



Network Performance

July – September 2003

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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, feel isolated and cut off from others, and may develop behavioral and 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 risky and dangerous behavior. These behaviors, which begin in reaction to trauma, can lead to trouble with the legal system or long-term developmental 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 disseminate 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 positive differences in the lives of children. Some of the accomplishments of the Network in this reporting period (July through September 2003) include the following:

- Network centers provided direct clinical services to **more than 10,000 children** who experienced 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.
- Network centers trained **more than 7,000** mental health professionals, teachers, primary care providers, and other professionals to treat or assess child traumatic stress.
- The NCTSN educated **over 11,500 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.
- Twenty-five **NCTSN collaborative groups** are now functioning. By the end of this quarter they were working on 54 different projects related to child traumatic stress.
- All **National Center for Child Traumatic Stress (NCCTS) cores** are now staffed with directors. This will permit more leadership and direction of collaborative groups and facilitate the accelerated projects process.

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. Electronic Data Capture System

The Data Core is in the process of developing an electronic data capture (EDC) system that Network centers will use to submit data using a common set of measures of trauma exposure and functional and clinical outcomes. This data system will allow centers to collect and send data via the Internet. During this quarter, as part of the planning and development process for this project, the Data Core completed a survey of Network centers to determine the resources and training they will need in order to administer core data set measures and electronically submit that data. Survey results indicate that a majority of the 36 centers (61 percent) are already using some form of electronic system for capturing data. A small number of centers currently are not connected to the internet (6 percent) or report having no resources for entering data (14 percent) or no IT support staff to assist in implementing the EDC system (14 percent). Approximately one in four centers (28 percent) indicated that their staff would need basic computer training in addition to training on the electronic data capture system. Training will also be needed by a number of centers on two critical core data set instruments, the UCLA PTSD Reaction Index (47 percent) and the Briere Trauma Symptom Checklist for Children (33 percent)

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 has been submitted to the Duke IRB to officially establish 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 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 was changed to spring 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. These instruments can then be used both to plan individual treatment regimens and to evaluate 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. Within the Network a wide range of projects are underway to develop effective services for traumatized youth. Some of these are being carried out under the auspices of Network collaborative groups operating within the Network's Learning from Research and Clinical Practice Core and Data Core while others are being conducted by individual Network centers.

I. Developing Assessments

An important part of determining the effectiveness of interventions is having instruments (e.g., surveys and questionnaires) that accurately assess the condition being studied. These instruments must be reliable and valid, in general, and effective when used with children and families from diverse ethnic and cultural backgrounds. Accurate assessments enable service providers to recognize the trauma-related needs of children and their families so that they can provide appropriate services. This section reports progress on projects that are underway (1) to develop and test assessment tools, and (2) to use assessment tools in improving treatment.

Progress Developing and Testing Assessment Instruments

- **Heartland International, FACES, Chicago, IL**, plans to translate a shortened form of the University of California Los Angeles Post Traumatic Stress Disorder Reaction Index (UCLA PTSD-RI) into other languages. The evaluation team is working closely with translators to ensure that the measure maintains its validity when translated.
- **Chadwick Center for Children and Families Trauma Counseling Program, San Diego, CA**, is investigating the validity of the Trauma Symptom Checklist for Young Children (TSCYC). At present it has a database containing 925 assessments based on the TSCYC.
- **Center for Pediatric Traumatic Stress, 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. They have completed a review of pertinent literature and other assessment tools, examined and synthesized previous data and information about posttraumatic stress assessment from their center, and developed and evaluated specific domains for assessment for these measures.
- **Children Who Witness Violence, Cleveland, OH**, is working with Case Western Reserve University on research into differences between child and caregiver reports of functioning.
- **New Mexico Alliance for Children with Traumatic Stress, Santa Fe, NM**, met with school-based mental health staff at the Acoma and Laguna To'hajaillee School to develop a PTSD screen for middle and high school age students.
- **NCTSN Medical Trauma Working Group** is evaluating available assessment tools and measures and determining which might be appropriate for use in medical settings.
- Project TAMAA staff of the **Children's Crisis Treatment Center in Philadelphia** has 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 involves developing a culturally appropriate screening instrument.

- **The Trauma Center, Massachusetts Mental Health Institute, Allston, MA**, is modifying the Child and Adolescent Needs and Strengths–Trauma Exposure and Adaptation measure (CANS-TEA) for use in various settings. It is also collaborating on the development of a manual on the use of this instrument that includes a training protocol and vignettes.
- **The Los Angeles Unified School District Community Practice Center, Van Nuys, CA**, is developing and refining measures of traumatic symptoms and experiences. It then plans to use these measures to refine its intervention and in evaluation of the intervention in a new community.

Progress Using Assessment Tools to Improve Service Effectiveness

- **Children’s Trauma Consortium of Westchester, Valhalla, NY**, is implementing an organization-wide training program on the use of screening tools that were selected based on a comprehensive review of professional literature. A study protocol has been developed and IRB approval obtained.
- **Chadwick Center for Children and Families Trauma Counseling Program, San Diego, CA**, will test the effect that a clinical pathway model has on the treatment of trauma. This model includes standardized assessment forms, an algorithm for triaging clients presenting for treatment, standardized assessment intake forms, and treatment planning aids that tie treatment goals to possible activities or interventions to meet those goals. The database will generate reports that will allow therapists to receive feedback in an easy-to-read manner.
- **Chadwick Center for Children and Families Trauma Counseling Program, San Diego, CA**, is evaluating the effectiveness of existing assessment practices in order to identify strategies for improving the use of assessments in treatment planning. A two-stage study is underway. In stage one, qualitative interviews are being conducted with clinical staff (i.e., team leaders and therapists) from the five sites that make up the Chadwick Center Trauma Counseling Program. Participants were asked to discuss their general experiences, attitudes, and opinions concerning the use of standardized assessment tools. In the second stage of this study, a paper-and-pencil survey will be administered to all clinical team leaders and therapists.
- **Cullen Center for Children, Adolescents and Families, Toledo, OH**, is conducting a clinical outcomes evaluation of the effectiveness of services. An evaluation logic model and a tool to collect data on clinician therapeutic behaviors have been completed.
- **Mid-Maine Child Trauma Network, Augusta, ME**, plans to pilot a triage assessment model. It has identified relevant literature on triage assessment, continuum of interventions, and outcome evaluation as well as literature on child trauma, resilience, rural mental health issues, and interagency coordination.
- In order to develop more precise treatment protocols, **Miller Children’s Abuse and Violence Intervention Center, Long Beach, CA**, is establishing a system and protocols for collecting assessment data that is age- and trauma- specific.
- The **NCTSN Medical Trauma Working Group** is developing a clinical pathway for assessing and treating medical traumatic stress.
- 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 is nearly completed on a database to store collected data from these assessments. This database will code, score, and print out clinical information from multiple measures on child and parent trauma history as well as their current functional status.

- **Wasatch Canyons Child Trauma Treatment Network, UT**, is developing a Continuous Quality Improvement process to identify evidence-based practices. Members are being trained in the use of objective assessment data to guide planning and treatment. A written protocol for objective assessment has been developed and sent to all team leaders. IRB approval has been obtained.

II. Developing and Testing New Interventions

This section reports the progress Network centers are making in developing evidence-based treatment models using studies of the effectiveness of new and existing interventions in treating trauma. There are a number of steps involved in developing and testing interventions. These include designing an intervention for a particular need or problem based on the best available information about the needs of the youth involved and the effectiveness of practices others have previously used with the same or similar populations, developing materials or training methods to teach people how to carry out the intervention, devising measures to tell if the intervention is being used as intended, testing the feasibility of implementing the practice in real-world settings, and evaluating the effectiveness of the intervention.

- The **Center for Medical and Refugee Trauma, Boston University Medical Center**, is developing the Neurons to Neighborhoods model for treating child traumatic stress among inner city children. This intervention was designed based on the Institute of Medicine's Neurons to Neighborhoods report. A curriculum has been developed and used to train clinical staff in this intervention. This center is also developing an intervention to be used with youth who are refugees from Sudan that uses testimonials to address the effects of trauma. Focus groups were conducted to ensure the applicability of testimonials for Sudanese youth and helpful materials were obtained from other Network centers that are also working with refugees. A manual, "Testimonial Psychotherapy with Young Refugees," has been completed.
- **Heartland International, FACES, Chicago, IL**, is developing an intervention for students in Chicago who are refugees. This intervention is intended to prevent the onset of trauma-related disorders, to introduce resources to staff and students who need them, and to identify students in need of individualized mental health services. Students are engaged through expressive therapies. Thus far, services have been provided in three distinct school environments: a school-based health center, a center for refugee students, and an English as Second Language classroom.
- **Children's Crisis Treatment Center, Project Tamaa, Philadelphia**, is developing a school-based intervention for West African refugee children at Tilden Middle School. Staff worked with West African community leaders and school personnel to establish children's therapy and support groups along with education and support groups for the children's caregivers. They also developed a curriculum to be used in seminars for teachers working with West African refugee children.
- **Chadwick Center for Children and Families Trauma Counseling Program, San Diego, CA**, is awaiting IRB approval to study an intervention designed to prepare children and their caregivers to testify in court via court visits and role play of a trial.
- **Children's Institute International, Central L.A Child Trauma Treatment Center**, developed and tested a group intervention for children affected by domestic violence and their mothers. Curricula have been developed that are appropriate for four different stages of child development. Each includes modules focusing on 11 specific topics. Data were collected on first-year participants and are being used to improve these curricula.
- **Healing the Hurt, Directions for Mental Health, Inc., Clearwater, FL**, is developing a treatment for bereaved youth and another for child sexual abuse. Treatment manuals have been developed and data are currently being collected on the effectiveness of these treatments.
- The **Early Trauma Treatment Network** developed the treatment manual, "Losing a Parent to Death in the Early Years," that outlines the treatment for traumatic bereavement in infancy and early childhood.

The manual will be published as a book by the Zero to Three Press, the publishing arm of the Zero to Three, National Center for Infants, Toddlers and Families.

- **Harborview Center for Sexual Assault and Traumatic Stress, Seattle, WA**, developed a protocol for responding to potentially traumatic incidents with multiple victims. This protocol calls for organizing a coordinated response to the needs of victims as well as responding to community concerns. It has been used in two situations of possible abuse of children at day care centers/preschools.
- **International C.H.I.L.D. Center for Multicultural Human Services, Falls Church, VA**, is developing tutoring and therapeutic school-based interventions to improve grades and responsible decision-making among children who are refugees from Sierra Leone. Pre-intervention assessments were conducted and data collected on 37 children attending this centers' summer program.
- **Jewish Board of Family and Children's Services, NYC**, is developing the Sanctuary model, an intervention for youth in residential programs. The aim of this treatment model is to create and maintain a nonviolent, democratic, therapeutic community in residential programs for youth. Personnel at an alternative learning school were trained in this model, and now the model is also being implemented at two other treatment sites.
- **New Mexico Alliance for Children with Traumatic Stress, Santa Fe, NM**, developed a year-long plan for implementing the To'hajillie School PTSD Project.
- **North Shore University Hospital Adolescent Trauma Treatment Development Center, Manhasset, NY**, is piloting a treatment project for traumatized adolescent girls in a school program for teen parents. Pre- and post-intervention data were collected on the first 12 adolescents who received this treatment. Two additional Network centers are also actively using this intervention. This center is also developing a peer education project. A manual for this intervention has been developed and piloted. Ninety peer educators from 16 schools have been trained.
- **The Trauma Center, Massachusetts Mental Health Institute, Allston, MA**, is developing a community-building group model to be used with children in a community elementary school. Children who received the intervention during the 2002-2003 school year improved in academic functioning and safe behaviors.

III. Adopting and Adapting Treatments

There are some interventions that, according to research evidence, produce favorable clinical and behavioral outcomes. When providers select these treatments, they are adopting them. In some cases, however, research may show that an intervention is effective but its effectiveness may not yet have been tested for children with the characteristics or problems that a provider is treating. For example, a provider may find that there is an intervention that has been tested with teenagers, but that it has not been used with preschoolers, or an intervention that was used in mental health settings but that has not been tested in school settings. When providers use interventions that have been tested, but modify them for a new group of children, different problem, or new setting, they are adapting a treatment.

Network centers are currently involved in multiple studies of treatment adoption and adaptation. One of the primary treatments being modified by centers for use with traumatized children is trauma focused cognitive behavioral therapy (TF-CBT) but there are others. TF-CBT, formerly Cognitive Behavioral Therapy for Child and Adolescent Traumatic Stress (CBT-CATS), is a treatment intervention designed to help children, youth, and their parents overcome the negative effects of traumatic life events such as child sexual or physical abuse; traumatic loss of a loved one; domestic, school, or community violence; or exposure to disasters, terrorist attacks, or war trauma. It was developed by integrating cognitive and behavioral interventions with traditional child abuse therapies, in order to focus on enhancing children's interpersonal trust and re-empowerment. TF-

CBT can be provided to children 3 to 18 years old, and their parents, by trained mental health professionals in individual, family, and group sessions in outpatient settings.

Cognitive Behavioral Treatment

- **Allegheny General Hospital Center for Child Abuse and Traumatic Loss, Pittsburgh, PA**, is testing the effectiveness of Trauma-Focused CBT (TF-CBT) for children who have been sexually abused. To date, 38 children have been enrolled in the study and eight have completed treatment. They are also studying the effects of TF-CBT combined with SSRI medication. **Aurora Mental Health Center, Aurora, CO**, is adopting the Allegheny TF-CBT model. Staff at Aurora have been trained in this model and are implementing the treatment in a variety of formats. Several children have completed the entire treatment protocol and more are enrolled in this study.
- **Cullen Center for Children, Adolescents and Families, Toledo, OH**, continues to receive clinical case consultation and support to implement Allegheny's TF-CBT model.
- **Healing the Hurt, Directions in Mental Health, Inc., Clearwater, FL**, is working with Allegheny General Hospital Center on plans to adopt TF-CBT. The Directions staff who will participate in this project were trained in August, 2003. Data are currently being collected on the effectiveness of this intervention.
- 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 TF-CBT. Project Liberty phase down will be making referrals to this study.
- **Early Trauma Treatment Network** members from Tulane University developed a manual for treating young children with PTSD using cognitive behavioral treatment. Tulane is currently piloting its manual, "Preschool PTSD Treatment," with four children exposed to domestic violence.
- **Harborview Center for Sexual Assault and Traumatic Stress, Seattle, WA**, is collaborating with the Asian Counseling and Referral Service and a Seattle School District middle school to implement Cognitive Behavioral Intervention for Trauma in Schools.
- **The Los Angeles Unified School District Community Practice Center, Van Nuys, CA**, is studying the effectiveness of a Cognitive Behavioral Intervention for Trauma in Schools. Focus groups with community leaders, parent leaders, and English- and Spanish- speaking parents provided feedback that LAUSD expects will improve the utilization and effectiveness of this model. School-based and community clinicians have been trained in the intervention.
- **Wasatch Canyons Child Trauma Treatment Network, UT**, is studying the effectiveness of TF-CBT versus usual care.
- The STAIR treatment model is a trauma-focused model of cognitive behavioral therapy being developed by the **Child and Adolescent Treatment Services Consortium at New York University** in collaboration with the **Jewish Board of Family and Children's Services, NYC**. Jewish Board will test the effectiveness of this model with adolescent girls' at the Montague day treatment program.

Others

- **Aurora Mental Health Center, Aurora, CO**, is adapting biofeedback methods to improve the ability of children who have experienced trauma to control their emotions and physical reactions. Children are trained to increase the temperature in their hands, which increases relaxation and decreases anxiety and anger. Several children have been successfully trained thus far, and additional staff members are being taught to use these methods.

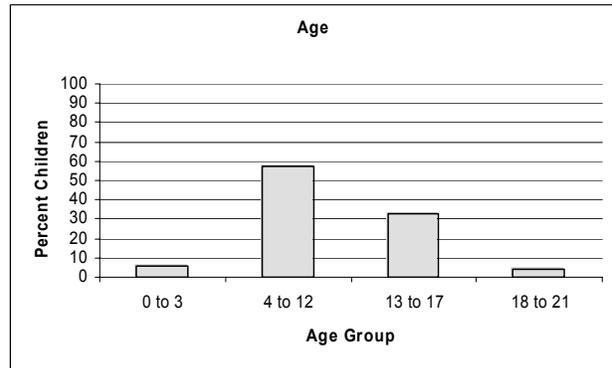
- Child-Parent Psychotherapy manuals have been distributed to over half of the Network centers. **The Early Trauma Treatment Network** is conducting a multisite study of the effectiveness of this treatment. Staff at **Healing the Hurt, Directions in Mental Health, Inc., Clearwater, FL**, and the **Wasatch Canyons Child Trauma Treatment Network in Utah** will be trained in this intervention.
- **The Trauma Center, Massachusetts Mental Health Institute, Allston, MA**, researched, designed, and implemented a 12-session threat and terror stress inoculation program in the metro Boston primary and secondary school systems. This model, Classroom-Based Intervention, for youth who have experienced trauma and loss, has been piloted in other countries following disasters. It consists of developmentally specific psycho-educational, cognitive behavioral, and expressive therapy interventions to help children ages 6 to 12 and their teachers explore definitions, understanding, and inoculation of the processes of threat and terrorism. Approximately 146 children received this intervention. Pre- and post intervention measures were collected to establish the efficacy of this model.
- 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 abilities of these young people. Evaluation shows that there has been a reduction in incidents of aggressive behavior.
- **Chadwick Center for Children and Families Trauma Counseling Program, San Diego, CA**, is using Parent Child Interaction Therapy (PCIT) to treat the effects of physical abuse and domestic violence.
- **Wasatch Canyons Child Trauma Treatment Network, UT**, has plans to implement PCIT.
- **Child Abuse Trauma Treatment Replication Center, Cincinnati, OH**, is using the Hembree-Kigin & McNeil PCIT manual to train providers. As of this quarter, 16 clinicians from four local agencies and two clinicians from **Healing the Hurt, Directions for Mental Health, Inc, FI**, have been trained and ongoing consultation is being provided to trainees to help them get started using PCIT.
- **Heartland International, FACES, Chicago Health Outreach** developed a parenting and marital issues training curriculum for refugee parents in collaboration with 14 other refugee and immigrant social services agencies.
- **The Trauma Center, Massachusetts Mental Health Institute, Allston, MA**, completed the outline for a parent education manual specific to traumatized children.
- **Safe Horizon-Saint Vincent's Child Trauma Care Initiative, NYC**, developed a trauma-specific model for the PEARLS (People Empowered to Address Real Life Situations) violence prevention curriculum. This curriculum was used in five student health classes of approximately 30 students each in the High School of Economics and Finance overlooking ground zero. Pre and post-test data were collected.
- **The Center for Medical and Refugee Trauma, Boston University Medical Center**, was awarded a grant to test Sertraline as a treatment for acute stress in children.
- **Child Abuse Trauma Treatment Replication Center, Cincinnati, OH**, received a \$2.5 million grant from NICHD to support replication of the Therapeutic Interagency Preschool model for children who are identified cases of child abuse and neglect in two counties. This model has been replicated three times in the past.

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 reported to SAMHSA on a quarterly basis via the Service Utilization and Quarterly Report Forms.

I. Demographic Characteristics of Children Served by NCTSN Centers¹

Approximately 57 percent of children served by Network centers in the past quarter 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).



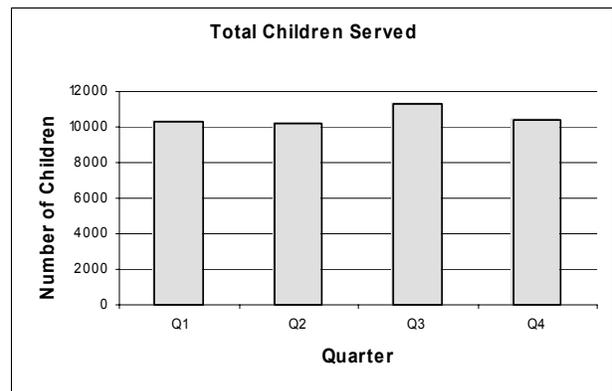
Ethnicity	% Children
Hispanic	33
Other	67
Race	% Children
White	60
Black	32
Multiracial	7
Asian	1
American Indian	1
Pacific Islander	<1

Ethnicity and race are reported separately in the table to the left. With respect to ethnicity, approximately one-third (33 percent) of children receiving services from the National Network are Hispanic. Within categories of race, slightly less than two-thirds are white (60 percent), one-third African American (32 percent), with the remainder distributed over other racial groups.

II.

Direct Clinical Services

Network centers provided services to approximately 10,362 children in the current quarter, bringing the total for this fiscal year to approximately 42,046². 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.

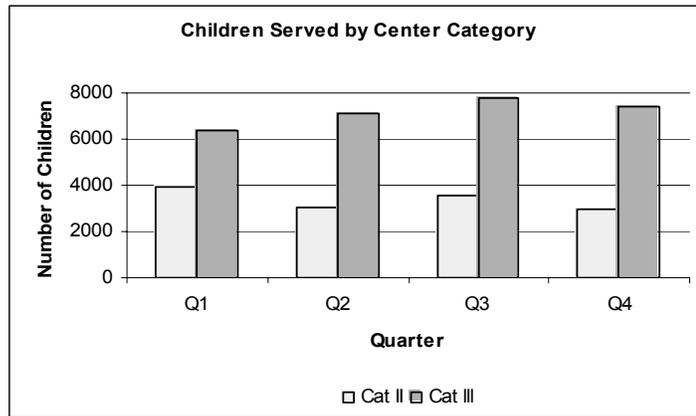


¹ It is not always possible for centers to report data in a way that is consistent across all centers. Consequently, this demographic information is based on the reporting of a subset of approximately 75 percent of the centers who were able to report these data using the categories requested on the Service Utilization Form.

² Each center is asked to provide an unduplicated count of children served during the quarter (meaning, that a child is counted only once regardless of the number of sessions or visits to the setting.). However, if the same child receives services in a subsequent quarter, the child is also included in the count for that subsequent quarter. Hence, the data provides unduplicated counts of children served within a quarter but not across quarters.

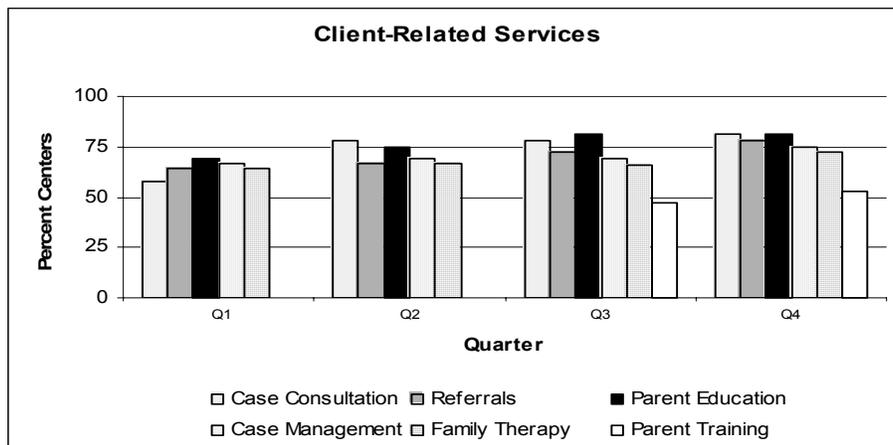
Direct Clinical Services by Center Category

Not surprisingly, Category III Community Treatment and Services Centers reported serving a greater number of children than did Category II Development and Evaluation Centers. The 26 Category III centers served a total of 7,378 children during this quarter while the 10 Category II centers reported serving 2,984 children, about 29 percent of all children served.³



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. The table below shows the percentage of Network centers that provide these types of services. Both this quarter, and over the course of the current fiscal year, there were increases in the number of centers reporting each of these services. The largest increases were in the number of centers providing case consultation (40 percent increase) and referrals (21 percent increase).



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. 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.

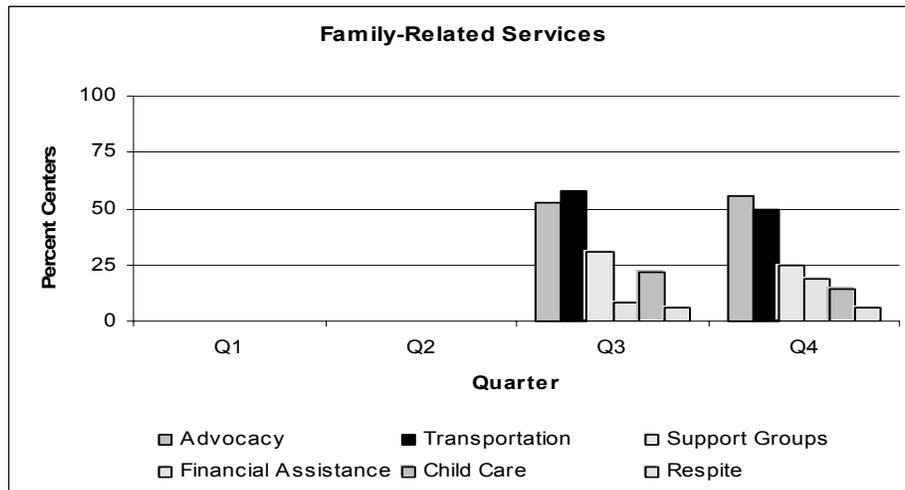
Family Therapy Planned therapeutic sessions involving the client and other family members.

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 the Q3 reporting period.

³ Based on 29 centers reporting information on services in Q1, 35 in Q2, 36 in Q3, and 35 in Q4.

IV. Family-Related Services

Network centers also sometimes provide services such as childcare, financial assistance, and transportation to family members. These services are not treatment, per se, but services that are needed to enable families to participate in treatment or cope effectively with problems their children are experiencing. Compared to the previous quarter, there was an increase in the percentage of centers reporting they provided advocacy and financial assistance and a decline in the percentage reporting they provided transportation, support groups, and childcare.



Transportation	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.
Advocacy	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.
Support Groups	Groups attended by parents or other primary caregivers that are not group therapy and which are not counted as parent education or parent training.
Childcare	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.
Financial Assistance	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.
Respite Care	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. Changes 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 have enabled a pre-existing mental health program to add new trauma-focused services for a previously underserved population of children. For the second quarter, centers were asked to report fluctuations in resources, in particular, 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. In the current quarter, 35 Category II and III Network centers provided information on these resources. As shown in the table on the following page, approximately one in four (26 percent) centers reported at least a small increase in staffing in the current quarter. A few centers (6 percent) also reported the addition of satellite facilities, space, and client transportation. Other centers reported decreases in resources; in particular, 18 percent of Network centers reported declines in funding or reimbursement levels and 15 percent reported a drop in staffing.

	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	94	6	0	0
Space	0	0	6	89	6	0	0
Client transportation	0	3	3	89	6	0	0
Funding	3	6	9	80	0	3	0
Staffing	3	3	9	63	20	3	3

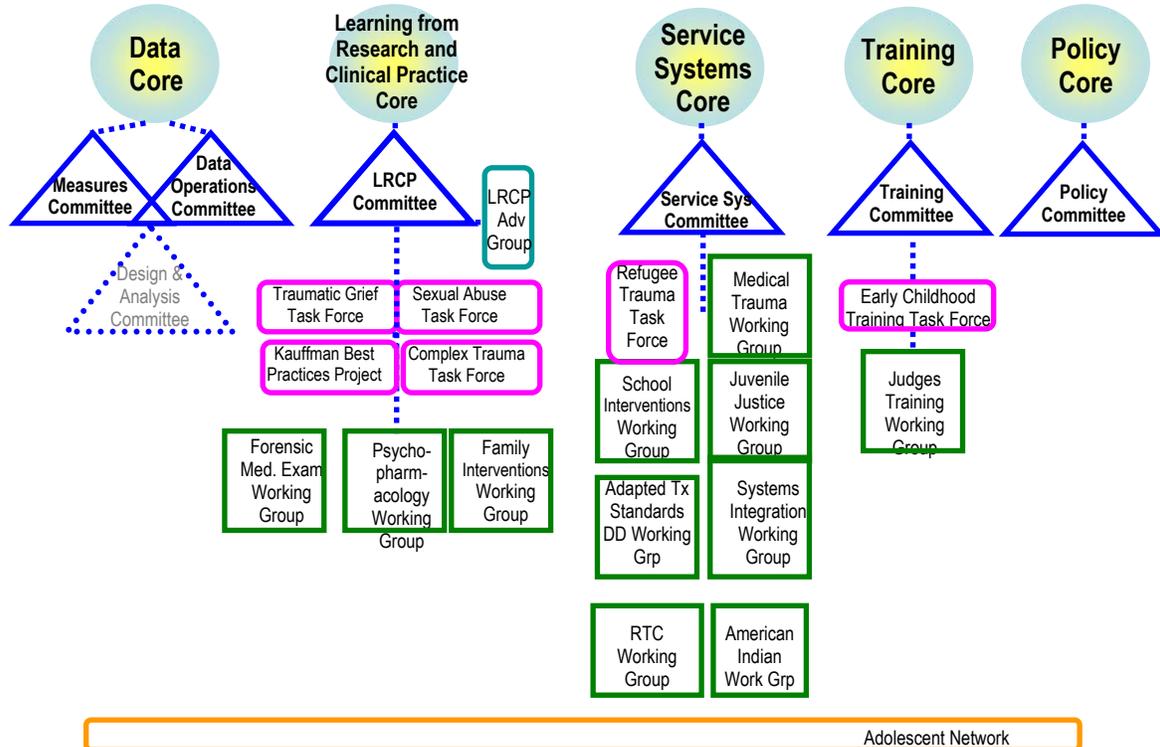
VI. Progress Improving the Availability of Services

- The **National Center's Terrorism and Disaster Branch (TDB)** launched the School and Family Preparedness Initiative in memory of the children and families impacted by terrorism on September 11, 2001. In the weeks surrounding the anniversary of 9/11, Network Centers met with 25 school districts nationwide to assist them in crisis and disaster planning. This initiative included several activities aimed at preparing schools and families in case of large-scale traumatic events. Activities included the distribution of school preparedness checklists, family preparedness wallet cards and guides, talking points for the media, and ongoing consultation with schools.
- **Project TAMAA, Children's Crisis Treatment Center, Philadelphia, PA**, is working with the Tilden Middle School to provide services to children who are refugees from West Africa. During the summer, 10 West African children participated in a therapy and support group.
- **La Clinica de Pueblo, Washington, DC**, continues to host Saturday support groups that teach stress management. These support groups are highly regarded by the parents participating in the groups.
- The **Early Trauma Treatment Network** received a grant to fund the Louisiana Rural Trauma Services Center. This grant will provide education for mental health workers and services for traumatized children and adolescents in 3 rural parishes in Louisiana.
- **North Shore University Hospital, Adolescent Trauma Treatment Development Center, Manhasset, NY**, became involved in helping a school district on Long Island where three adolescent boys on the football team had been severely sexually assaulted by teammates. This center's co director met with administrators from the school district to discuss the needs of the victims and the school as a whole.

COLLABORATIVE GROUP ACTIVITIES AND ACCOMPLISHMENTS

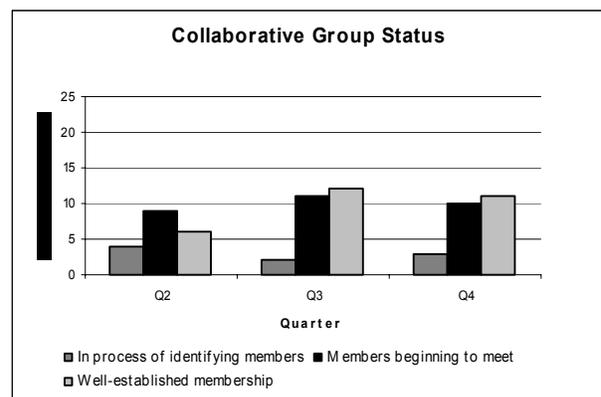
Collaborative groups are a vital mechanism through which members of NCTSN centers exchange and pool their knowledge and experience. It is through these groups that the NCTSN bridges professional affiliations, professional and public concerns, geographic and cultural differences, competition among specialists, and varying agendas to accomplish its goals of improving the availability and quality of services for youth with traumatic stress and their families. This report contains information on the progress of the Network in developing collaborations and the progress made by Network collaborative groups during the period July through September, 2003.

Functional Cores and Associated Collaborative Groups



I. Collaborative Group Status

During the past quarter, directors were hired for three of the five Network functional cores – the training core, service systems core, and policy core – making this quarter the first during which each core had a director. A total of 25 collaborative groups were operating under the five Network functional cores (see figure above) in the past quarter. Eleven of these groups met regularly and were actively working on clearly defined products, 11 were in the process of planning products, and three were identifying members.



II. Collaborative Group Progress

As of the end of the present quarter, the 25 Network collaborative groups were involved in a total of 54 projects. Half (51 percent) of these projects involved developing informational or training products. The other half was distributed between projects to assess the current state of knowledge in a group's areas of concern (19 percent), or with establishing specifics about the needs or problems to be addressed by the group (30 percent).

Focus of Activities	Collaborative Projects
	No. (%) N=54
Education or Training Products	28 (51%)
Reviews of the Field	10 (19%)
Needs Assessments	16 (30%)

Group Products

Of the 28 group projects that involve products, seven (25 percent) are brief informational materials summarizing information on the causes, consequences, and/or treatment of trauma for parents and a wide variety of other audiences. A further seven (25 percent) involve training materials (e.g., curricula or videos) for teaching professionals skills in assessing and treating trauma. Practice guidelines and manuals make up another six (21 percent) of the products. These provide information for professionals on appropriate therapeutic responses for addressing the needs of traumatized youth and their families, but are not generally as detailed or skill-focused as training materials. Additional information about specific collaborative groups and products is located in Appendix C.

Type of Product	Total No. (%)	Planned No.	Stage of Completion	
			In Progress No.	Completed No.
Brief informational materials	7 (25)		2	5
Training materials	7 (25)	1	3	3
Practice guidelines/manuals	6 (21)		4	2
White papers	5 (18)	1	3	1
Books for children	2 (7)	1	1	
Reading lists	1 (4)			1
TOTAL	28 (100)	3	13	12

Brief informational materials – Materials such as fact sheets or information sheets for children, parents, or professionals that provide a brief synopsis of key information about different types of trauma or treatments for trauma.

Training materials – Materials used by professionals to convey skill-based knowledge about assessment or treatment practices. Includes such things as training curricula and videos.

Practice guidelines/manuals – Materials containing information for professionals on appropriate practices for the assessment or treatment of youth who have been traumatized. Generally intended for use in the absence of an expert.

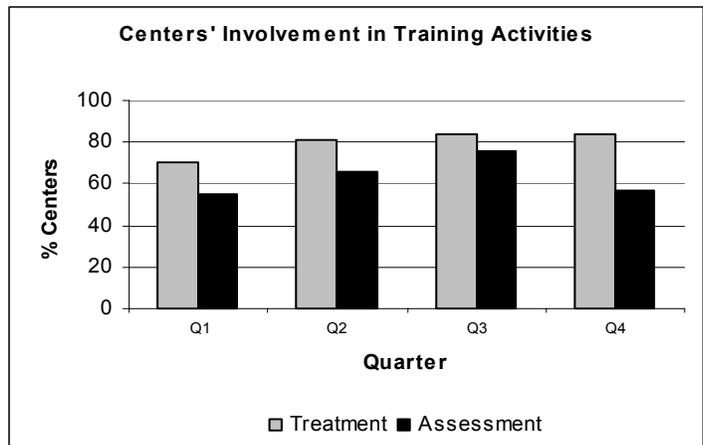
White papers – Relatively lengthy and thorough reviews of the state of knowledge with respect to the etiology, characteristics, prevalence, treatment, and policy issues relevant to a particular type of treatment or population of traumatized youth

TRAINING

During this quarter, Network centers reported reaching 7,307 people with training on the treatment of traumatic stress and 2,160 with training on the assessment of traumatic stress. Over the fiscal year this makes a reported total of 39,233 (duplicated) individuals trained in treatment topics and 15,367 individuals trained in assessment topics.

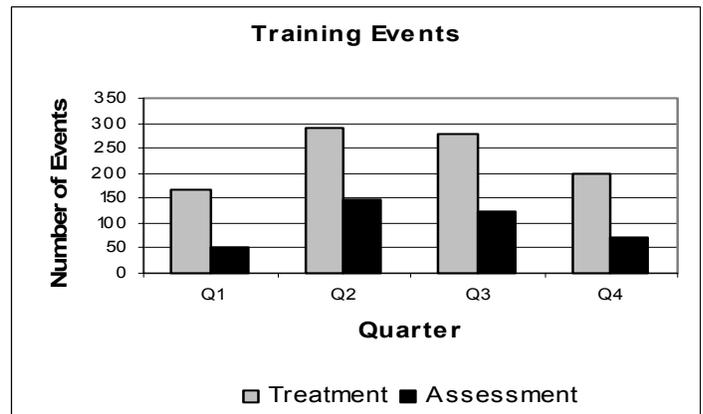
I. Centers' Training Activities

This quarter, as in the previous, 84 percent of Network centers reported conducting training sessions on the *treatment* of traumatic stress. There was a decrease, however, in the percent of centers reporting training activities on the *assessment* of traumatic stress (57 percent in the current quarter compared to 76 percent in the previous quarter).



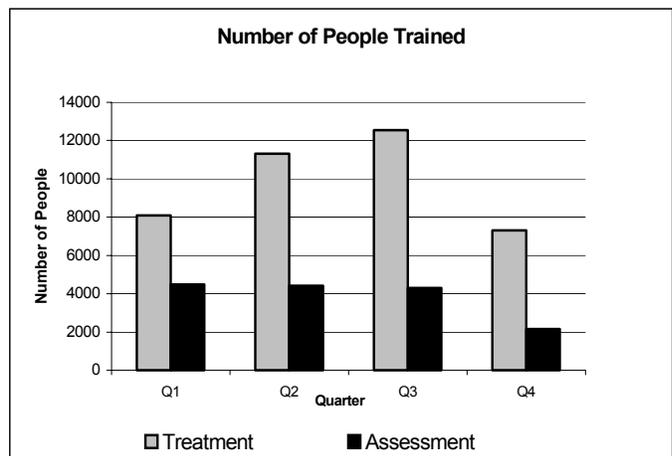
Number of Events

Centers reported a total of 199 training events on the treatment of traumatic stress this quarter, bringing the total for the year to 933. Seventy-two training events focused on the assessment of traumatic stress, bringing the total number of reported trainings on this topic to 432 for the year.



Number of People Trained

As stated above, 7,307 people attended trainings on the treatment of traumatic stress in the current quarter, bringing the total for the year to 39,233. Training events on the assessment of traumatic stress were attended by 2,160 people this quarter, bringing the total number of people attending this of type of training to 15,367 for the year.



Categories of People Trained

Treatment of Traumatic Stress

Approximately four out of five (78 percent) centers trained mental health professionals to treat traumatic stress this past quarter. Compared to the previous quarter, there was an increase in centers training school professionals (43 percent), child welfare workers (41 percent), and health care professionals (43 percent).

	Categories of Trainees			
	Treatment (N=37) % Centers		Assessment (N=37) % Centers	
	Q3	Q4	Q3	Q4
Mental health	81	78	68	49
School professionals	38	43	24	22
Child welfare	35	41	30	14
Health care	35	43	35	30
Legal system	30	11	14	8
Child care	27	30	19	11
Dom. violence shelter staff	22	16	16	5
Parent/family	19	11	3	3
Government	14	8	8	5
Faith-base groups	14	5	0	0
Consumers	11	0	3	0
Fire/emergency personnel	5	0	0	0

Assessment of Traumatic Stress

Approximately one out of two (49 percent) centers trained mental health professionals to assess traumatic stress, a decrease from 68 percent in the previous quarter. There were also declines in the number of centers that trained health care workers (30 percent), child welfare workers (14 percent), legal system personnel (8 percent), and domestic violence shelter staff (5 percent).

II. Progress in Training Activities

- **Aurora Mental Health Center, Aurora, CO**, played a major role in developing a statewide conference on trauma in the lives of children. Three hundred professionals and family members from around Colorado heard presentations from local and Network experts. They also have undertaken significant activities to improve services through specialized training, program innovation, and improved clinical supervision in a variety of areas, including sexual abuse, children with developmental disabilities, biofeedback methods, and services for pre-school and kindergarten children.
- **Children's Institute International, Central L.A Child Trauma Treatment Center**, initiated a series of activities to improve care for traumatized children. Monthly in-service trainings were held on a variety of trauma-related topics such as family violence assessment and treatment, child sexual abuse, and strengths-based integrated approaches to service delivery. Weekly clinical staff meetings are being held to discuss the treatment of specific children, review professional articles, and provide training on specific assessment tools.
- Presenters from seven different Network centers were featured throughout this past year in trainings conducted by **Healing the Hurt, Directions in Mental Health, Clearwater, FL**. A follow-up survey indicates that these trainings influenced how participants' approach treatment and their views on working with traumatized children. An example of the comments of survey respondents is the statement: "I saw the needs of these children in a different light and gained hope for their treatment."
- **Intercultural Child Traumatic Stress Center of Oregon, Portland, OR**, conducted a 30-week Child Trauma Awareness Seminar to educate their staff as well as school counselors, mental health professionals, and social service providers.

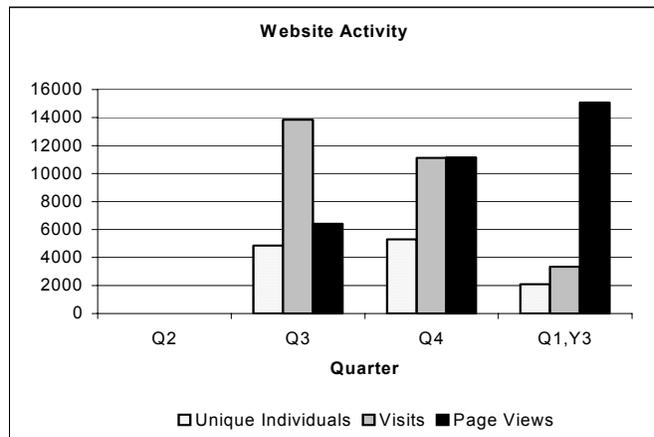
DISSEMINATION OF INFORMATION AND PUBLIC AWARENESS

An important goal of the National Child Traumatic Stress Network is to increase awareness among professionals and members of the public of the causes and prevalence of child traumatic stress. A related goal is to inform them of effective treatments that can help children and their families. During the past quarter, Network centers took part in a special initiative to assist schools nationwide in evaluating and improving their school crisis and disaster plans. Details of this initiative are provided in part V, "Progress Increasing Public Awareness," at the end of this section.

I. Web Site Activity

The National Resource Center 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, which reopened with a new design at the beginning of the previous quarter.

During the current quarter, the terrorism and disaster portion of the Network Web site was enhanced by the addition of new graphics and content. The new content addresses readiness, response, and recovery with respect to specific events such as earthquakes, epidemics, biological terrorism, hurricanes, and tornadoes. New graphics were also developed to depict the various systems children and families might come in contact with in the event of terrorism or disaster. These systems include first responders, health care, government agencies, schools, and the NCTSN.



In this quarter, the second since the launch of the redesigned Web site, 5,290 unique individuals visited over 11,000 times for more than 11,000 page views. In short, there has been an increase in individuals visiting and, though they made fewer visits this quarter, they received more page views.

Top Ten Publication Downloads

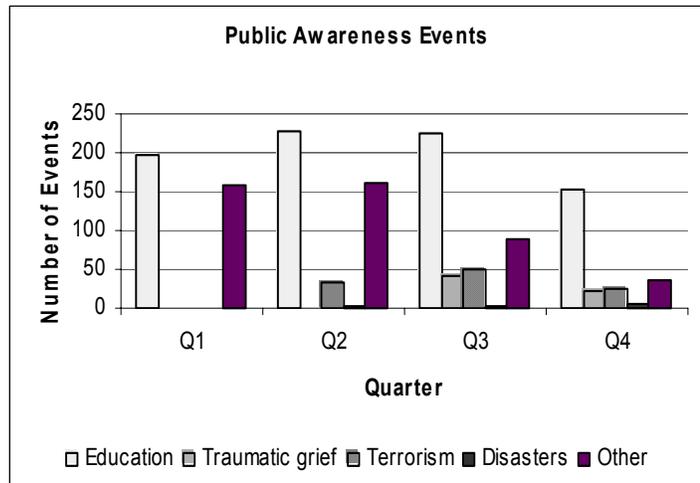
The most frequently downloaded document this quarter was, "Short- and Long-Term Consequences of Adolescent Victimization", downloaded 413 times. "Talking to Children about War and Terrorism" (272 downloads) was the second most downloaded file. It was number one in the previous quarter. Also in the ten most downloaded publications were two reading lists on topics related to child traumatic stress. The most frequently downloaded of these was a reading list on interventions for child traumatic stress.

Document	# Times File was Downloaded
"Short- and Long-Term Consequences of Adolescent Victimization"	413
"Talking to Children about War and Terrorism"*	272
"Effectiveness of Insurance Coverage and Federal Programs for..."	267
"Reading List:: Interventions for Child Traumatic Stress"*	217
Chapter 3 "Children and Mental Health" Surgeon General's Report	197
"In the Wake of Childhood Maltreatment"	197
"Violent Victimization as a Risk Factor for Violent Offending Among ..."	176
"Reading List: General Child Traumatic Stress"*	116
"School Planning for the September 11 th Anniversary"*	96
"Mental Health: Culture, Race, and Ethnicity"	95

* Network publications

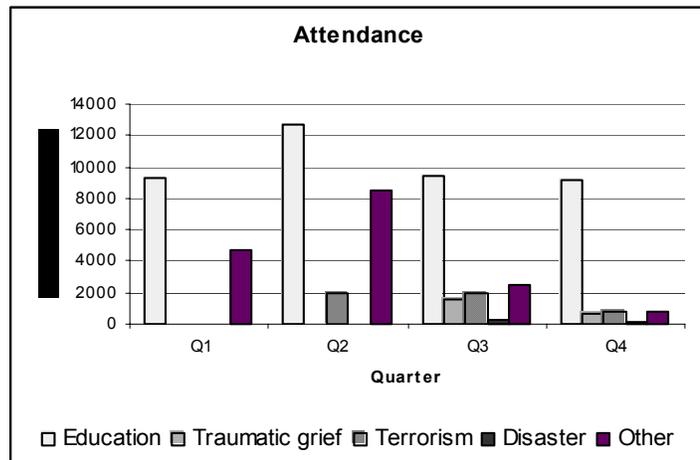
II. Public Awareness Events

A total of 240 public awareness events were reported this quarter, bringing the total for the year to 1,428. The graph to the right shows that the number of public awareness events focusing on traumatic grief, terrorism, natural disasters and general education on traumatic stress fluctuated throughout the year. In all quarters general education on traumatic stress was the most frequent. Events on “other” topics declined over the course of the year. In part, this is due to the addition of new topic categories throughout the year that allowed more precise reporting of activities.



Attendance

Network public awareness events were attended by a total of 11,696 people this quarter, bringing attendance for the year to 64,461. The graph to the right indicates that the number of people attending general education events and events on other related topics peaked in the second quarter (Jan-Mar). Attendance at events on terrorism and traumatic grief showed a decline in the fourth quarter (Jul-Sep).



Categories of Attendees

The table on the following page provides information on Network centers providing training/education to different categories of attendees. Compared to the previous quarter, there were notable increases in the percent of Network centers conducting public awareness events on terrorism/war and disasters targeting mental health profession, school personnel, child welfare workers, and faith-based and other groups. Other notable increases occurred in the number of centers holding events on the topic of traumatic bereavement attended by school, health care, child welfare, child care, and parents or family members.

	Education		Terrorism/War		Natural/Man-made Disaster		Traumatic Bereavement		Other	
	Q3 %	Q4 %	Q3 %	Q4 %	Q3 %	Q4 %	Q3 %	Q4 %	Q3 %	Q4 %
Mental health professionals	68	57	9	24	3	8	24	24	50	27
School personnel	49	49	4	11	3	5	5	11	13	14
Health care professionals	38	35	6	5	3	3	13	22	24	24
Child welfare workers	49	30	3	8	3	3	3	14	16	19
Domestic violence shelter staff	24	24	0	0	3	0	3	3	0	11
Child care workers	34	22	3	5	3	0	5	11	11	11
Law enforcement/juvenile justice	32	22	5	0	0	0	5	5	11	14
Parent/family	37	16	2	5	0	5	0	11	3	5
Faith based	21	16	1	5	0	8	0	0	13	5
Government	16	16	3	3	0	3	3	5	11	11
Consumers	16	5	1	0	3	0	0	0	0	3
Fire/emergency	3	5	2	0	0	3	0	0	16	0
Other	21	16	2	3	3	11	0	8	0	3

Cells with grey shading and bold numbers indicate an increase of 5 percent or more.

III. Outreach Activities

In addition to reaching people with information about traumatic stress through training and public awareness activities, Network centers also are involved with 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. Eighty-nine percent of Network centers were involved in these types of activities in the current quarter. During this quarter centers most frequently engaged in outreach to schools (59 percent of centers), the legal system (57 percent), mental health (54 percent) and child welfare organizations (49 percent). Overall, there was somewhat less involvement this quarter with health care organizations and domestic violence shelters relative to the previous quarter.

System/Organization	Outreach Activities	
	Q3 %	Q4 %
Schools	38	59
Legal System	43	57
Mental Health	35	54
Child Welfare System	19	49
Public	16	49
Health Care	68	38
Child Care	38	35
Parent/Family Organizations	16	32
Government	16	27
Faith-based Organizations	24	24
Other	38	22
Domestic Violence Shelters	51	19
Consumer Organizations	24	11
Fire/Emergency Services	27	8

IV. Media Activity

Eighteen centers (49 percent) reported a total of 175 media events this quarter, a 90 percent increase over the number of events reported in the previous quarter. The most common events this quarter were articles in local print media (81 events) followed by local television (49), and radio (20). Media activities targeting statewide audiences declined from the previous quarter.

	Media Events	
	Q3 No. Events	Q4 No. Events
Local		
Print	27	81
Radio	4	20
Television	8	49
State		
Print	10	4
Radio	2	1
Television	17	1
National		
Print	16	11
Radio	4	4
Television	4	4
TOTAL	92	175

V. Progress Increasing Public Awareness

During the weeks surrounding the second anniversary of 9/11, the National Child Traumatic Stress Network launched the NCTSN School and Family Preparedness Initiative. During this period, 22 Network centers met with schools and school districts across the nation to assist them in evaluating and improving their school crisis and disaster plans.

This 9-11 initiative, spearheaded by the National Center's Terrorism and Disaster Branch and School Crisis and Intervention Unit, involved the production and dissemination of materials to assist schools and families in regard to large-scale catastrophic events. These include a School Preparedness Checklist, Family Preparedness Wallet Card, Family Preparedness Guide, press releases, and points for talking to the media. The School Preparedness Checklist was prepared in coordination with the U.S. Department of Education to help administrators and principals assess and address mental health issues in the aftermath of a school crisis, terrorism, or disaster. The Family Preparedness Wallet Card is a useful tool for listing important numbers for parents/caregivers to have at their fingertips. It is available to school districts in multiple languages. Accompanying the card is a guide for preparing a family emergency plan, a communication plan, and an emergency supply kit.

Some of the highlights of the initiative include:

- The School Preparedness Checklist was published in the **U.S. Department of Education** "Challenger Newsletter" and "Security Products" newsletter, which are circulated to school resource officers.
- **Jewish Board of Family and Children's Services, NY**, worked with schools in New York City, made the family preparedness cards available to their clinicians to provide to their clients, and also reached out to a New York City Public Advocate for assistance in distributing materials.
- A working group will be formed to develop crisis and emergency plans for special education schools and programs.
- All three of the products (School Preparedness Checklist, Family Preparedness Wallet Card, and Family Preparedness Guide) were circulated to every school in Oklahoma with assistance from the **Oklahoma Department of Education's** Safe and Drug Free Schools Program.
- Wallet cards were translated into five languages by the **Los Angeles Unified School District Community Practice Center, Van Nuys, CA**, and a local printing company in Los Angeles donated 5,000 printed cards.
- **Parsons Child and Family Center, Albany, NY**, circulated the products to 40 local school districts

Selected Publications by National Network Members (10/1/02-9/30/03)

- Greenhill, L., Jensen, P., Abikoff, H., Blumer, J., DeVaugh-Geiss, J., Fisher, C., Hoagwood, K., Kratochvil, C. J., Lahey, B., Laughren, T., Leckman, J., Petti, T., Pope, K., Rapoport, J., Shafer, D., Vitiello, B., & Zeanah, C. H. (2003). Optimizing strategies for developing and implementing psychopharmacological studies in preschool children. *Journal of the American Academy of Child and Adolescent Psychiatry*, 42, 406-414.
- Harvey, M. R., Liang, B., Harney, P., & Koenen, K. C. (2003). A multidimensional approach to the measurement of trauma recovery and resiliency. *Journal of Aggression, Maltreatment and Trauma*, 6, 87-109.
- Koenen, K. C., Goodwin, R., Struening, E., Hellman, F., & Guardino, M. (2003). PTSD and treatment seeking in a national screening sample. *Journal of Traumatic Stress*, 16, 5-16.
- Koenen, K. C., Moffitt, T., Caspi, A., Taylor, A., & Purcell, S. (2003). Domestic violence is associated with environmental suppression of IQ in young children. *Development & Psychopathology*, 15, 297-311.
- Liebschutz, J., Frayne, S., Saxe, G. (2003). *Violence against women: A physician's guide to identification and management*. Philadelphia: American College of Physicians.
- Lustig, S., Kia-Keating, M., Grant Knight, M., Geltman, P., Ellis, H., Kinzie, D., Keane, T., & Saxe, G. (in press). Review of child and adolescent refugee mental health. *Journal of the American Academy of Child and Adolescent Psychiatry*, 43(1).
- Lyons-Ruth, K., Zeanah, C. H. & Benoit, D. (2003). Disorder and risk for disorder during infancy and toddlerhood. In E. J. Mash & R. A. Barkley (Eds.), *Child Psychopathology* (2nd ed.). New York: Guilford.
- O'Connor, T. & Zeanah, C. H. (2003). Introduction to the special issue: Current perspectives on assessment and treatment of attachment disorders. *Attachment and Human Development*, 5, 221-222.
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- O'Connor, T. & Zeanah, C. H. (2003). Current perspectives on attachment disorder: Rejoinder and synthesis. *Attachment and Human Development*, 5, 321-326.
- Stafford, B., Zeanah, C. H. & Scheeringa, M. (2003). Exploring psychopathology in early childhood: PTSD and attachment disorders in DC: 0-3 and DSM-IV. *Infant Mental Health Journal*, 24, 398-409.
- Saxe, G., Chawla, N., Stoddard, F., Kassam-Adams, N., Courtney, D., Cunningham, K., Lopez, C., Hall, E., Sheridan, R., King, D., & King L. (2003). Child stress disorder checklist: A measure of ASD and PTSD in children. *Journal of the American Academy of Child and Adolescent Psychiatry*, 42(8), 972-978.
- Saxe, G., Vanderbilt, D., & Zuckerman, B (2003). Traumatic stress in injured and ill children. *PTSD Research Quarterly*, 14(2), 1-8.
- Zeanah, C. H. (2003). Commentary on Fits and starts: A mother-infant case study involving intergenerational violent trauma and pseudoseizures across three generations. *Infant Mental Health Journal*, 24, 526-528.
- Zeanah, C. H., Stafford, B., Boris, N. W. & Scheeringa, M. (2003). Infant development: The first three years of life. In A. Tasman, J. Kay, & J. Lieberman (Eds.)(pp. 91-117). *Psychiatry* (2nd ed.). Philadelphia: W. B. Saunders.
- Zeanah, C. H., Nelson, C. A., Fox, N. A., Smyke, A. T., Marshall, P., Parker, S., & Koga, S. (2003). Effects of institutionalization on brain and behavioral development: The Bucharest early intervention project. *Development and Psychopathology*, 15, 885-907.

NCCTS OPERATIONS

The National Center held a NCCTS staff retreat on September 23rd & 24th in Santa Monica, California. This was the first face-to-face meeting for the entire staff of the UCLA-Duke NCCTS. One focus of the retreat was the introduction of new NCCTS staff. Presentations by each of the core directors helped shape an understanding of the work of each of the cores. Another focus of the retreat was the first group meetings concerning the accelerated projects for the coming 12 months.

I. National Resource Center

The National Resource Center (NRC) filled two more staff positions, executive editor and research librarian, while the search for a public relations manager continued. Network products that have been disseminated during this quarter include a tip sheet for parents dealing with children's reactions to 9/11 and a white paper on refugee trauma.

II. Media Activity

Media activity this quarter has focused on relaying information to the nation to help understand children's responses to the natural disaster events facing our nation during this period (wildfires and hurricanes). On the second anniversary of 9/11, *Mental Health Weekly* ran an op-ed by NCTSN Co-directors Robert Pynoos and John Fairbank.

III. Terrorism and Disaster Branch

The TDB and the School Crisis and Intervention Unit spearheaded the 2003 9/11 School and Family Preparedness Initiative that brought together representatives from 25 NCTSN centers. They worked on the design of Web content and printed materials (checklist, family preparedness card and guide), a media plan, outreach to local school districts, and interviews with local, national and international press. The family preparedness cards and guide were translated into five languages and widely distributed.

The TDB enhanced the Terrorism and Disaster portion of the NCTSN website with new graphics and content. There was also new content on specific events such as earthquakes, epidemics, biological terrorism, hurricanes, and tornadoes that addressed readiness, response, and recovery for each event.

IV. Monitoring and Evaluation

In this quarter, Abt Associates worked with NCCTS staff on plans for an initial survey of the Network. Its focus will be on the effectiveness of collaborative work within the Network. The M&E team focused on preparing a prototypic, quarterly Network Performance Report to present assorted network information in one place. Some of this information, for example, came from implementing WebTrends, a state-of-the-art Web use tracking system, to monitor for the first time Web site page views, downloads, time spent on the site, etc.

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			Total No. Centers
	Sep 2001 No. Centers	Jul 2002 No. Centers	Sep 2002 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 preeminent 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 continuing the efforts of centers that will 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

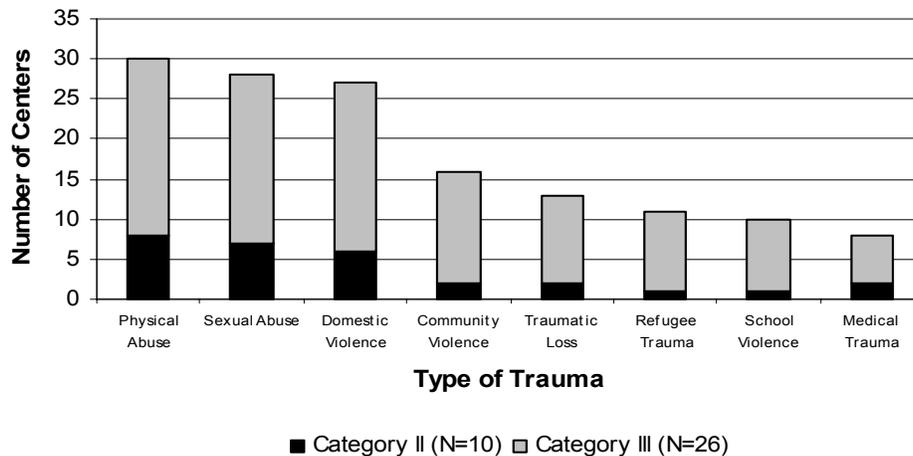
The third category of grantees, Community Treatment and Service Programs, will establish or continue community practice centers where children who have experienced a wide range of traumas and their families receive needed treatment and services. These centers will:

- 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).

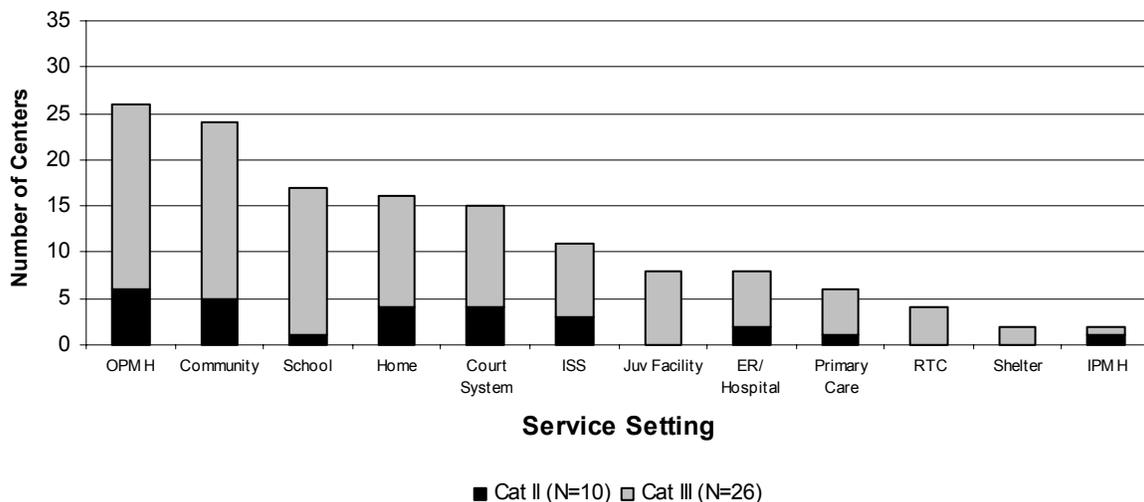
Types of Trauma Treated by NCTSN Centers

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

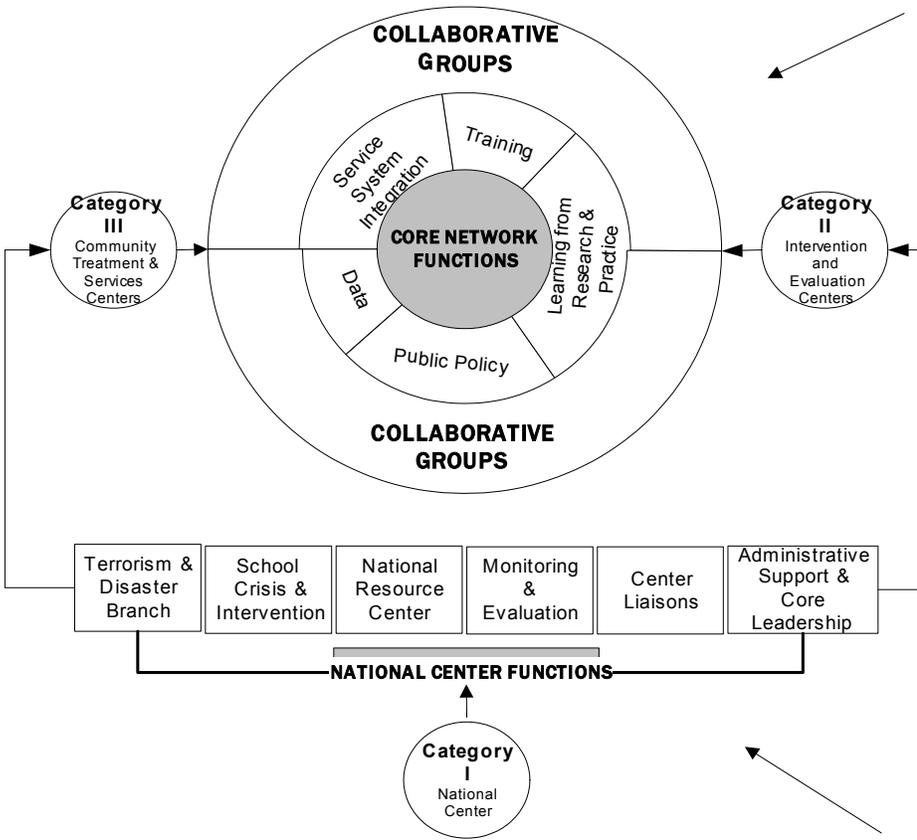
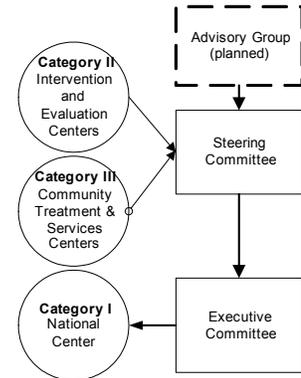
Organizations participating in the NCTSN reach youth and their families in many diverse settings, particularly non-restrictive settings such as outpatient mental health programs and communities, homes, and schools. Children in the court system, juvenile facilities, and medical settings are also served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



- CORE NETWORK FUNCTIONS**
- Learning from Research and Clinical Practice**: Learn about effective interventions for childhood trauma from research and clinical practice, and disseminate such learning to policymakers, practitioners, and children and families
 - Training**: Develop, support, and provide state-of-the-art, multi-platform, effective training programs that incorporate advances in the development of knowledge, cultural competencies, and ecological frameworks
 - Service System Integration**: Strengthen the ability of child-serving systems to identify and respond to traumatized children and their families with effective, developmentally, and culturally appropriate interventions
 - Public Policy**: To develop and advance a strategic policy agenda for the NCTSN aimed at improving the visibility and understanding of the problem of child traumatic stress, and strengthening the infrastructure, funding, and public will to address it.
 - Data**: To provide oversight and guidance in the design, collection, and analysis of Network data.
- NATIONAL CENTER FUNCTIONS**
- Terrorism and Disaster Branch**: Build a national resource to enhance our country's capacity to provide mental health care for traumatized and bereaved children and families after mass casualty events
 - School Crisis and Intervention Unit**: Improve the quality and availability of school-based mental health services and enhance school crisis, terrorism, and disaster recovery plans and services
 - National Resource Center**: Provide relevant, practical information and resources to Network members, other professionals and the public. Act as a repository of information and dissemination center for materials on child traumatic stress.
 - Monitoring and Evaluation**: Provide practical performance measurement and feedback on the progress of the NCTSN toward its goals and objectives
 - Network Liaisons**: Establish, maintain, monitor, and coordinate the collective activities of Network Centers
 - Administration & Core Leadership**: Support the operations of the National Center and of Network collaborative activities

APPENDIX B NCTSN CENTERS

Center Name	Location	Cong. District
Category I National Center for Child Traumatic Stress (NCCTS)		
National Center for Child Traumatic Stress – UCLA	Los Angeles, CA	29
National Center for Child Traumatic Stress – Duke University	Durham, NC	4
Category II Implementation and Evaluation Centers		
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
Chadwick Center for Children and Families Trauma Counseling Program	San Diego, CA	49
Center for Pediatric Traumatic Stress, Children’s Hospital of Philadelphia	Philadelphia, PA	2
Early Trauma Treatment Network, San Francisco General Hospital	S. Francisco, CA	8
National Children’s Advocacy Center	Huntsville, AL	5
New York University Child Study Center	New York, NY	14
North Shore Univ. Hosp. Adolescent Trauma Treatment Development Center	Manhasset, NY	5
Category III Community Treatment and Services Centers		
Aurora Mental Health Center	Aurora, CO	6
Heartland International FACES, 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
Healing the Hurt, 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 Community Practice Center	Van Nuys, CA	24
Mid-Maine Child Trauma Network	Augusta, ME	1
Mental Health Corporation of Denver’s Family Trauma Treatment Program	Denver, CO	1
The Children Who Witness Violence Program	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
Intercultural Child Traumatic Stress Center of Oregon	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 Initiative	New York, NY	8
The Trauma Center, Massachusetts Mental Health Institute	Allston, MA	8
The Greater St. Louis Child Traumatic Stress Program	St. Louis, MO	1
Children’s Trauma Consortium of Westchester	Valhalla, NY	18
William Wendt Center for Loss and Healing	Washington, DC	DC
Harborview Center for Sexual Assault and Traumatic Stress	Seattle, WA	7
Parson’s Child and Family Center	Albany, NY	21

APPENDIX C COLLABORATIVE PROJECTS AND PRODUCTS

Needs Assessments		
Collaborative Group	Project	Stage of Completion
Complex Trauma Task Force	Survey of complex trauma among youth treated by Network clinicians - data analysis underway	3
Complex Trauma Task Force	Multi-site epidemiological/co morbidity study (planned)	1
Family Interventions Working Group	Survey of family interventions used by Network centers -	2
Forensic Medical Exam Working Group	Survey of 100 forensic medical exam providers - ongoing data collection	2
Kauffman Best Practices Project	Survey NCTSN experts to identify barriers to disseminating TF-CBT for sexual abuse, PCI, and Abuse-focused CBT for physical abuse - developing interview schedule	1
Measures Committee	Survey of centers' needs for assessment tools- developing interview schedule	1
Policy Committee	Survey of Network centers to determine policy concerns - developing interview schedule	1
Policy Committee	Survey of groups external to the Network to determine policy concerns- developing interview schedule	1
Refugee Trauma Task Force	Survey of Network centers treating refugees - ongoing data collection	2
Service System Integration WG	SIG survey summary - data analysis completed	3
Service System Integration WG	Interview with community service providers- developing interview schedule	1
Sexual Abuse Task Force	Survey 250 NCTSN therapists about knowledge of and attitudes toward manualized, evidence-based treatments - data analysis completed	3
Sexual Abuse Task Force	Focus groups at Centers participating in Sexual Abuse Task Force - data analysis completed	3
Training Committee	Inventory training materials used by centers - data analysis completed	3
Training Committee	Survey of centers' training needs - data analysis completed	3
Traumatic Grief Task Force	Study of epidemiology/co morbidity of traumatic grief - ongoing data collection	2
1= Planned 2= In progress 3=Completed		

Reviews of the Field		
Collaborative Group	Project	Stage of Completion
Adolescent Network	Map the field of adolescent trauma	2
Family Interventions Working Group	Review of literature on family interventions	2
Kauffman Best Practices Project	Establish expert consensus on evidence-based trauma treatments	3
LRCP Advisory Group	Meta-analysis of research on effectiveness of trauma interventions	2
LRCP Advisory Group	Identify common elements across multiple treatments for trauma	2
Measures Committee	Review measures of traumatic stress and related phenomena - data	2
Medical Trauma Working Group	Evaluate available assessment tools and measures and determine which are appropriate for medical settings	2
Residential Treatment Working Group	Review literature on residential care models	2
School Intervention Working Group	Identify critical components of a school-based program	2
Service System Integration WG	Review literature on best practices of service system agencies with respect to reducing secondary trauma and facilitating health of children.	3
1= Planned 2= In progress 3=Completed		

Products			
Collaborative Groups	Project	Stage	Code
Adapted Treatment Standards for Children with Disabilities WG	Information sheets on trauma among children who are developmentally disabled and methods for adapting treatment	3	BIM
Adapted Treatment Standards for Children with Disabilities WG	Information sheets on pr trauma among children who are deaf and methods for adapting treatment	2	BIM
American Indian Working Group	Information package on trauma resources	2	BIM
American Indian Working Group	Medicine wheel for healing trauma	2	PG
American Indian Working Group	Comic book or children's book on trauma	1	BK
Complex Trauma Task Force	White paper on clinical issues relating to complex trauma	2	WP
Complex Trauma Task Force	Curriculum for training on complex training	2	TM
Complex Trauma Task Force	White paper on policy issues relating to complex trauma	1	WP
Complex Trauma Task Force	Clinical case studies	1	TM
Juvenile Justice Task Force	Compendium of readings on juvenile justice and trauma	3	RL
Juvenile Justice Task Force	Fact sheets on prevalence of trauma among youth in jj. system	3	BIM
Juvenile Justice Task Force	Reference sheets on assessments, interventions, and various other topics affecting traumatized youth in jj. system	3	BIM
Juvenile Justice Task Force	Guidelines for delinquency courts working with traumatized youth	2	PG
Medical Trauma Working Group	White paper on medical traumatic stress	2	WP
Medical Trauma Working Group	White paper on crisis intervention and treatment of medical trauma	2	WP
Medical Trauma Working Group	Clinical pathway for assessing and treating medical traumatic stress	2	PG
Medical Trauma Working Group	Curriculum for training medical and mental health professionals on assessment and treatment of medical trauma	2	TM
Refugee Trauma Task Force	White paper on refugee trauma	3	WP
School Intervention Working Group	9/11 anniversary products in conjunction with TDB and School Crisis and Intervention Unit	3	BIM
School Intervention Working Group	Crisis response educational materials	2	TM
Service System Integration WG	Guideline recommendations for model programs that focus on child trauma and the interaction of systems	2	PG
Sexual Abuse Task Force	Training manual on trauma focused-CBT	3	TM
Sexual Abuse Task Force	Video taped trainings (2) on trauma-focused CBT	3	TM
Traumatic Grief Task Force	Information sheets on traumatic grief	3	TM
Traumatic Grief Task Force	Guidelines for treatment of traumatic grief in pre-schoolers	3	PG
Traumatic Grief Task Force	Manuals on the treatment of traumatic grief in school-aged children and adolescents	3	TM
Traumatic Grief Task Force	Video taped trainings on traumatic grief	3	TM
Traumatic Grief Task Force	Book for children on traumatic grief	2	BK
1= Planned 2= In progress 3=Completed			
BIM= Brief information materials; BK= Book; PG= Practice guidelines or manual; RL= Reading list; TM= Training materials; WP= White paper			