for Child Abuse and Traumatic Loss** developed a study to test the effectiveness of trauma-focused cognitive behavioral therapy for children exposed to domestic violence.

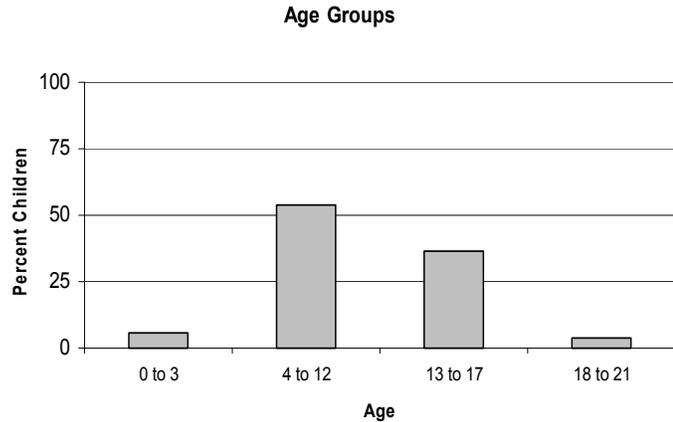
- **Directions in Mental Health, Inc.**, Clearwater, FL is working with Network members at **Allegheny General Hospital Center for Child Abuse and Traumatic Loss** on plans to adopt trauma-focused cognitive behavioral therapy. The Directions staff who will participate in this project have been identified, and initial training in the intervention is scheduled for next quarter.

# AVAILABILITY OF AND ACCESS TO SERVICES

A major goal of the National Child Traumatic Stress Network (NCTSN) is to increase the availability of services for traumatized youth and their families. The Network's progress in attaining this goal is tracked using information centers report to SAMHSA on a quarterly basis – the Service Utilization Form and the Quarterly Report Form.

## I. Demographic Characteristics of Children Served by NCTSN Centers<sup>1</sup>

Approximately 50 percent of children served by National Network centers were ages 4 through 12; approximately 33 percent were teens (age 13 to 17). A slight majority of these young people were female (53 percent).



Ethnicity	
<b>Ethnicity</b>	<b>% Children</b>
Hispanic	38%
Other	62%

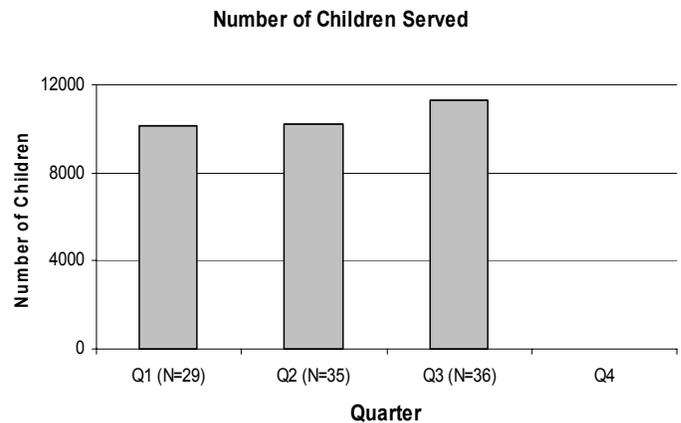
  

Race	
<b>Race</b>	<b>% Children</b>
White	56
Black	33
Multiracial	7
Asian	2
American Indian	1
Pacific Islander	<1

Ethnicity and race are reported separately for children in the table to the left. With respect to ethnicity, approximately one-third (38 percent) of children receiving services from the Network are Hispanic. Within categories of race, approximately one-half are white (56 percent), one-third are African American (33 percent), and the remainder are distributed over other racial groups.

## II. Direct Clinical Services

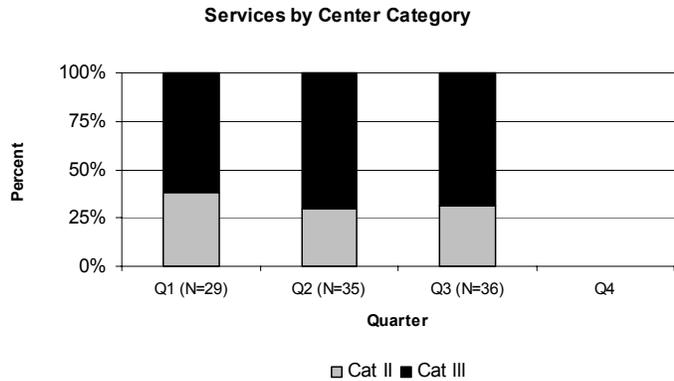
Network centers provided services to approximately 11,318 children in the current quarter, an increase over previous quarters in the current fiscal year. Direct clinical services include individual and group therapy, evaluation, crisis response, medication check, etc. These services may have been delivered in a clinic, school, home, or other location.



<sup>1</sup>One of the challenges facing a group as diverse as the Network is that members keep records in very different ways. This means that it is not always possible for centers to report data in a metric that is consistent across centers. Consequently, demographic information is based on the report of subsets of approximately 75 percent of centers who are able to report these data using the categories requested by the Service Utilization Form.

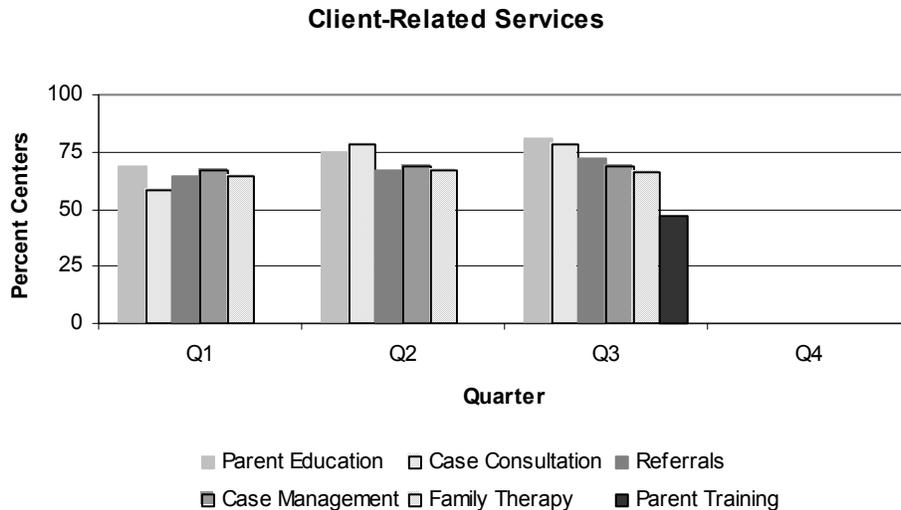
## Direct Clinical Service by Center Category

Category III Community Treatment and Services Centers reported serving a greater number of children than did Category II Development and Evaluation Centers. This is consistent with the greater emphasis on service provision among Category III centers and their greater representation (72 percent) among Network centers.



## III. Client-Related Services for Children

Children served by Network centers receive not only the direct therapeutic services described above, but they and/or their parents also receive case management, parent education, parent training, case consultation, family therapy, or referrals. There has been an upward trend in parent education over the course of the year. Case consultation has also increased since the first quarter. Reported rates of other services have been more stable.



### Parent Education

Providing information to parents or other caregivers that increases their understanding of children's needs related to traumatic stress.

### Case Consultation

Providing professional or clinical expertise to another provider for the benefit of a specific client.

### Referrals

Services that direct, guide, or link the client with other appropriate services.

### Case Management

Activities related to locating services for clients other than those provided by the center, linking the client with those services, and monitoring the client's receipt of services. Case management can be provided by an individual or a team and may include both face-to-face and telephone contact with the client and other service providers.

### Family Therapy

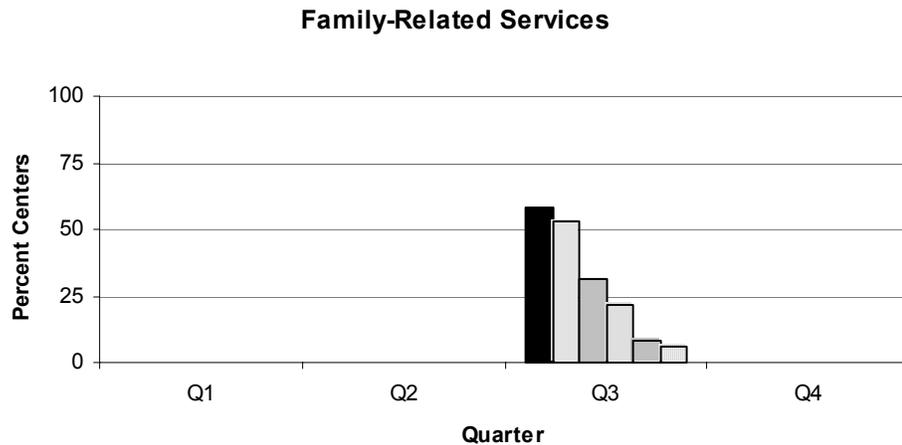
Planned therapeutic sessions involving the client and other family members.

### Parent Training

Teaching of specific skills for managing children's behaviors taught to individual parents or groups of parents. This category was reported for the first time in Q3 reporting period.

## IV. Family-Related Services

For the first time this quarter, centers were asked to provide information about services provided to family members. These services are not treatment per se, but services that are sometimes needed to enable families to participate in interventions or cope effectively with problems their children are experiencing. As shown below, key services provided by more than half the NCTSN centers are transportation and advocacy.



■ Transportation □ Advocacy □ Support Groups □ Child Care □ Financial Assistance □ Respite

<b>Transportation</b>	Transportation arrangements made or provided by the program for the purpose of allowing the target child and/or parent/caregiver to take part in treatment or treatment related activities.
<b>Advocacy</b>	Actions taken with or on behalf of a specific child or parent/caregiver to ensure the person's views and/or needs are understood and addressed.
<b>Support Groups</b>	Groups attended by parents or other primary caregivers that are not group therapy and that are not counted as parent education or parent training.
<b>Childcare</b>	Childcare provided for targeted child and/or other children living in the home for the purpose of allowing the parent or other primary caregiver to take part in treatment-related services.
<b>Financial Assistance</b>	Direct financial assistance paid by the program to or on behalf of a parent or caregiver such as assistance paying for utility bills, rent, making repairs to a home, fees for after-school programs, or expenses for summer camp.
<b>Respite Care</b>	Childcare or other activities arranged by the center for the targeted child for the purpose of reducing caregiver strain. Service may be provided in the home or another setting.

## V. Change in Capacity to Provide Services

The trauma services provided by some centers occur in the context of a broader mental health program. For example, participation in the Network may make it possible for a pre-existing mental health program to add new trauma-focused services for a previously underserved population of children. For the first time this quarter, centers were asked to report fluctuations in their resources, particularly changes in funding or reimbursement levels for services not funded by SAMHSA, the number of staff providing services, the availability of transportation for clients, and the amount of space available for providing services.

As shown in the table on the following page, 25 percent of centers reported at least a small increase in staffing, 16 percent reported a small or moderate increase in funding or reimbursement, 9 percent reported increased availability of client transportation, and 6 percent reported an increase in space. At the same time, 8 percent of centers reported a drop in staffing, 11 percent reported small to moderate decreases in funding, 6

percent a small decrease in client transportation, and 3 percent a decrease in the space available for providing services.

	Large Decrease	Moderate Decrease	Small Decrease	Unchanged	Small Increase	Moderate Increase	Large Increase
	% Centers	% Centers	%Centers	% Centers	%Centers	%Centers	%Centers
Satellite facilities	0	0	0	100	0	0	0
Space	3	0	3	89	6	0	0
Client transportation	0	0	6	86	3	3	3
Funding	0	3	8	72	8	8	0
Staffing	0	0	8	67	17	8	0

## VI. Progress Improving the Availability of Services

- **Oregon Health and Science University**, Portland, OR, received the 2002-03 Partners in Education Award from the Northwest Regional Education Service District for developing an intercultural child psychiatry program based on the school districts' needs. This quarter, they assessed and/or treated 36 child and adolescent clients from 13 different countries.
- **Aurora Mental Health Center**, CO, is collaborating with the Sexual Abuse Recovery Team of the Arapahoe Department of Human Services to ensure smooth coordination between these two agencies.
- **Project TAMAA staff** at the **Children's Crisis Treatment Center** in Philadelphia are working to develop and implement culturally sensitive trauma-related services for West African refugee children at the Tilden Middle School in Philadelphia. Project Tamaa's Case Manager/Social Service Coordinator met with 92 West African refugee families and obtained parental consent from 22 of them for their children to be screened. Completed screening forms have been reviewed to determine for which children the Children's Therapy/Support Groups are appropriate and which children need other services. They are also working with West African community leaders to identify culturally appropriate consultants from the refugee communities of the West African countries of Liberia, Sierra Leone, and Guinea to assist the Social Service Coordinator/ Case Manager with community outreach and to serve as interpreters when necessary.
- **La Clinica del Pueblo** is experiencing success in making Latinos in the DC metropolitan area aware of the importance of mental health services when they experience emotional/psychological symptoms. This is manifested in the growing and continuous attendance and participation of members of the Latino community in Saturday psycho-educational support groups and the increased request for individual services following attendance at workshops.
- **Children's Institute International, Central LA Child Trauma Treatment Center**, is holding monthly meetings of a council of providers from various child-serving systems of care. The focus of this council is to develop an area survey to address local needs/gaps in services and develop better coordination of services. The survey has been written and a Web site version has been developed. The Web site will be available for providers to begin responding to the survey next quarter.
- In collaboration with the Chicago Public Schools' Newcomers Centers, **Chicago Health Outreach International FACES** program completed a school-year program at Senn High School and Taft High School. Newcomers' Centers are schools within schools that specialize in curricula addressing the unique linguistic and cultural needs of refugee and immigrant adolescents. International FACES staff developed and conducted weekly activities with these students for the purpose of identifying students demonstrating symptoms of traumatic stress. Staff engaged students through artistic activities to create an environment of communal support. The broader aim of this program was to explore whether

a relationship could be established between the schools, students' guardians, and International FACES.

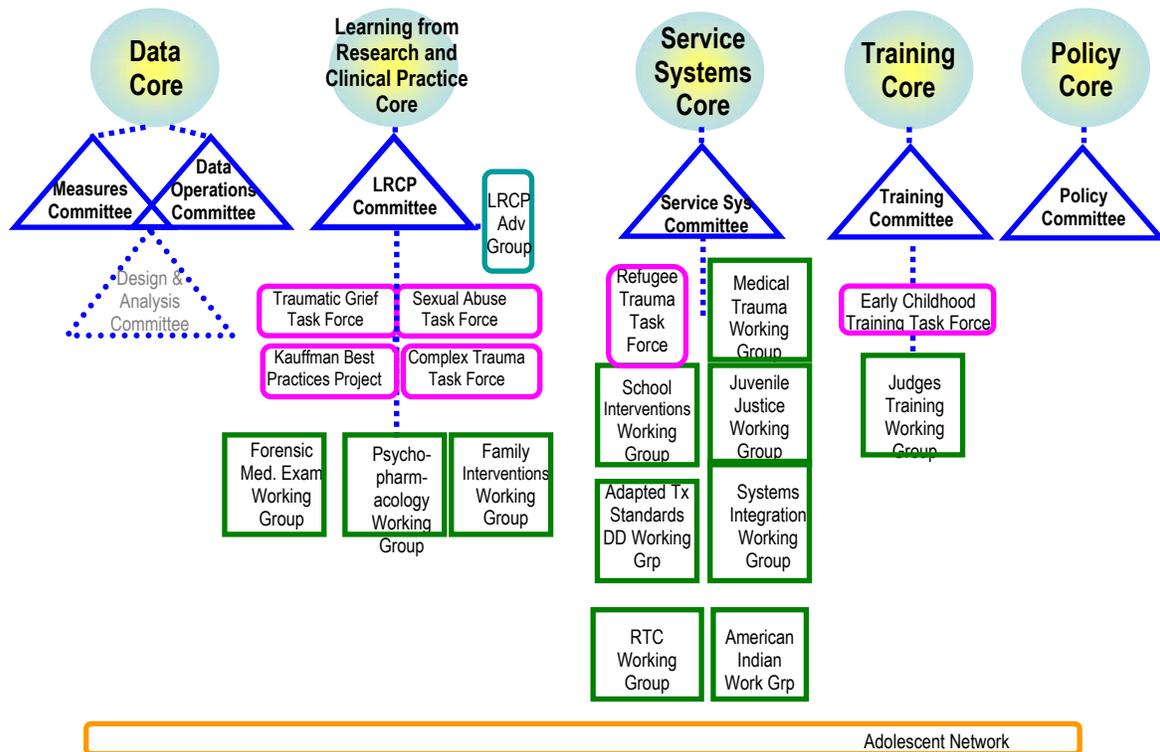
- **New Mexico Alliance for Children with Traumatic Stress** (NewMACTS) is working with the Grant County Community Health Council and Border Area Mental Health Services to form a network of providers and agencies to expand and improve services to traumatized children, particularly immigrant and refugee populations who have recently crossed the border into the United States from Mexico. This quarter, NewMACTS representatives met with school-based mental health staff at the Acoma and Laguna To'hajaillee School to develop a PTSD screen for middle and high schoolers. A year-long plan was established to implement the To'hajaillee School PTSD Project.
- Since receiving funding, the **Cullen Center for Children, Adolescents and Families**, Toledo, OH, has been able to serve 154 traumatized youth regardless of their socioeconomic or insurance status. The Center reports that it "has seen children who have faced horrifying situations be able to share their experiences, utilize therapy and support, and experience great relief and a renewed sense of hope." They are participating in a newly developed Parent Leadership Initiative with the mission of educating parents and professionals and providing a supportive environment so that families can have meaningful involvement in local family-serving organizations. They continue to facilitate Northwest Ohio's Child Trauma Treatment Network. This local treatment network is growing and developing an increased knowledge of core components of evidence-based treatment and assessment. This is a key step in raising the standard of care for child trauma survivors in this community.
- In May, the Kansas City metropolitan area was struck by tornadoes. The **Kansas City Metropolitan Child Traumatic Stress Center** (KCMC), Kansas City, MO, worked with the Regional Mental Health Disaster Response Committee convened by the Red Cross to make the expert knowledge of the Network available to this disaster response effort. KCMC is also involved in conducting a community-wide needs assessment to collect data on services available for traumatized children and their families in the Kansas City metropolitan area. These data will be compiled into a written and Web-based resource guide.
- Stemming from collaboration with the National Center's **Terrorism and Disaster Branch, Directions in Mental Health**, Clearwater, FL, is organizing a group of clinicians to volunteer for the Red Cross' Mental Health Training course.
- A goal of the **Maine General Medical Center**, Augusta, ME, is to facilitate the development and coordination of child trauma services across the state. This group is in the process of identifying local and national resources through stakeholder interviews and research.
- **Harborview Medical Center**, Seattle, WA, developed a protocol for responding to potentially traumatic incidents with multiple victims. This protocol includes both organizing a coordinated response to the needs of victims as well as responding to community concerns. There were two situations involving possible abuse of children at day care/preschools that required invoking the protocol. In both cases, Harborview helped plan and was present for community meetings with parents at the day care/preschools. More than 50 families attended each meeting during which Harborview staff responded to high levels of parental concern and created a mechanism for follow-up support and assessment services. In addition, Harborview staff provided guidance and support to school staff.
- **Mount Sinai Adolescent Health Center** (AHC), NYC, continues to be actively involved in making services available to young women (ages 13 to 21) who have been sexually exploited. AHC is increasing the availability of services for this population by working with Girls Educational and Mentoring Services (GEMS) to provide needed mental and physical health care services as well as rendering consultation, support, crisis intervention, and mental health education to the counseling staff at GEMS. AHC staff have also met several times with Partnership for After School Education (PASE), a New York City youth development program. They will provide technical assistance and develop a trauma training tool-kit/curricula for the program's youth workers on best practices for identifying, responding to, and providing referral resources for traumatized youth.

- The National Center's **Terrorism and Disaster Branch (TDB)** staff provided consultation to one of the university deans and the head of the counseling services at Case Western Reserve University in response to the shooting of faculty and students at the university. Consultation included program design, intervention strategies, needs assessment, and preparation for services during the next academic year. The TDB also provided a range of rapid response services following tornadoes that struck Kansas and Oklahoma.

# COLLABORATION AND ACCOMPLISHMENTS

Collaborative groups are a vital mechanism through which members of NCTSN centers exchange and pool their knowledge and experience. It is through these groups that the NCTSN bridges professional affiliations, professional and public concerns, geographic and cultural differences, competition among specialists, and varying agendas to accomplish its goals of improving the availability and quality of services for youth with traumatic stress and their families.

## Functional Cores and Associated Collaborative Groups

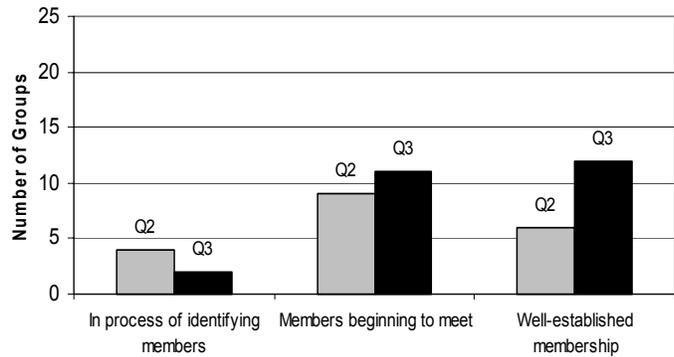


## I. Collaborative Group Status

Six new collaborative groups were established in the current quarter, bringing the total number of groups to 25. Within the Service Systems Integration Core, new groups include the Service Systems Integration Committee and two new working groups – the Residential Treatment Center Working Group and the American Indian Working Group. A Public Policy Committee was established under the Policy Core. An Adolescent Network was also established but has not been assigned to a core at this time. As of this quarter, collaborative groups are operating under each of the five Functional Cores for the first time.

### Collaborative Group Status

Of the 25 collaborative groups within the NCTSN, 12 were meeting regularly and actively working to produce clearly defined products; 11 had identified members and were beginning to plan products, and two were in the start-up phase of identifying members. Information about individual groups is found below in the table titled “Collaborative Group Membership by Network Functional Cores”.



### Collaborative Group Membership by Network Functional Cores Apr-Jun (Q3) 2003

#### Data Core

	Q2	Q3	Q4
Measures Committee	2	3	
Data Operations Committee	3	3	

#### Learning from Research and Clinical Practice Core

	Q2	Q3	Q4
Learning from Research & Clinical Practice Committee		2	
Family Intervention Work Group	2	2	
Learning from Research & Clinical Practice Ad. Group	1	3	
Kauffman Best Practices Project Task Force	1	3	
Forensic Medical Exam Working Group	1	3	
Complex Trauma Task Force	3	3	
Psychopharmacology Work Group	3	3	
Traumatic Grief Task Force	3	3	
Sexual Abuse Task Force	2	3	

#### Service Systems Core

	Q2	Q3	Q4
School Intervention Working Group	1	1	
Service System Committee		2	
American Indian Working Group		2	
Residential Treatment Working Group		2	
Service System Integration Working Group	2	2	
Juvenile Justice Working Group	2	2	
Medical Trauma Working Group	1	3	
Adapted Treatment Stds for Ch with DD Working Group	1	3	
Refugee Trauma Working Group	2	3	

#### Training Core

	Q2	Q3	Q4
Judges Training Work Group	1	1	
Training Committee	2	2	
Early Childhood Trauma Task Force	2	2	

#### Public Policy Core

	Q2	Q3	Q4
Public Policy Committee		2	

**1**=Newly formed group/members being identified; **2**=Members beginning to meet; **3**=Well-established membership

**Note:** The tables above do not include the Adolescent Network, which has not yet been assigned to a core.

## Group Size

There were 210 people from the 36 Network centers who were active in Network collaborative groups. (The number of participants shown in the table to the right totals more than this because some participants were members of multiple groups.) The largest groups are those focused on specific types of trauma (e.g., traumatic grief, sexual abuse, complex trauma).

Group Size					
Group	No. Members	Group	No. Members	Group	No. Members
TGTF	35	MC	18	LRPCAG	10
SATF	27	TC	16	PPC	9
JJWG	27	PWG	15	ASDWG	9
CTTF	25	SSIWG	13	FIWG	9
ECTTF	21	RTCWG	12	JTWG	9
RTTF	20	AI	14	SSIC	9
SCIWG	20	FMEWF	14	MTWG	8
DOC	19	AN	11	KTF	7
				LRCPC	*

\*Newly formed -- in process of recruiting members.

## Center Participation

The Network's success in bringing together professionals across organizational boundaries can be seen in the number of different centers involved in the various Network collaborative groups. In almost half of all Network collaborative groups, 10 or more different centers have come together to plan and carry out projects to improve services for traumatized youth. Groups with a relatively specialized focus or time-limited goal are less diverse, but still demonstrate considerable collaboration among multiple Network centers.

Center Participation					
Group	No. Centers	Group	No. Centers	Group	No. Centers
JJWG	16	TC	10	FMEWF	8
SATF	16	DOC	10	ASDWG	7
CTTF	16	JTWG	9	ECTTF	7
SCIWG	14	RTCWG	9	AN	6
TGTF	14	SSIC	9	MTWG	5
MC	13	PPC	9	KTF	3
PWG	11	SSIWG	8	LRCPAG	3
RTTF	10	FIWG	8	AI	*
				LRCPC	*

\*Newly formed -- in process of recruiting members.

AI	American Indian Working Group
AN	Adolescent Network
ASDWG	Adapted Treatment Standards for Children with Disabilities Working Group
CTTF	Complex Trauma Task Force
DOC	Data Operations Committee
ECTTF	Early Childhood Training Task Force
FMEWF	Forensic Medical Exams Working Group
FIWG	Family Intervention Working Group
JJWG	Juvenile Justice Working Group
JTWG	Judges Training Working Group
KTF	Kauffman Best Practices Project Task Force
LRCPC	Learning from Research and Clinical Practice Committee
LRCPAG	Learning from Research and Clinical Practice Advisory Group

### ABBREVIATIONS

MC	Measures Committee
MTWG	Medical Trauma Working Group
NAWG	Native American Working Group
PPC	Public Policy Committee
PWG	Psychopharmacology Working Group
RTCWG	Residential Treatment Center Working Group
RTTF	Refugee Trauma Task Force
SATF	Sexual Abuse Task Force
SCIWG	School Intervention Working Group
SSIC	Service System Integration Committee
SSIWG	Service System Integration Working Group
TC	Training Committee
TGTF	Traumatic Grief Task Force

## Participation by Center Category

One of the Network's goals is to provide an environment that enables researchers and practitioners to combine their respective knowledge and skills to make effective services available to traumatized youth and their families. An indicator of whether or not such an environment exists is the mix of Category II Intervention and Evaluation Centers and Category III Community Treatment and Services Centers within collaborative groups. The table to the right shows the percentage of centers represented in groups. Although Category II centers prevail in some groups and Category III centers in others, with only minor exceptions, both categories of centers are working together in Network collaborative groups.

Participation by Center Category			
Group	% CAT I	% CAT II	%CAT III
	N=1	N=10	N=26
LRPCAG	75	25	0
KTF	67	33	0
AN	57	22	0
DOC	53	21	26
ECTTF	16	63	21
PWG	27	60	13
SSIWG	27	47	27
MTWG	13	50	38
ATSDWG	7	13	80
RTC	6	12	82
PC	11	11	77
RTWG	5	19	76
CTTF	0	32	68
SCIWG	10	30	60
FMEWG	7	29	64
SATF	7	36	57
JTTF	11	33	56
JJWG	11	33	56
FIWG	22	22	56
SSC	0	44	55
TC	15	31	54
MC	28	28	44
TGTF	29	26	44

*A list of group name abbreviations is found on the previous page*

## II. Collaborative Group Accomplishments

Several Network collaborative groups have completed or are in the process of developing an array of products to improve care for traumatized children. For example, a videotape training on the treatment for traumatic bereavement has been produced that will be made available to all Network centers and a multi-center psychopharmacology intervention study is being designed. Information about the stage of development of specific collaborative projects is listed in the table below titled "Collaborative Product Development".

### Collaborative Product Development by Network Cores Apr-Jun (Q3) 2003

#### Data Core

		STATUS		
		Q2	Q3	Q4
Data Operation Committee	Center Survey (Year 1) Preliminary Findings	3		
	NCTSN Data Project Proposal Form	3		
	Core Dataset	2	2	
Measures Committee	Measurement Domains and Conceptual Framework	3	2	
	Measure Review Sheet	3		
	Measures Needs Assessment	3		
	Measures Review Database		2	

#### Learning from Research and Clinical Practice

Complex Trauma Task Force	Complex Trauma Clinician Survey protocol		3	
	Complex Trauma Cross-Center Survey	2	2	
	Complex Trauma White Paper	2	2	
	Complex Trauma Clinical Case Book	1	1	
Psychopharmacology Working Group	Multi-center Psychopharmacology Intervention Study		2	

1=Planned      2=In progress      3=Completed

Learning from Research and Clinical Practice (cont)		STATUS		
		Q2	Q3	Q4
Traumatic Grief Task Force	Treatment Manuals - modified and compiled for adolescents and school-aged children	3		
	Videotapes of Traumatic Bereavement Trainings	3		
	Traumatic Grief Guidelines for Very Young Children	2	2	
	Educational Materials on Child Traumatic Grief	2	2	
	CTG Measures and Epidemiology Work Group	2	2	
Family Interventions Working Group	Family Interventions Survey		2	
	Literature Review and Report		2	
Sexual Abuse Task Force	Workshop materials/manual from Allegheny General Hospital Clinician Assessment Workshop	3		
	Clinician Surveys on Treatment of Sexually Abused Children (Trauma Tx, CBT, Manualized Tx)	3		
	Modification of TF-CBT manual after use in 10 Network training		3	
	Production of 2, 6-hour training tapes of TF-CBT		3	
	Empirical study of 3 different levels of training on therapist attitudes and practices for abused children		2	
	Strategies for disseminating TF-CBT to community providers		2	
	MHCD Study of Trauma-Focused CBT vs. Usual Treatment	2	2	
Focus Groups at SATF Centers	2	2		
Forensic Medical Exam Working Group	Forensic Medical Exam Interview Format		3	
	Forensic Medical Exam Clinician Interviews		2	
<b>Service System Core</b>				
Refugee Trauma Task Force	Refugee Trauma White Paper	2	2	
	Refugee Trauma White Paper – Version 1		3	
	Refugee Trauma Center Survey		2	
Service System Integration WG	Literature Review and Service Systems Model Development		2	
	Interviews of Community Service Providers		2	
Juvenile Justice Task Force	Review of Data on Prevalence of Trauma among JJ youth		2	
	Reference Sheets on Assessments, Interventions, and Various Topics Affecting Traumatized JJ Youth		2	
	Reviewing NCJFCJ delinquency court guidelines		2	
	Compendium of Readings on Juvenile Justice and Trauma		1	
Medical Trauma Working Group	Medical Traumatic Stress White Paper	2	2	
	Crisis Intervention and Treatment White Paper	2	2	
School Intervention Working Group	Crisis Response Educational Materials		2	
	Critical Components of a School-Based Program	2	2	
Adapted Tx Stnd for Children/Disabilities WG	Fact Sheets – Deafness and Developmental Disabilities		2	
<b>Training Core</b>				
Training Committee	Training Materials Inventory	2	2	
	Training Needs Assessment	2	2	
Early Childhood Trauma Task Force	Task Force Concept Paper	3		
	Grant proposal submitted to foundation			3
1=Planned    2=In progress    3=Completed				

**Note:** The table above does not include the Adolescent Network, which has not yet been assigned to a core.

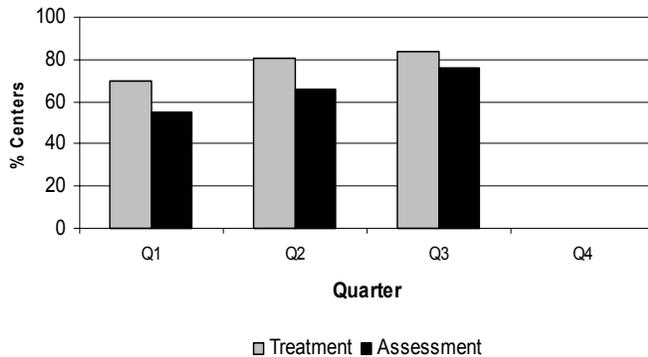
# TRAINING

One of the core functions of the NCTSN is training. Training is a vehicle through which professionals and lay people learn to recognize symptoms of traumatic stress and make appropriate referrals. It is also the means for service providers to learn specific skills for assessing and treating the effects of trauma.

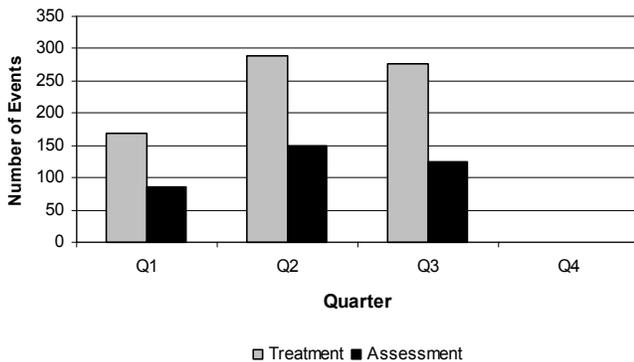
## I. Training Activities

There was a modest increase over the past quarter in the number of Network centers reporting training activities. This quarter, 84 percent of centers reported trainings on the treatment of traumatic stress and 76 percent reported trainings on the assessment of traumatic stress.

Centers' Involvement in Training Activities



Training Events



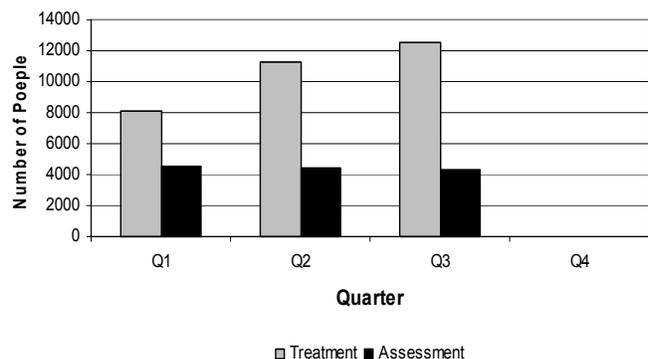
## Number of Events

A total of 277 training events on the treatment of trauma were reported in the current quarter – a slight decrease from the previous quarter (289 trainings). This quarter, 125 trainings on assessing traumatic stress were reported compared to 149 last quarter.

## Number of People Trained

There was a marked increase over the previous quarter in the number of people who received training on treating trauma. This quarter, 12,536 people were trained compared to approximately 11,614 last quarter. The number of people receiving training on the assessment of trauma remained at just under 4,500.

Number of People Trained



## Categories of People Trained

### Treatment of Traumatic Stress

Approximately 4 of 5 (81 percent) centers trained mental health professionals to treat traumatic stress this past quarter. Approximately 1 in 3 centers also trained school personnel (38 percent), child welfare workers (35 percent), health care professionals (35 percent), and law enforcement or juvenile justice system employees (30 percent).

### Assessment of Traumatic Stress

A majority of centers (68 percent) trained mental health professionals to assess traumatic stress. Health care professionals (35 percent), child welfare workers (30 percent), and school personnel (24 percent) received training on assessment from one-fourth to one-third of all Network centers.

	Categories of Trainees			
	Treatment (N=37)		Assessment (N=37)	
	No. Centers	%	No. Centers	%
Mental health	30	81	25	68
School professionals	14	38	9	24
Child welfare	13	35	11	30
Health care	13	35	13	35
Legal system	11	30	5	14
Child care	10	27	7	19
Dom. violence shelter staff	8	22	6	16
Parent/family	7	19	1	3
Government	5	14	3	8
Faith-based groups	5	14	0	0
Consumers	4	11	1	3
Fire/emergency personnel	2	5	0	0
Other	2	5	4	11

## II. Progress in Training Activities

- Primary Children’s Medical Center Safe and Healthy Families**, Salt Lake, UT, is a network of over 200 mental health professionals. These individuals are organized into 21 teams with a designated leader and 2 to 10 members. These teams meet monthly on issues regarding the treatment of child abuse and neglect. They are being trained in the use of objective assessment data to guide treatment planning and measure the effectiveness of care. To date, written protocols and training videotapes have been developed. A six-month survey of members (based on a 50 percent response rate) indicates that 87 percent of members have received training, 82 percent attended at least two monthly meetings, and 65 percent have had direct personal contact with staff from Safe and Healthy Families. Several methods of training are being tested including collaboration with national experts by telephone, direct training, manuals, videotapes, and peer review during team meetings. Experts from other Network centers are participating in this endeavor by conducting specialized training. Each expert has completed two of three scheduled teleconference trainings. Ongoing response from several of the teams indicates that the specialized training is well received and helpful.
- New Mexico Alliance for Children with Traumatic Stress** is devising plans for a collaborative evaluation of training methods across two sites and evaluating training retention using a pre- and post-training measure of the reflective supervision model.
- Jewish Board of Family and Children’s Services**, NY, is evaluating the effectiveness of trauma training in changing practice in child abuse prevention programs. Trauma ASK was developed to provide a pre- and post-training assessment.
- The **Los Angeles Unified School District** in Van Nuys, CA, conducted a two-day training on cognitive behavioral interventions for trauma in schools for the Los Angeles Child Guidance Clinic.
- The National Center’s **School Crisis & Intervention Unit** conducted its second Advanced School Crisis Training for the Yakima Washington Education Region, which includes 25 local school districts.

- **Children's Institute International, Central LA Child Trauma Treatment Center**, held a two-day conference entitled "Children and Trauma: Coping in the Aftermath," which was followed by a one-day think tank. Several Network representatives presented and participated in both the conference and think tank. The conference was attended by over 700 participants from across the country including educators, mental health professionals, social workers, law enforcement officials, and child advocates.
- **Early Trauma Treatment Network** members conducted numerous trainings and consultations with child protective services workers, family courts, police, childcare providers, and staff at battered women's shelters. Among these were a one-day training for therapists in Baltimore on cognitive behavioral treatment for preschool children with PTSD and a 20-hour training on the Circle of Security, a group-based model that provides parent education and intervention for caregivers who have experienced trauma and other high-risk parenting stressors.
- The **National Children's Advocacy Center** in Huntsville, AL, is making scholarships available for Network members to attend training on forensic evaluations. It also conducted its annual symposium on child sexual abuse, which was attended by approximately 195 professionals.
- In response to requests from centers throughout the Network, the National Center's **Terrorism and Disaster Branch (TDB)** developed a plan to respond to requests for specific trainings in preparedness and response. It has also designed a training for mental health professionals – "Practical Front-line Assistance for Health with Kids" (Kflash). Training will include modules for professionals in the areas of primary care, mental health, education, law enforcement, public health, and emergency operations. TDB also participated in trainings on terrorism and disaster for the seven regional health departments in Florida and was invited by the American Red Cross and the Centers for Disease Control to participate in TOPOFF-II.
- **Maine General Medical Center**, Augusta, ME, took part in training for primary care providers on medical counterterrorism preparedness sponsored by the Maine Primary Care Association, Maine Center for Public Health, Harvard School of Public Health, and Maine Bureau of Health. Staff also took part in a satellite broadcast about the roles and responsibilities of local, state, and federal agencies in emergency situations.
- Staff of the **Cullen Center for Children, Adolescents and Families**, Toledo, OH, received training in family treatment for traumatic stress, the assessment of trauma, child development issues, dynamics of court intervention in domestic violence cases, and the dynamics of sexual offending.
- Experts from **Miller Children's Abuse and Violence Intervention Center**, in Long Beach, CA, continue to provide training for centers and other professionals in the New York City area providing trauma-related services to children affected by 9-11.
- **Directions in Mental Health**, Clearwater, FL is working with the **Early Trauma Treatment Network (ETTN)** to train local clinicians in parent-child psychotherapy. Pinellas Safe Start will assist with training costs in exchange for pro bono services for children they may refer.
- **Harborview Medical Center**, Seattle, is using a modified version of the therapy practices questionnaire developed by the **Allegheny General Hospital Center for Child Abuse and Traumatic Loss**, Pittsburgh, to evaluate its therapist training programs.
- **Allegheny General Hospital Center for Child Abuse and Traumatic Loss** in Pittsburgh is providing ongoing training and consultation to NYC programs treating children impacted by 9-11. During this quarter, a two-day booster training was provided to more than 50 providers. Weekly phone consultation was also provided to NY Times Fund, NY Consortium for Child Mental Health programs.

# DISSEMINATION OF INFORMATION AND PUBLIC AWARENESS

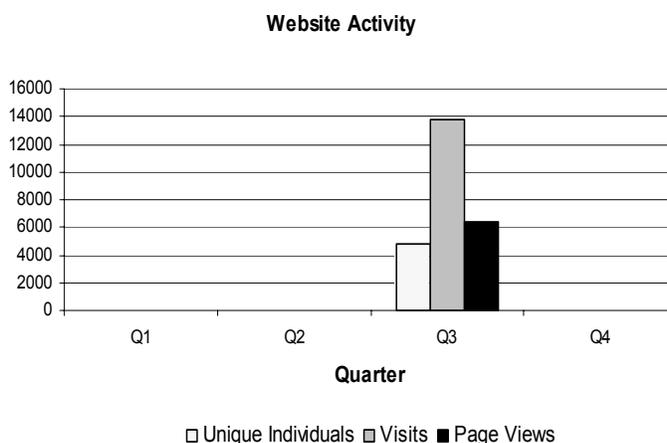
An important goal of the NCTSN is to help professionals and the public to be more aware of the causes and prevalence of child traumatic stress and to inform them of effective treatments available to help children and their families.

## I. Web Site Activity

The National Resource Center (NRC) for Child Traumatic Stress supports the mission of the Network by disseminating relevant, practical information, and resources to professionals and the public, including the media, policy makers, and all those who serve children as well as survivors of childhood trauma and their families. One of the major vehicles through which the NRC distributes this information is the Network Web site – [www.NCTSNet.org](http://www.NCTSNet.org). The Web site reopened with a new design on April 1. Use of the Web site is tracked using WebTrends software.

### Web Site Use

In this quarter, the first quarter since the launch of the redesigned Web site, 4,850 unique individuals visited the Web site a total of 13,834 times; 30 percent visited more than once. Ninety-five percent of visits were for one minute or less. Visitors generated 6,402 page views – an average of 1.32 per visitor. Page views are the number of unique pages a visitor views.



### File Downloads

The most frequently downloaded document this quarter was the pdf file “Talking to Children about War and Terrorism”. It was downloaded on 451 visits. The second most frequently downloaded document was the “Reading List: Interventions for Child Maltreatment”. It was downloaded on 40 visits.

Document	No. Visits File was Downloaded
“Talking to Children about War and Terrorism”*	451
“Reading List: Interventions for Child Maltreatment”*	40
“Reading List: General Child Traumatic Stress”*	37
“Short- and Long-Term Consequences of Adolescent Victimization”	30
“In the Wake of Child Maltreatment”	30
“Effectiveness of Insurance Coverage and Federal Programs for Children Who Have Experienced Trauma”	21
“Children and Mental Health”	17
“Trauma/Grief-Focused Group Psychotherapy Program” *	13
“Mental Health: Culture, Race, and Ethnicity”	7

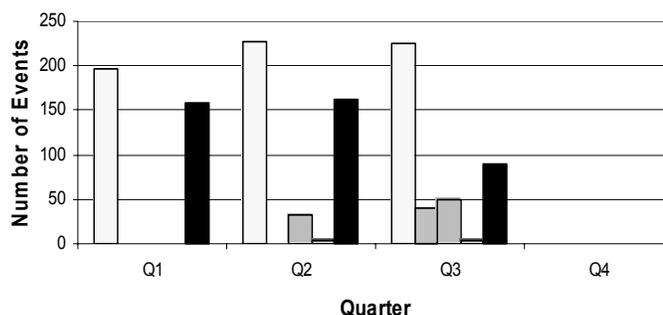
\*National Network publications

## II. Public Awareness

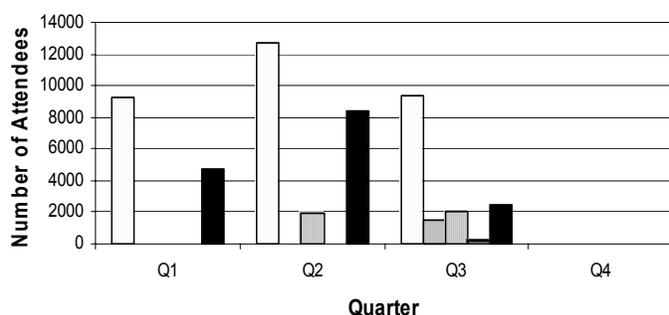
### Events

A total of 307 public awareness events were reported this quarter compared to 422 the prior quarter. Approximately half (225) of these events provided general information about the cause and nature of child traumatic stress. Other topics included terrorism and war (49 events), traumatic grief (41 events), and natural or man-made disasters (3).

Number of Public Awareness Events



Attendance at Public Awareness Events



□ Education □ Traumatic grief □ Terrorism ■ Disasters ■ Other

### Attendance

Network public awareness events were attended by a total of 15,662 people, bringing attendance for the year to 54,656. In the current quarter, public awareness events on the topic of terrorism and war were attended by 1,999 people. Events on traumatic grief were attended by 1,539 people.

□ Education □ Traumatic grief □ Terrorism ■ Disaster ■ Other

### Categories of Attendees

Centers report categories of people who attended public awareness events. As shown in the table below, two-thirds of centers (66 percent) conducted a public awareness event providing general education on traumatic stress that was attended by mental health professionals. Almost half (47 percent) of all Network centers held similar events attended

	General CTS		Terrorism/War		Natural/Man-made Disaster		Traumatic Bereavement		Other	
	Number	%	Number	%	Number	%	Number	%	Number	%
Mental health professionals	25	68	9	24	1	3	9	24	19	50
Child welfare workers	18	49	3	8	1	3	1	3	6	16
School personnel	18	49	4	11	1	3	2	5	5	13
Health care professionals	15	38	6	16	1	3	5	13	9	24
Parents	14	37	2	5	0	0	0	0	1	3
Child care workers	13	34	3	8	1	3	2	5	4	11
Law enforcement/juvenile justice	12	32	5	13	0	0	2	5	4	11
Domestic violence shelter staff	9	24	0	0	1	3	1	3	0	0
Faith Based	8	21	1	3	0	0	0	0	5	13
Consumers	6	16	1	3	1	3	0	0	0	0
Government	6	16	3	8	0	0	1	3	4	11
Fire/emergency	1	3	2	5	0	0	0	0	6	16
Other	8	21	2	5	1	3	0	0	0	0

welfare and school professionals, and one-third (32 to 39 percent) reported education events attended by professionals from health care, child care, the legal system, and parents.

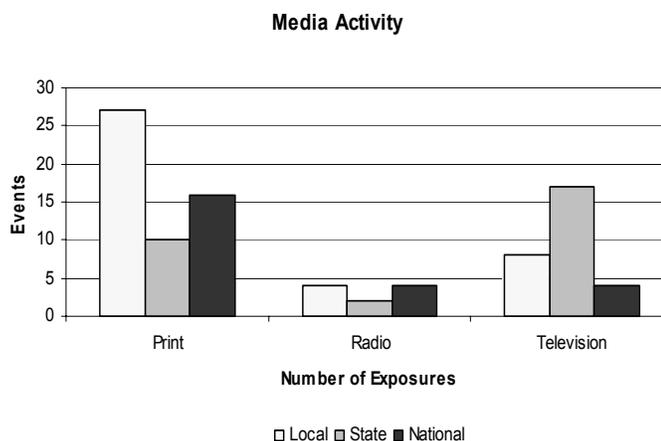
### III. Outreach Activities

In addition to the more structured activities to reach people with information about traumatic stress discussed so far, Network centers also reach out to a wide range of individuals and organizations in other ways such as face-to-face meetings with members of key local, state, and national organizations. Ninety-eight percent of Network centers were involved in these types of activities last quarter. The table to the right shows that centers are most often engaging groups in the health care, domestic violence, and legal system.

Outreach Activities		
System/Organization	No. Centers	%
Health Care	25	68
Domestic Violence Shelters	19	51
Legal System	16	43
Child Care	14	38
Schools	14	38
Other	14	38
Mental Health	13	35
Fire/Emergency Services	10	27
Consumer Organizations	9	24
Faith-based Organizations	9	24
Child Welfare System	7	19
Parent/Family Organizations	6	16
Government	6	16
Public	6	16

### IV. Media Activity

Eighteen centers (49 percent) reported a total of 92 media events this quarter. The most common were articles in local print media (27) followed by state-level television broadcasts (17) and national print media (16).



### V. Progress Increasing Public Awareness

- In response to requests from Clearwater, FL, police and the Pinellas Safe Start initiative, **Directions in Mental Health** developed written information about the impact of trauma on children and local and national resources. This was developed in conjunction with **Yale University Childhood Violent Trauma Center**. Most of the printing costs will be borne by Safe Start.
- **Allegheny General Hospital Center for Child Abuse and Traumatic Loss**, Pittsburgh, sponsored an all-day conference in which Network members from three New York Centers – **Safe Horizon-Saint Vincent’s Child Trauma Care Continuum**, **Jewish Board of Family and Children’s Services**, and **North Shore University Hospital Adolescent Trauma Treatment Development Center** – presented information on the effects of trauma on the self, and on adolescents as parents of infant and toddlers. Other Network members participated in a panel discussion on program and policy development relative to adolescents.
- Staff from **Miller Children’s Abuse and Violence Intervention Center**, Long Beach, CA, participated in a community mental health special event with state assembly members to discuss community needs and resources.

- Demand continues to be high for the play “Children of War” which was developed by the **International C.H.I.L.D. Center for Multicultural Human Services** in Falls Church, VA to educate the public about the impact war, displacement, and abuse have on children and to explore the therapeutic value of using trauma narratives as part of the healing process. This quarter, the play was presented to audiences at World Refugee Day in Washington, DC, and at the Nathan Cummings and Ford Foundations in New York City. International C.H.I.L.D. also produced two manuals – one for school staff and one for parents – to help them understand how to recognize and respond effectively to the mental health needs of refugee and immigrant children who are exposed to events of terrorism and related trauma (such as the events of 9-11).
- The Center for **Medical and Refugee Trauma**, Boston University Medical Center, conducted workshops with school-aged students on how to cope with the aftermath of 9-11 stress and issues related to interpersonal and domestic violence. They also provided information to teachers from Boston Public Schools and health care professionals about ways to help children cope with trauma as a result of interpersonal violence, domestic violence, and other disasters.
- **Children’s Hospital of Philadelphia** influenced the *Journal of Pediatric Psychology* to publish a special issue focusing on traumatic stress related to pediatric illness, injury, medical procedures, or medical emergencies.
- The National Center’s **Terrorism and Disaster Branch** assisted the University of Oklahoma Health Sciences Center, College of Public Health, Southwest Center for Terrorism Preparedness in preparing a supplemental funding request to their CDC grant to provide preliminary work in developing terrorism preparedness messages related to children. The Terrorism and Disaster Branch also participated on Health and Human Services Secretary Tommy Thompson’s EPC Advisory Board leading to recommendations in the board’s final report on the need for specific strategies for children and families in risk communications.
- Members of the National Center’s **School Crisis and Intervention Unit** contributed to the Institute of Medicine’s report “Preparing for the Psychological Consequences of Terrorism: A Public Health Strategy”. Members also participated in the Center for Governmental Research Round Table on issues of mental health, trauma, and suburban families held in NYC and in a summit on responding to terrorism sponsored by the Oklahoma City National Memorial.
- The National Center’s **Terrorism and Disaster Branch** expanded its linkage program to include contacts at the National Association of State Mental Health Program Directors, the Association of Academic Health Centers, the International Nursing Coalition for Mass Causality Education, NORTHCOM, California Department of Mental Health, LA County Department of Health/Bioterrorism Preparedness Program, and the Center for Disaster Preparedness at the University of Alabama at Birmingham.

## Selected Publications by National Network Members

Abramovitz, R, & Bloom, SL (2003). Creating sanctuary in residential treatment for youth: From the “well-ordered asylum” to a “living-learning environment.” *Psychiatric Quarterly*, 74, 115-118.

Bloom, SL, Bennington-David, M, Farragher, B, McCorkle, D, Nice-Martini, K, & Welbank, K (2003). Multiple opportunities for creating sanctuary. *Psychiatric Quarterly*, 74, 173-190.

Cloitre, M, Stovall-McClough, MR, & Chemtob, CM (in press). Therapeutic alliance, negative mood regulation and treatment outcomes in child abuse related post traumatic stress disorder. *Journal of Consulting and Clinical Psychology*.

Cohen, JA, & Mannarino, AP (in press). Childhood traumatic grief. In K Kendall-Tackett & S Giacomoni (Eds.) *Victimization of Children & Youth*. New York: Civic Research Institute.

- Cohen, JA, Mannarino, AP, & Knudsen, K (under review). One year follow-up of a randomized controlled trial for sexually abused children. *Child Abuse & Neglect*.
- Cohen, JA, Deblinger, E, Mannarino, AP, & Steer, RA (under review). A multisite randomized controlled trial for sexually abused children with PTSD symptoms. *Journal of American Academy of Child & Adolescent Psychiatry*.
- Gabbay, V, Silva, RR, Kringsman, S, Neal, D, & Alonso, CM (2003). The psychiatric effects of 9/11 on an adolescent day hospital population. Proceedings of the Research Colloquium for Junior Investigators, 2003 Annual Meeting of the American Psychiatric Association, Abstract p. 120, San Francisco, CA, May 18, 2003.
- Gabbay, V, Silva, RR, Kringsman, S, Neal, D, Ngai, I, & Alonso, CM (2003). TV exposure and anxiety symptoms in day hospital adolescents post 9/11. Proceedings of the 3<sup>rd</sup> International Congress on Disaster Psychiatry, Abstract p. 62, Washington, DC, April 25, 2003.
- Harvey, MR, Liang, B, Harney, P, & Koenen, KC (2003). A multidimensional approach to the measurement of trauma recovery and resiliency. *Journal of Aggression, Maltreatment and Trauma*, 6, 87-109.
- Madsen, LH, Blitz, LV, McCorkle, D, & Panzer, PG (2003). Sanctuary in a domestic violence shelter: a team approach to healing. *Psychiatric Quarterly*, 74, 155-172.
- Osofsky, J (Ed) (in press). *Young children and trauma: What we know and what we need to know*.
- Panzer, PG, & Bloom, SL (2003). Introduction to special section on Sanctuary principles and practice in clinical settings. *Psychiatric Quarterly*, 74, 115-117.
- Pfefferbaum, B, Sconzo, GM, Flynn, BW, Kearns, L, Doughty, DE, Gurwitch, RH, Nixon, SJ, & Nawaz, S (2003). Case findings and mental health services for children in the aftermath of the Oklahoma City bombing. *Journal of Behavioral Health Services & Research*, 30, 2-15-227.
- Pfefferbaum, RL, Gurwitch, RH, Robertson, MJ, Brandt, EN Jr, & Pfefferbaum, B (2003). Terrorism, the media, and distress in youth: Research implications for prevention and intervention. *The Prevention Researcher*, 10, 14-16.
- Rivard, JC, Bloom, SL, Abramovitz, R, Pasquale, LE, Duncan, M, McCorkle, D & Gelman, A (2003). Assessing the implementation and effects of a trauma-focused intervention for youths in residential treatment. *Psychiatric Quarterly*, 74, 137-154.
- Saltzman, WR, Pynoos, RS, Layne, CM, Steinberg, AM, & Aisenberg, E (2003). School-based trauma and grief intervention for adolescents. *The Prevention Researcher*, 10, 8-11.
- Saxe, G, Vanderbilt, D, & Zuckerman, B (in press). Traumatic stress in injured and ill children. *PTSD Research Quarterly*.
- Saxe, G, et al. (in press). Child stress disorder checklist: A measure of ASD and PTSD. *Journal of the American Child and Adolescent Psychiatry*.
- Saxe, G, Kharasch, S, & Zuckerman, B (in press). Interventions for pain. *Journal of Pediatrics*.
- Silva, R et al. (in press). *Handbook for PTSD in children and adolescents*. Norton Medical Publications.
- Varela, RE, & Vernberg, EM (2003). Developmental perspectives on post-traumatic stress disorder. *The Prevention Researcher*, 10, 4-7.

## **Selected Presentations by National Network Members**

Presentation: "Parenting after Trauma: Clinical Implications", Women's Mental Health Conference, Tulane University Health Sciences Center.

Presentation: "A Comprehensive Program for Abused and Neglected Infants and Toddlers", National Governors Association Health Policy Advisors National Meeting.

Presentation: "Child-Parent Psychotherapy", Children's Hospital, Boston, Massachusetts.

Presentation: "Chicago's Healing Community for Torture Survivors and their Families". National Conference of the Torture Abolition and Survivor Support Coalition.

Presentation: "Effects of Community Violence on the Social, Emotional and Academic Lives of Children". University of Southern California, Department of Educational Psychology and Counseling Lecture Series, Los Angeles, CA, April 2003.

Presentation: "Healing Children Exposed to Violence: A School-Based Program for Traumatized Students". Children's Institute International Forum, Pasadena, CA, April 2003.

Presentation: "Effects of Violence on the Social, Emotional and Academic Lives of Children". All State School Safety Center Directors Meeting, Sponsored by the US Department of Education, Cincinnati, Ohio, June 2003.

# NCCTS OPERATIONS

## I. National Resource Center

The National Resource Center is fully up and running with a new NRC director in place and recruitment underway to fill additional staff positions. Several products developed by Network collaborative groups are ready for editing, formatting/design, and dissemination, and a system is in place to track the completion and dissemination of Network products across the five Functional Cores. Network products that will be disseminated in the upcoming quarter include a detailed report on the Network's response to 9-11, a white paper on refugee trauma, and a series of educational materials on childhood traumatic grief for a variety of audiences. An NCCTS writing team has been formally established to support the efforts of collaborative groups as they begin to develop Network products such as white papers and educational materials

## II. Media Activity

In this past quarter, media stories were developed about Network members' response to pediatric organ transplants and tornados, as well as several letters to editors highlighting the Network and issues related to child traumatic stress connected with the War in Iraq and TOPOFF II. Media messages for the general public have been refined and the NRC has begun tracking media coverage of issues related to child traumatic stress and assisting Network centers in reaching out to their own local media. The overall media strategy as well as media messages for the general public were presented to the NCTSN Steering Committee for its review and approval.

## III. Public Policy

The National Center hired a senior policy advisor with a vital presence in Washington, DC who will help to educate key stakeholders regarding the National Network and its accomplishments. The policy advisor has been participating in important coalition meetings and is reaching out to national stakeholder groups concerned with children, families, and mental health. She is advising and assisting the National Center in exploring potential partnerships with other federal agencies, including the CDC and NIMH, and serves as a central figure in the Network's Policy Core.

## IV. Monitoring and Evaluation

In this quarter, an RFP was circulated seeking a third-party partner to evaluate aspects of the Network. Proposals from six applicants were received and reviewed. Abt Associates was selected from among the six applicants to assist in evaluating various aspects of National Center operations and outcomes.

## APPENDIX A NCTSN BACKGROUND

Created in 2001, the NCTSN is an extraordinary national program specifically designed to provide a structure where the academic best practices of the clinical research community are blended with the wisdom and skills of front-line community services providers to help children who have experienced trauma. The Network allows leaders in the field of child traumatic stress to work collectively and individually across disciplines and settings to effect sustainable improvements in the quality and availability of services for traumatized youth and their families.

The Network was created through a series of cooperative agreements awarded to three categories of organizations by the U.S. Department of Health and Human Services through Substance Abuse and Mental Health Services Administration under the auspices of the Center for Mental Health Services. Centers received their initial funding at three different points in time beginning in September 2001.

	Initial Funding for NCTSN Centers			
	Sep 2001 No. Centers	Jul 2002 No. Centers	Sep 2002 No. Centers	Total No. Centers
Category I	1			1
Category II	5	2	3	10
Category III	12	4	10	26

### Category I Centers – The National Center for Child Traumatic Stress

Designated to lead the NCTSN as the National Center for Child Traumatic Stress, UCLA and Duke University have individually and collectively provided leadership in the developmental understanding of child traumatic stress, pioneered evaluation and treatments of children, families, and communities, and are at the forefront in developing public mental health strategies to reach the large population of children, families, and communities affected by traumatic events. These two learning institutions, through their medical schools and departments of psychiatry, jointly provide leadership and support for the day-to-day operations of the Network.

### Category II Centers – Intervention Development and Evaluation Programs

By funding the Intervention Development and Evaluation Programs (Category II centers) of the NCTSN, the Center for Mental Health Services is funding the establishment or continuation of efforts of centers to identify, support, improve, or develop:

- treatment and service approaches for different types of traumatic events children and adolescents experience;
- developmentally appropriate trauma evaluation and intervention for children and adolescents of all ages;
- identification, assessment, and appropriate treatment and services for youth service providers in mental health, the juvenile justice system, the refugee service system, the child welfare and protective service system, and services for vulnerable children including the disabled.

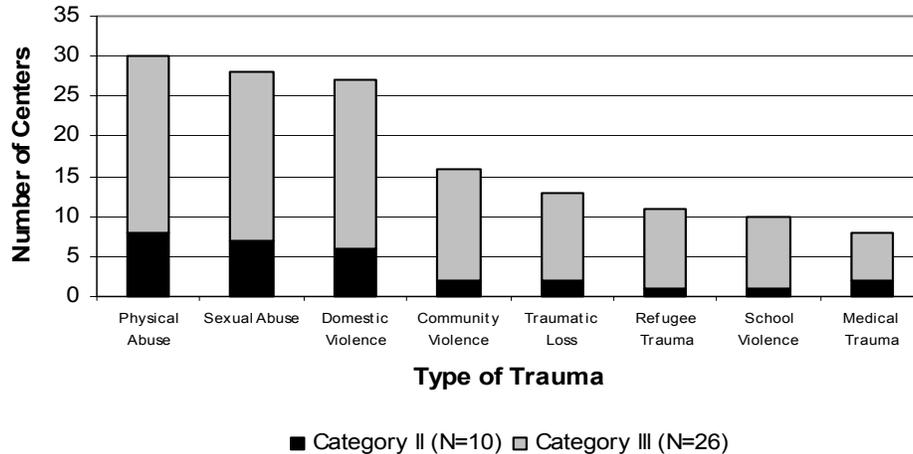
### Category III Centers – Community Treatment and Service Programs

The third category of grantees, Community Treatment and Service Programs, will establish or continue community practice centers where children who have experienced a wide range of traumas and their families receive needed treatment and services. These centers will:

- implement and evaluate effective treatment and services in community settings,
- provide expertise on effective practices, service financing and other service issues, and
- develop and provide leadership and training on child trauma for service providers in a variety of child service sectors (e.g., school, mental health settings, medical settings, etc).

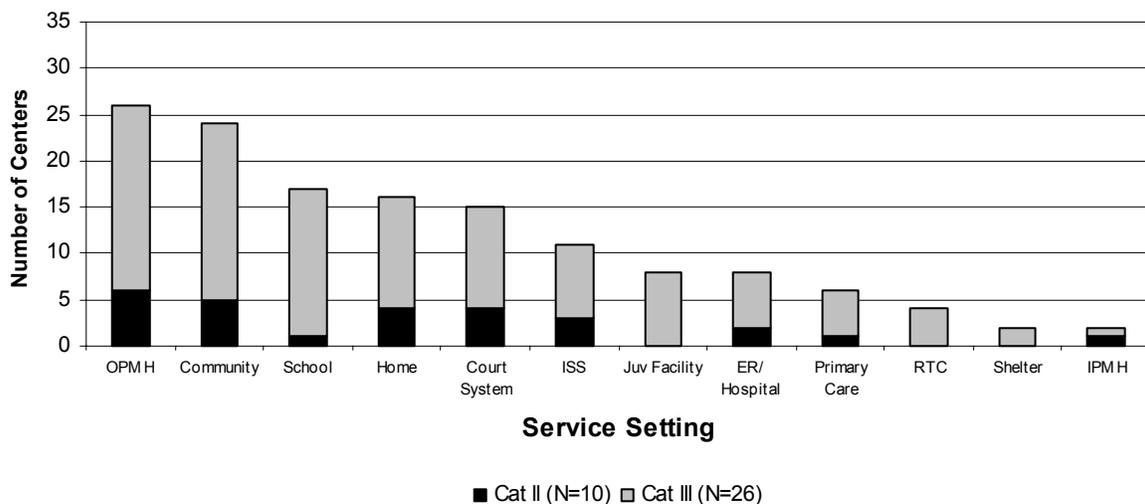
## Types of Trauma Treated by NCTSN Centers

Organizations participating in the NCTSN operate programs that address a wide range of traumas. Although the most common are physical and sexual abuse and domestic violence, NCTSN centers are also addressing the effects on youth of community and school violence, medical trauma, traumatic loss, and the trauma associated with political violence and war.



## Service Settings

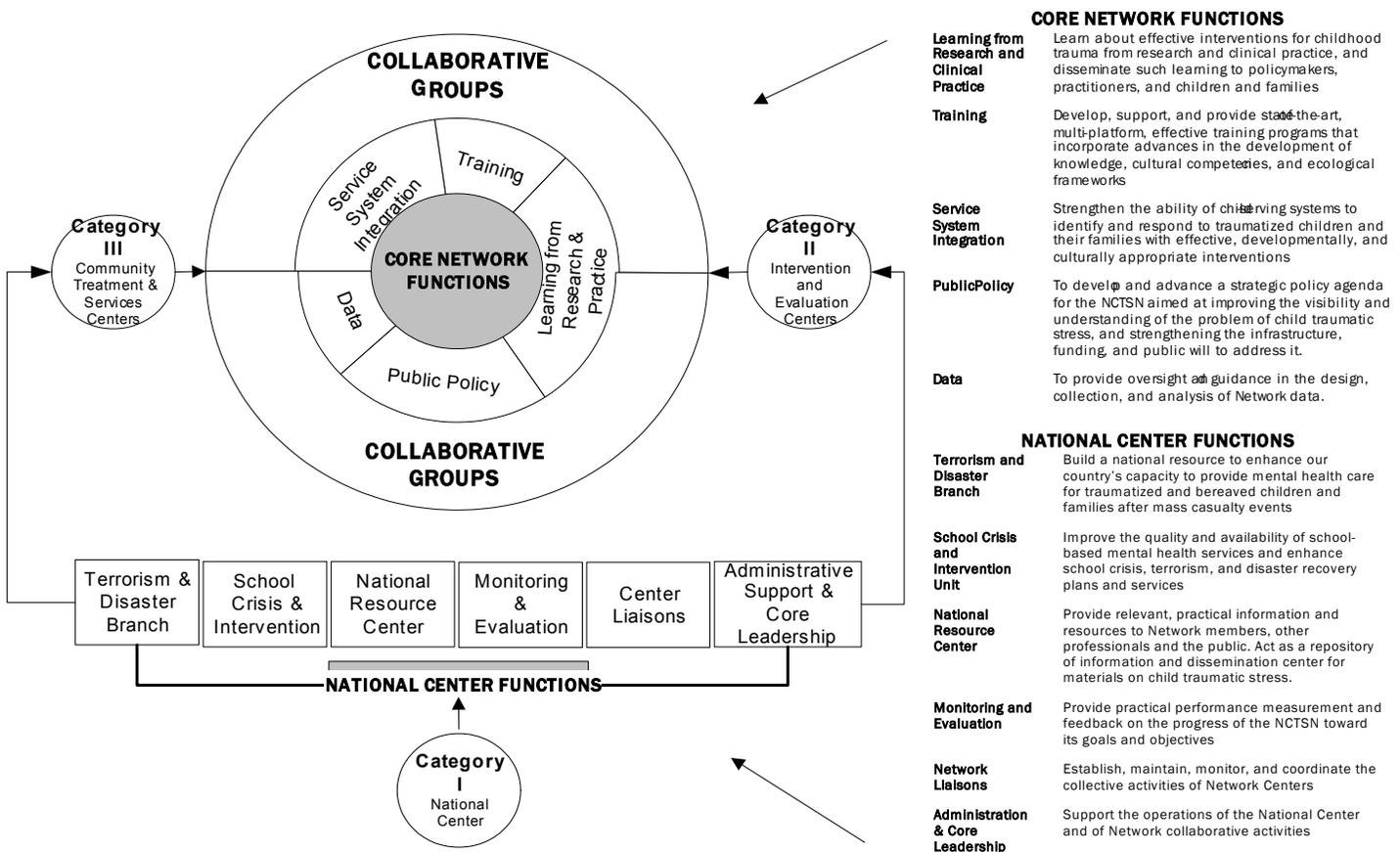
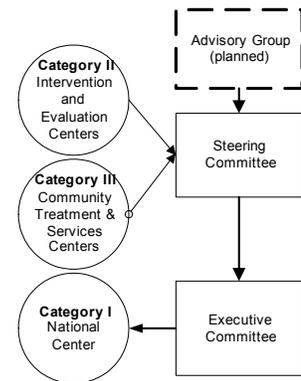
Organizations participating in the NCTSN reach youth and their families in many diverse settings, particularly non-restrictive settings such as outpatient mental health programs and communities, homes, and schools. Children in the court system, juvenile facilities, and medical settings are also served by NCTSN organizations.



OPMH= Outpatient Mental Health, ISS = Integrated Service Setting, Juv Facility = Juvenile Facility, RTC= Residential Treatment Center, IPMH = Inpatient Mental Health

### III. Organization of the National Child Traumatic Stress Network

The Network is lead by a steering committee, an advisory board (planned), and an executive committee. Representatives of Category II and Category III centers serve on the steering committee that assists the executive committee in setting and carrying out Network goals. The executive committee, in turn, is made up of staff from the Category I National Center and has responsibility for assuring the day-to-day support of Network operations. This support takes the form of the six National Center functions: Terrorism and Disaster Branch, School Crisis and Intervention Unit, National Resource Center, Monitoring and Evaluation, Center Liaisons, and Administrative Support and Core Leadership. A key purpose of these functions is to support the collaborative work of Network centers. This collaborative work is organized under the five cores of the National Center: Learning from Research and Clinical Practice, Service System Integration, Public Policy, Training, and Data (see figure below).



## APPENDIX B NCTSN CENTERS

Center Name	Location	Cong. District
<b>Category I National Center for Child Traumatic Stress (NCCTS)</b>		
National Center for Child Traumatic Stress – UCLA	Los Angeles, CA	29
National Center for Child Traumatic Stress – Duke University	Durham, NC	4
<b>Category II Implementation and Evaluation Centers</b>		
Allegheny General Hospital Center for Child Abuse and Traumatic Loss	Pittsburgh, PA	14
Center for Medical and Refugee Trauma, Boston University Medical Center	Boston, MA	9
Child Abuse Trauma Treatment Replication Center	Cincinnati, OH	1
Childhood Violent Trauma Center	New Haven, CT	3
Children’s Hospital and Health Center	San Diego, CA	49
Children’s Hospital of Philadelphia	Philadelphia, PA	2
Early Trauma Treatment Network	S. Francisco, CA	8
National Children’s Advocacy Center	Huntsville, AL	5
New York University	New York, NY	14
North Shore Univ. Hosp. Adolescent Trauma Treatment Development Center	Manhasset, NY	5
<b>Category III Community Treatment and Services Centers</b>		
Aurora Mental Health Center	Aurora, CO	6
Chicago Health Outreach, Inc.	Chicago, IL	9
Children’s Crisis Treatment Center	Philadelphia, PA	2
Children’s Institute International, Central L.A. Child Trauma Treatment Center	Los Angeles, CA	30
Cullen Center for Children, Adolescents and Families	Toledo, OH	9
Directions for Mental Health, Inc.	Clearwater, FL	9
International C.H.I.L.D. Center for Multicultural Human Services	Falls Church, VA	8
Jewish Board of Family and Children’s Services	New York, NY	14
Kansas City Metropolitan Child Traumatic Stress Center	Kansas City, MO	5
La Clinica del Pueblo, Inc.	Washington, DC	DC
Los Angeles Unified School District	Van Nuys, CA	24
Maine General Medical Center	Augusta, ME	1
Mental Health Corporation of Denver’s Family Trauma Treatment Program	Denver, CO	1
Mental Health Services for Homeless Persons, Inc.	Cleveland, OH	10
Miller Children’s Abuse and Violence Intervention Center	Long Beach, CA	37
Mount Sinai Adolescent Health Center	New York, NY	14
New Mexico Alliance for Children with Traumatic Stress	Sante Fe, NM	3
Oregon Health and Science University	Portland, OR	1
Primary Children’s Medical Center Safe and Healthy Families	Salt Lake City, UT	2
Safe Horizon-Saint Vincent’s Child Trauma Care Continuum	New York, NY	8
The Trauma Center, Massachusetts Mental Health Institute	Allston, MA	8
University of Missouri- St. Louis	St. Louis, MO	1
Westchester County Health Care Corp.	Valhalla, NY	18
William Wendt Center for Loss and Healing	Washington, DC	DC
Harborview Medical Center	Seattle, WA	7
Parson’s Child and Family Center	Albany, NY	21