NCTSN The National Child Traumatic Stress Network

Network Performance

January – March 2004

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Executive Summary

Summary of Accomplishments

The National Child Traumatic Stress Initiative was created through Congressional legislation authorizing the creation of a national network focusing on the needs of traumatized children, and has received continuing bipartisan support. The National Child Traumatic Stress Network (NCTSN) was established by 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 traumatic stress. 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 goal of the NCTSN is to bring 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 positive differences in the lives of children. Some of the accomplishments of the Network in this reporting period (January through March 2004) include:

- **Providing direct clinical services to 12,551 children** who were traumatized by physical abuse, sexual abuse, domestic violence, community violence, traumatic loss, refugee experiences, school experiences, or medical experiences.

- **Training 20,342 mental health professionals, teachers, primary care providers, and other professionals** to treat and/or assess child traumatic stress.

- **Educating over 29,000 people** 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.

- **Sustaining 31 collaborative groups** that are currently working on **over 70 projects** dealing with child traumatic stress.

- **Assisting communities in responding to crises and disasters** including school shootings, youth homicides and suicides, the California wildfires, the Ricin scare on Capitol Hill, and the earthquake in Bam, Iran.

Changes in the Report

Since the first Network Performance report was produced, the number of centers and collaborative groups active in the Network has increased as has their activity. Consequently, there are now a tremendous number of activities to monitor, evaluate, and report. In order to keep this report short enough to be readable and still cover the multiple content areas it addresses, several changes have been made. These include: (1) limiting the number of examples of center activities listed in the report by presenting summary information on projects that are in the planning, "looking around", "getting to know" stage, and listing a limited number of examples where centers are actively testing, adapting, adopting, training, and so forth (see Appendix B for a more complete list of projects/products); (2) omitting "Appendix A – Background"; (3) omitting the partial list of presentations made by centers; and (4) limiting the publications that are listed to those specifically about child traumatic stress.

CLINICAL AND BEHAVIORAL OUTCOMES

Core Data Set

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. The data the system will yield have come to be known as the core data set (CDS). It is an essential Network-wide mechanism for learning about the children and families being served by the Network, the range of traumas these children have experienced, the types of treatments being provided, and the success of those treatments.

Key to the CDS is an electronic data capture (EDC) system that Network centers will use to collect and submit data via the internet. This quarter's efforts focused on formatting, programming, and developing the reports that the EDC will generate. An implementation and training plan was also devised and initial training began in the use of the ECD. Four centers have been identified that will take part in the initial roll out of the system in the spring of 2004.

Many Network centers are in the process of obtaining a written decision from their local IRB as to whether their IRB considers their CDS collection activities quality improvement or research. After local IRBs make this determination, centers must then take appropriate steps to obtain IRB approval if needed. Data Use Agreements (DUA) must also be signed by each participating center. To assist centers with these efforts, a complete set of sample documents and templates were developed and posted on the NCTSN website.

Other Clinical and Behavioral Outcome Assessment Activities

In addition to contributing to the CDS, Network centers are also involved in a number of other activities to assess the outcomes of the services they are providing at their individual sites or those that extra-Network organizations are providing. For example, two centers reported working on the design and development of outcome evaluation systems this quarter.

Other NCTSN activities are concerned with assessing the clinical and behavioral outcomes attributable to certain specific interventions such as trauma-focused cognitive-behavioral treatment or parent-child interaction therapy. These later types of activities are described in more detail in the following section of this report, "Development and Adoption of Assessments and Treatments."

DEVELOPMENT AND ADOPTION OF ASSESSMENTS AND TREATMENTS

A wide range of projects are underway within the Network to develop and test assessments and interventions. Some of these are 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.

Assessments

Assessment instruments provide information service providers need to plan treatment regimens for individual children and their families as well as information for evaluating the outcomes of care. This section reports progress on projects that are underway to (1) develop and test assessment instruments, and (2) use assessment tools to improve treatment.

Instrument Development. This quarter, seven Network Centers and the National Center's Terrorism and Disaster Branch reported a total of nine instrument development projects that are currently in the planning and development stages. Examples include revising instruments to make them more user-friendly or to incorporate findings from pilot studies, selecting items based on their expected predictive strength, and reviewing literature on the cultural relevance of instruments for Native Americans. In addition to these nine projects:

- **Children's Trauma Consortium of Westchester, Valhalla, NY,** is conducting a trial of screening tools at four sites. These tools include the Traumatic Events Screening Inventory, the Trauma Symptom Checklist, the Child Trauma Questionnaire, and the Trauma Symptom Inventory.

- The **Children Who Witness Violence Program, Cleveland, OH**, in conjunction with faculty from Case Western Reserve, is evaluating the use of the Pediatric Emotional Distress Scale when used with children who witness violence.

- **Healing the Hurt, Directions for Mental Health, Inc., Clearwater, FL,** has completed a study of the Traumatic Events Screening Inventory and presented the results at a conference.

- **Safe Horizon-Saint Vincent's Child Trauma Care Initiative, NYC,** is working with staff from **Allegheny General Hospital Center for Child Abuse and Traumatic Loss, Pittsburgh, PA,** on a feasibility study that involves piloting measures of traumatic grief in Safe Horizon's Families of Homicide Victims Program.

Adoption of Instruments and other Assessment Tools. Three Network centers reported progress on five projects currently in the planning and development phase that are concerned with using various assessment tools. Some of these involve innovative approaches to helping practitioners integrate data from assessment instruments with treatment planning. In addition to these activities:

- **Family, Adolescent, and Child Enhancement Services (FACES), Chicago, IL,** has developed a database of client background and service information and is now administering the Harvard Trauma Questionnaire and UCLA PTSD Index. Staff are also being trained to administer the Child and Adolescent Functional Assessment Scale.

- **Children's Institute International, Central L.A Child Trauma Treatment Center,** trained staff on using assessment measures in developing service plans and intervention priorities.

- **Mid-Maine Child Trauma Network, Augusta, ME,** is piloting and evaluating a triage assessment system for children receiving foster care, domestic violence services, emergency room care, and mental health services.

Treatments

There are a number of steps involved in developing and testing treatment interventions. These include designing an intervention for a particular need or problem based on the best information available about 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, testing the feasibility of implementing the practice in real-world settings, devising measures to tell if the intervention is being used as intended, and evaluating the effectiveness of the intervention. This section reports progress Network centers are making in developing interventions.

Development of New Treatments.

Twenty-eight centers reported a total of 36 treatment development efforts this quarter. Of those 36 projects, 21 (almost two-thirds) were activities associated with designing interventions or planning for their evaluation. Included among these activities are such things as planning replication studies, collaborating with intra- and extra-Network programs on modifications to treatments to make them appropriate to additional groups, and revising interventions to take into account previous pilot work. Fifteen additional activities are reported below:

- **Boston University, Adolescent Traumatic Stress and Substance Abuse Treatment** is developing an integrated treatment model that addresses trauma and substance abuse in adolescents. Detail outlines of all treatment sessions have been completed and efforts are underway to recruit teens and parents to participate in a study of this treatment.

- **The Center for Pediatric Traumatic Stress, Children's Hospital of Philadelphia** and **North Shore University Hospital Adolescent Trauma Treatment Development Center, Manhasset, NY**, are working together to help a national not-for-profit agency plan and evaluate mental health interventions for children and adolescents with cancer. During this quarter, the Center for Pediatric Traumatic Stress worked on revising the intervention manual and staff from North Shore led five trauma-focused groups for families with children with cancer at a retreat sponsored by the non-profit.

- **Chadwick Center for Children and Families Trauma Counseling Program, San Diego, CA,** is developing a pathway model. During this reporting period the center (1) designated a clinical consultant to work with existing team leaders and staff to implement and test aspects of their clinical pathway, (2) began training staff on the administration and clinical utility of measures in the assessment pathway, and (3) added a crisis response pathway (including a specific pathway for school crises) and medical trauma pathway.

- **Children's Crisis Treatment Center, Project Tamaa, Philadelphia, PA**, continues to evaluate its innovative therapy and support groups for West African children youth at the Tilden Middle School.

- **Children's Institute International, Central L.A Child Trauma Treatment Center**, continues to collect and analyze data on their domestic violence group intervention. They are working with another Network center, **North Shore University Hospital Adolescent Trauma Treatment Development Center, Manhasset, NY,** to adapt this treatment for use with adolescents in inner-city areas.

- **Childhood Violent Trauma Center, Yale University, CT,** conducted training in the Child Development – Community Policing model with mental health, police, and child protective services representatives from Raleigh, NC. They also provided consultation to other communities with plans for replicating the CD-CP model and they are making progress toward developing an intensive national evaluation as well. Data collection protocols are currently in place at 10 CD-CP sites, including Network centers in Nashville, TN and Clearwater, FL.

- **The Early Trauma Treatment Network (ETTN)** is collecting data on the Kids in Court Program in order to understand factors associated with access to the program, case disposition, and children's emotional experience of testifying in court.

- **Institute for Trauma and Stress, NYU Child Study Center, NYC,** is implementing and evaluating their STAIR treatment model at the Montague Day Treatment Program operated by the **Jewish Board of Family and Children's Services**, **Center for Trauma Program Innovation, NY**. Round two of training has been completed and staff are now receiving weekly phone supervision. The Supervision Experiences Scale and Questionnaire is being used to assess the effectiveness of this supervision.

- **North Shore University Hospital Adolescent Trauma Treatment Development Center, Manhasset, NY**, is developing several interventions. One is a manualized intervention for adolescents living with chronic trauma. There are three versions of this intervention: a general trauma-focused one, a general trauma-focused intervention for use in schools, and one specific to adolescents living with domestic violence. Revisions are being made based on feedback from clinicians and adolescents. Post-intervention assessments are being conducted with approximately 15 adolescent girls who began receiving this treatment in the fall of 2003. North Shore staff are in regular contact with two Network centers (Children's Institute International and Safe Horizon) who are implementing the manual. A second intervention is the Peer Trauma Education Program which is currently being implemented in a local parochial school.

- **Parson's Child and Family Center, NY,** continues development of START, a trauma-informed curriculum for residential treatment center (RTC) paraprofessionals. During this quarter, research and evaluation staff conducted a focus group with staff from residential services who were trained in START last fall. The focus group addressed the RTC staff members' perceptions of how principles imparted in the START training continued to influence their work. Final post-training measures were collected. Parson's is also developing an arts/narrative based treatment entitled Real Life Heroes. After training and supervision in the use of the intervention and the measures that will be collected, clinicians have begun implementing the treatment with clients. Data are being collected on treatment fidelity and client outcomes.

- **Staff from Safe Horizon-Saint Vincent's Child Trauma Care Initiative, NYC,** are currently piloting the Enhancing Resiliency group model developed by **North Shore University Hospital Adolescent Trauma Treatment Development Center, Manhasset, NY**. The model is being piloted in two Safe Horizon Safe Harbors: one in a school in the South Bronx and one in a school overlooking Ground Zero in lower Manhattan. Monthly conference calls are being held between Safe Horizon and North Shore.

- **Wendt Center for Loss and Healing, Washington, DC**, is updating the program model for their Recover program based at the DC Office of the Chief Medical Examiner. The Center continues its children's bereavement groups based on its Three-dimensional grief model at two public elementary schools. Pre- and post- tests continue to be collected to evaluate the groups' impact on child clients. This center also completed analysis of data on follow-up evaluations from 2003 Camp Forget-Me-Not.

Adoption and Adaptation of 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 pre-school children, or an intervention that was used in mental health settings but has not been tested in school settings. When providers use interventions that have been tested, but modify them for use with a new group of children, a different problem, or a new setting they are adapting them.

Network centers are currently involved in multiple studies of the effectiveness of previously-tested treatments that they have adopted or adapted. 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 designed to help children, adolescents, 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. This treatment integrates cognitive and behavioral interventions with traditional child abuse

therapies for the purpose of 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, or group sessions.

This quarter, 14 projects were reported involving the adoption or adaptation of interventions that are in various stages of planning and development. The majority (nine) of these 14 are projects being undertaken by the newest cohort of Network centers. An additional 13 activities reflecting active efforts to train people to implement treatments such as those described in the previous paragraph or to study the effectiveness of these treatments are listed below:

- Staff at the **Greater St. Louis Child Traumatic Stress Program, St. Louis, MO**, have begun a series of three, 12-session intensive trainings for community professionals and graduate students in TF-CBT.

- Thirty-five clinicians **at Healing the Hurt, Directions for Mental Health, Inc, Clearwater, FL**, are currently providing treatment according to one of the three protocols (TF-CBT, PCIT, and Child-Parent Psychotherapy) or a locally developed treatment. Data on 50 children have been collected.

- **Mental Health Corporation of Denver's Family Trauma Treatment Program, Denver, CO**, is conducting a treatment effectiveness study comparing TF-CBT to treatment as usual. They are recruiting 4 to 10 families per month into this study. This quarter, 17 pre-treatment and four post-treatment evaluations were completed.

- **Allegheny General Hospital Center for Child Abuse and Traumatic Loss, Pittsburgh, PA**, completed a pilot study of TF-CBT for children with traumatic grief based on pre-/post- evaluation data on 22 children.

- Staff at **Aurora Mental Health Center, Aurora, CO,** are implementing TF-CBT. They have received initial training in the model and are now participating in ongoing consultation by phone. Several children have completed the entire protocol.

- **Center for Child and Family Health, Durham, NC**, is continuing to pilot and implement Parent Child Interaction Therapy (PCIT) for maltreated children. Ongoing training and supervision are being provided to therapists interested in using this intervention program.

- **Chadwick Center for Children and Families Trauma Counseling Program, San Diego, CA**, is conducting a qualitative study of Parent-Child Interaction Therapy to understand which clients engage in PCIT and which clients enroll but do not complete the PCIT program. The goal of this project is to explore access to services and to identify barriers to treatment using PCIT.

- **Harborview Center for Sexual Assault and Traumatic Stress, Seattle, WA**, is providing PCIT-"lite" classes for child advocates at domestic violence programs throughout the county in which the center is located. Child advocates in domestic violence shelters and transitional housing often witness parent child interactions that tend to reinforce negative interactions and behavior problems. Center staff, in collaboration with domestic violence program child advocates, determined that it would be useful to increase child advocates knowledge of PCIT principles and use of PCIT intervention skills. The idea is to expose mothers to positive parenting skills in the natural environment rather than relying entirely on formal therapy. Project staff developed a training program that would convey the principles, the skills, and ways to intervene and informally coach mothers in shelters and transitional housing.

- **Trauma Treatment Replication Center, Cincinnati, OH**, is in the second cycle of their PCIT replication effort. This quarter, they conducted PCIT training at **Healing the Hurt, Directions for Mental Health, Inc, Clearwater, FL** and they trained nine clinicians from six local agencies.

- The **L.A. Unified School District (LAUSD)** continues development of CBITS, a school-based program for students exposed to community violence. Preliminary results from the first two groups indicate

significant improvements in symptoms of traumatic stress and depression following the intervention. This center is providing training in CBITS and on-going consultation to Network centers in Colorado, Montana, New Mexico, New York, Washington state, and Wisconsin.

- The **Intercept Center at Aurora Mental Health Center, Aurora, CO**, has implemented a program of Dialectical Behavior Therapy (DBT) for developmentally disabled children. Three modules of DBT have been modified for this population. A fourth is under study.

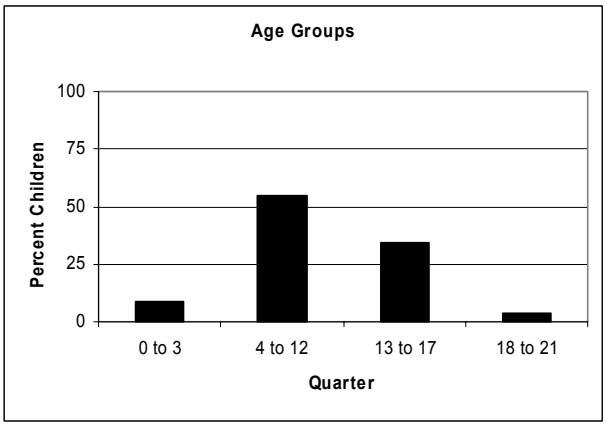
- **Safe Horizon-Saint Vincent's Child Trauma Care Initiative, NYC**, is participating in a city-wide initiative that provides mental health treatment and services to children and families affected by trauma, particularly the events of September 11th. This collaborative program, coordinated by the New York State Office of Mental Health, involves seven agencies/organizations from across New York City and Long Island. The program focuses on (1) improving access to care for children and families affected by trauma; and (2) utilizing evidence-based treatment models, including an evidence-based engagement model, as well as two evidence-based CBT treatment models. Data are currently being gathered.

- **Aurora Mental Health Center, Aurora, CO,** is using biofeedback methods to train children to increase the temperature in their hands, which increases relaxation and decreases anxiety and anger. The initial group of students has finished learning the process, and results are being analyzed.

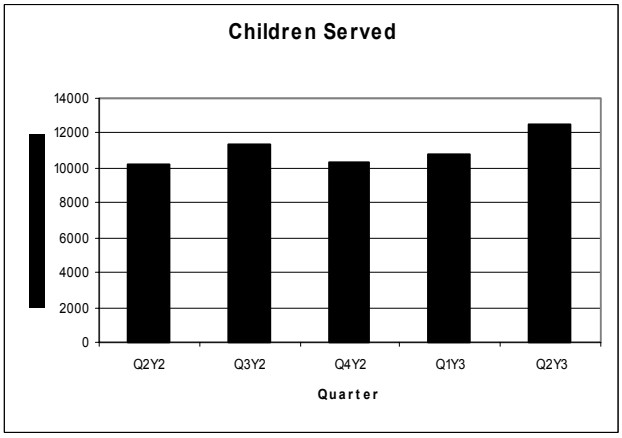
AVAILABILTY OF AND ACCESS TO SERVICES

This section reports progress towards improving the availability and accessibility of trauma-informed services for youth and their families. Information is provided about the number of children served by Network centers, the types of services they receive, and factors potentially affecting the capacity of centers to provide services. Another closely related area of activities is efforts to increase the number of service providers trained to provide trauma-focused services to youth. Training activities are reported in the "Training" section of this report and also under "Development and Adoption of Assessments and Interventions."

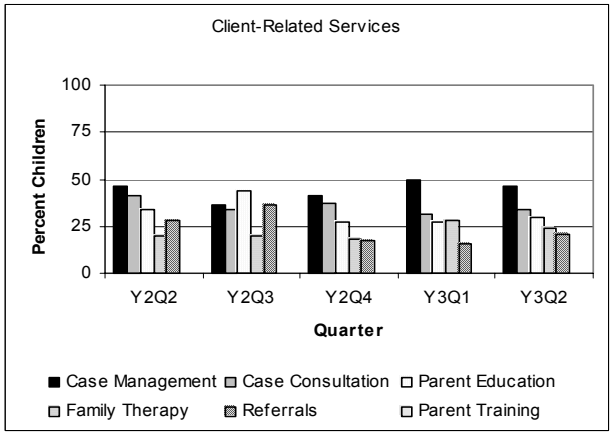
Services Provided by Network Centers



Characteristics of Children Served. Approximately half (55 percent) of the 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 (55 percent). With respect to ethnicity, approximately one-third (32 percent) were Hispanic. Within categories of race, approximately half were white (55 percent), one-third were African American (36 percent), and the remainder were distributed over other racial groups.



Direct Clinical Services.[1] Network centers reported providing clinical services such as individual and group therapy, evaluation, crisis response, and so forth to 12,551 children this quarter[2]. This is approximately 16 percent more than in the previous quarter (10,795) and 23 percent more than one year ago (10,200).

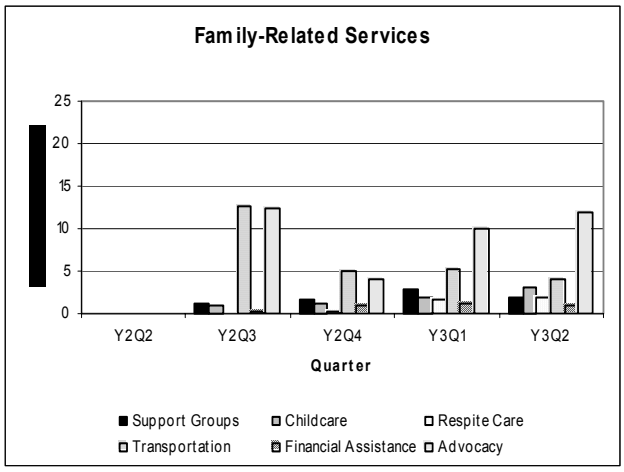


Client-Related Services for Children. Children served by Network centers and/or their parents also receive case management, parent education, parent training, case consultation, family therapy, and referrals. Approximately one-half to three-quarters of all Network centers provided these types of services in the current quarter. The most common of these services were case consultation, referrals, and parent education. Approximately one-quarter to one-half of all children served by Network centers received client-related services in the past quarter. The service most often received by children this quarter, as in most past quarters, was case management.

[1] Y2Q2/Q3 =31 Y2Q4=34 Y3Q1 N=43 Y3Q2 N=48

[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 visits to the setting. If the same child receives services in a subsequent quarter, that child is also included in the count for that subsequent quarter; data are "unduplicated" within, but not across quarters.

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 may be needed to enable families to participate in treatment or cope effectively with problems their children are experiencing. A somewhat larger proportion of centers reported providing advocacy services, support groups, child care, and respite care this quarter compared to last quarter. At the same time, there has been a decline over the past several quarters in the proportion of centers reporting they provide transportation services (not shown). Of all the children served by Network centers this quarter, 12 percent or fewer received family-related services (see graph).



Crisis Response. In addition to services Network centers provide at their agencies, centers also work closely with other organizations in their communities to assure that trauma-focused services are available to children in the wake of crises or disasters. This quarter, centers responded to:

- A shooting at a day care center in Madison, Wisconsin. Staff from the **Adolescent Trauma Treatment Project** provided post-event intervention and psychological first aid to members of the police and EMS system. They also provided support, information, assessment, and referral to the peers of a boy who hung himself.

- The **Early Trauma Treatment Network** member at LSU provided crisis intervention for several events in the New Orleans area: the murder of a high school student, a gang fight at a high school, the murder of a man outside of his home, and a suicide.

- The **Louisiana Rural Trauma Services Center**, New Orleans, LA, assembled a crisis intervention team to provide services immediately following an incident where a high school student shot a classmate.

- A potential shooting at Palm Middle School in San Diego in which two students brought a gun on campus. The school district requested assistance from the National Center's Terrorism **and Disaster Branch and School Crisis Intervention Unit** (TDB/SCIU), who, along with the Network center in San Diego (**Chadwick Center for Children and Families Trauma Counseling Program**) consulted with the school district on acute strategies and intervention needs, media interview strategies, and long-term recovery issues.

In addition, members of the National Center's **Terrorism and Disaster Branch (TDB) Rapid Response Support Team** (RRST) piloted a new incident management and tracking system in responding to the Bam, Iran earthquake. RRST members provided scientific literature, psychoeducation materials, and assessment tools and strategies to various international agencies including the World Health Organization, International Federation of the Red Cross, and the Iranian Child Psychiatry Association. Also, in response to the Ricin incident on Capital Hill, at the request of Senator Dole, RRST members developed strategies and talking points for Capital Hill staff within 24 hours.

At the request of SAMHSA, members of the Network's School Crisis Intervention Unit (SCIU) provided consultation to the Roccori, Minnesota school district. This county requested SAMHSA Emergency Response Grant monies following a school shooting that killed two students. The School Unit provided this county with program and grant development consultation and agreed to provide training to the school and mental health team staff.

Progress Improving the Availability of Services

Network centers are working closely with agencies in their communities to make certain that specific groups of children who need trauma-related services have access to them. This may involve Network centers providing onsite mental health professionals or establishing systems for assuring that children in need of services are identified and referred to Network centers. This quarter, for example, National Center staff developed a project with the U.S. Department of Defense and military service sites to address the needs of children and families of marines and reservists who are returning from the Gulf. In addition:

- The **Center for Child and Family Health, Durham, NC,** continues to collaborate with law enforcement, a faith-based organization, and several community leaders in working with families who have experienced a homicide and/or loss due to serious physical violence.

- Staff at the **Cullen Center for Children, Adolescents, and Families, Toledo, OH**, are collaborating with the School Counseling and Mental Health Services Department at the University of Toledo to provide educational assessments and tutoring services to traumatized youth who are experiencing academic difficulties in school.

- **De Pelchin Children's Center Child Traumatic Stress Program, Houston, TX**, is providing consultation for children at Casa de Esperanza, a local agency serving traumatized children. Weekly counseling is also being provided to mothers of traumatized children at the Salvation Army Homeless Shelter.

- **Harborview Center for Sexual Assault and Traumatic Stress, Seattle, WA**, in cooperation with the Medical Examiner's Office, is studying the service seeking behavior of children whose parents have died violently.

- **Mount Sinai Adolescent Health Center, NY,** continues its relationship with the Girls Educational Mentoring Services (GEMS), an organization which works with girls and young women who have been involved or are at high risk to become involved in the sex industry.

- **Mount Sinai Adolescent Health Center, NYC**, is working to increase access to treatment for difficult-to-engage youth at West Side High School. Mount Sinai staff provide onsite mental health care for these students, referrals to other services, and screen for substance abuse.

- Clinicians from **North Shore University Hospital Adolescent Trauma Treatment Development Center, Manhasett, NY,** continue to provide services for traumatized adolescents at a Nassau County school program for teenage mothers.

- **Miller Children's Abuse and Violence Intervention Center, Long Beach, CA**, has been working with school personnel (teachers, counselors, aides, and social workers) at Jordan High School on a new trauma-grief school-based program. Consequently, referrals to the program significantly increased and additional space was made available at the school for trauma-related services.

Activities for Systemic Changes.

A number of Network centers have either established or have joined multi-organization groups in order to bring about systemic changes in the availability of trauma-focused services for children. This quarter, 15 centers reported involvement in groups of this nature that are engaged in 11 system-change projects currently in the planning stages. In addition to those 11 projects the Kansas City Metropolitan Child Traumatic Stress Program, Kansas City, MO, reports that they now have 91 Agency Partners representing mental health, law enforcement, medical, social service, and other professionals serving traumatized children and their families in the Kansas City area. KC Metro is working with these Agency Partners to collect data on the scope of child trauma and related services.

Changes in Capacity to Provide Services

Each quarter centers are 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. As shown in the table on the following page, 42 percent of all Network centers reported a change in staffing in the current quarter; 21 percent reported an increase (usually only small), and 19 percent reported a decrease (also usually only small).

Resource	**Large Decrease**	Moderate Decrease	Small Decrease	Unchanged	Small Increase	Moderate Increase	**Large Increase**
	% Centers	% Centers	%Centers	% Centers	%Centers	%Centers	%Centers
Satellite facilities	0	2	0	91	7	0	0
Client transportation	2	0	6	90	2	0	0
Funding	0	6	8	83	4	0	0
Space	0	4	0	89	4	4	0
Staffing	0	6	13	58	19	2	2

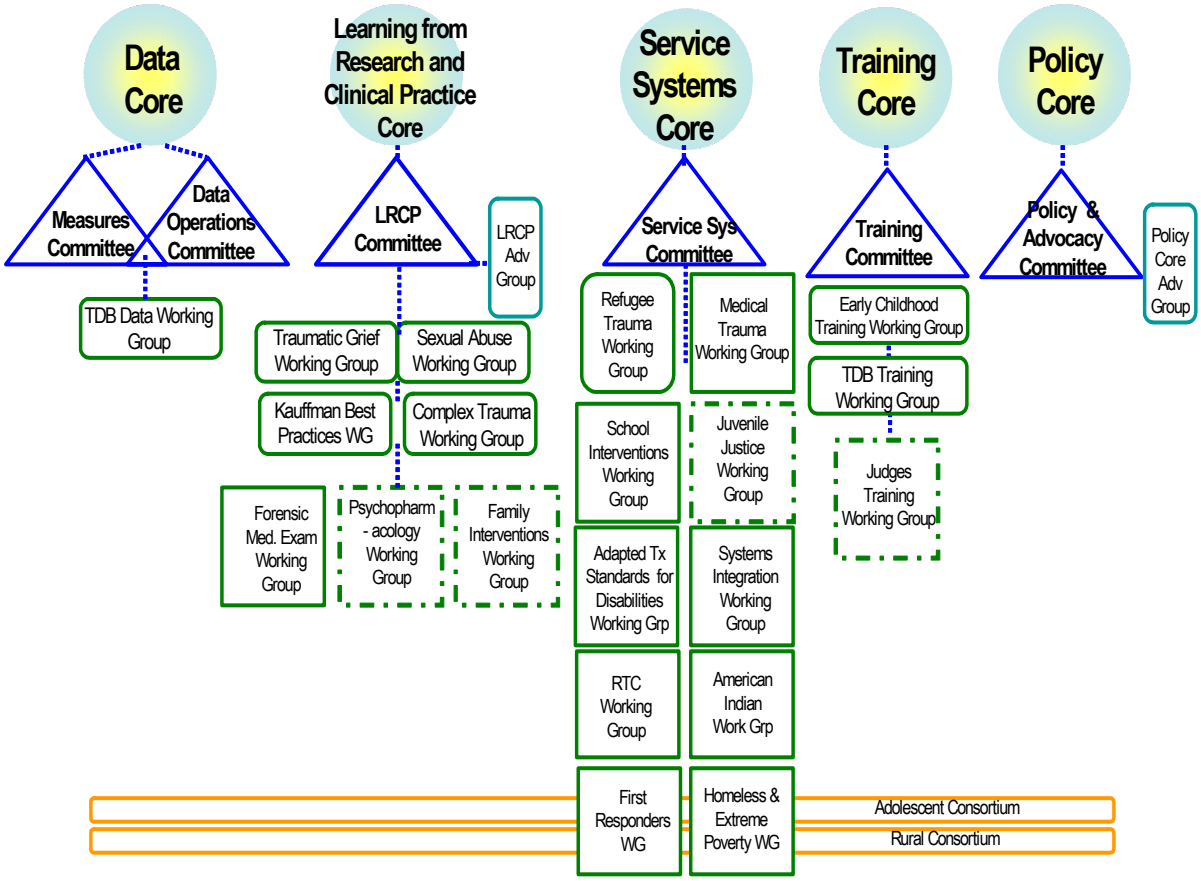
COLLABORATIVE GROUP ACTIVITIES AND ACCOMPLISHMENTS

The President's New Freedom Mental Health Commission Report stresses that the mental health system must rely on greater collaboration and integration to ensure more effective and efficient delivery of services. Collaboration is a quintessential part of the Network. The collaborative groups that have been established within the Network provide a vital mechanism for members of NCTSN centers to 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 their activities for the period January through March 2004.

Current Collaborative Groups

Several additional collaborative groups were established this quarter. They include: (1) the Terrorism and Disaster Branch Data Working Group, the First Responders Working Group, the Homeless and Extreme Poverty Working Group, the Policy Core Advisory Group, and the Rural Consortium (see figure below). This brings the number of formal collaborative groups within the Network to 31.

Functional Cores and Associated Collaborative Groups



(as of 3/04)

Group Size. There were 367 people from the 54 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 adolescence and then two focused on specific types of trauma (e.g., traumatic grief, medical trauma), then the first responders working group.

Group Size

Group	No. Members	Group	No. Members	Group	No. Members
AC	70	SSIWG	27	LRPCAG	20
TGWG	52	TDB grps	27	ATSWG	19
MTWG	48	TC	25	PPC	17
FRWG	42	RTCWG	24	FIWG	16
AIWG	35	RTWG	23	RC	9
ECTWG	34	PWG	23	JTWG	9
SAWG	32	DOC	21	EPHWG	8
SSIC	29	JJWG	21	KWG	8
CTWG	28	MC	21	PCAG	5
SCIWG	28	FMEWG	20	LRCPC	4

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 more than 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
FRWG	21	JJWG	13	FMEWF	8
AC	20	MC	12	ASDWG	7
MTWG	20	PPC	12	EPHWG	7
ECTWG	18	FIWG	12	RTWG	7
SAWG	17	CTWG	11	KWG	7
TDB Grps	17	TGWG	11	RTCWG	6
SSIWG	15	PWG	10	AIWG	6
SSIWG	14	LRCPAG	9	JTWG	6
SCIWG	13	RC	9	LRCPC	3
TC	13	DOC	8	PCAG	1

*Newly formed -- in process of recruiting members.

ABBREVIATIONS

AIWG	American Indian Working Group
AC	Adolescent Consortium
ATSWG	Adapted Treatment Standards for Children with Disabilities Working Group
CTWG	Complex Trauma Working Group
DOC	Data Operations Committee
ECTWG	Early Childhood Training Working Group
EPHWG	Extreme Poverty & Homelessness Working Group
FRWG	First Responders Working Group
FMEWG	Forensic Medical Exams Working Group
FIWG	Family Interventions Working Group
JJWG	Juvenile Justice Working Group
JTWG	Judges Training Working Group
KWG	Kauffman Best Practices Project Working Group
LRCPC	Learning from Research and Clinical Practice Committee
LRCPAG	Learning from Research and Clinical Practice Advisory Group
MC	Measures Committee
MTWG	Medical Trauma Working Group
PCAG	Policy Core Advisory Group
PPC	Policy & Advocacy Committee
PWG	Psychopharmacology Working Group
RTCWG	Residential Treatment Center Working Group
RTWG	Refugee Trauma Working Group
RC	Rural Consortium
SAWG	Sexual Abuse Working Group
SCIWG	School Interventions Working Group
SSIC	Service Systems Integration Committee
SSIWG	Service Systems Integration Working Group
TC	Training Committee
TDB grps	Terrorism and Disaster Branch
TGWG	Traumatic Grief Working Group

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 Development and Evaluation Centers and Category III Community Treatment and Services Centers within collaborative groups. The table below shows the percentage of center membership represented in groups. With the exception of one very new group, category III centers prevail in a majority of the groups. With only minor exceptions, staff members of all categories of centers are well represented in Network collaborative groups.

Participation by Center Category

Group	% CAT I N=1	% CAT II N=15	%CAT III N=38
PCAG	100%	0%	0%
KTF	38%	38%	25%
LRPCAG	25%	40%	30%
MC	24%	43%	33%
FRWG	19%	48%	33%
DOC	38%	24%	38%
MTWG	19%	42%	40%
AC	10%	43%	44%
SSIWG	19%	33%	44%
TGWG	25%	29%	46%
TDB Grps	33%	19%	48%
LRPC	25%	25%	50%
SSIC	21%	17%	52%
TC	16%	28%	52%
PWG	22%	26%	52%
RC	33%	11%	56%
JTWG	11%	33%	56%
FIWG	19%	25%	56%
RTCWG	17%	8%	58%
FMEWG	15%	25%	60%
EPHWG	13%	13%	63%
CTWG	7%	29%	64%
ECTWG	12%	24%	65%
SAWG	6%	28%	66%
SCIWG	11%	21%	68%
RTWG	4%	26%	70%
AIWG	11%	17%	71%
JJWG	10%	14%	71%
ATSDWG	11%	11%	74%
PPC	6%	18%	76%

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

Collaborative Projects

Accelerated Project Development. The National Center, with input from the NCTSN Steering Committee and SAMHSA, identified seven Network projects to receive supplemental support in the current program year (October 2003 through September 2004) to accelerate their development. At the half-way point of the year, each project is well underway.

Progress. As of the end of the present quarter, the 31 Network collaborative groups were involved in a total of 71 projects (including the seven accelerated projects). Almost two-thirds (61 percent) of these are focused on developing materials for use in educating or training the public and professionals. The remaining projects focus on assessing the current state of knowledge in a group's area of concern (13 percent), or establishing specifics about the needs or problems to be addressed by the group (27 percent).

Focus of Activities	Collaborative Projects No. (%) N=71
Education and Training Products	43 (61)
Review of the Field	9 (13)
Needs Assessment	19 (27)

Of the 43 group projects that involve products (table to the right), approximately half (49 percent) have been completed, approximately two-fifths (44 percent) are ongoing, and a small proportion (7 percent) are in the planning stages.

Approximately one-quarter of current products (28 percent) are training materials (including implementation kits) that provide specific information professionals need in order to recognize and apply trauma-focused treatments. Half of these products have been completed.

Type of Product	Total No. (%)	Stage of Completion		
		Planned No.	In Progress No.	Completed No.
Training materials	12 (28)		6	6
Brief informational materials	8 (19)		2	6
Practice guidelines/manuals	7 (16)	1	2	4
Other	6 (14)	2	3	1
White papers	5 (12)		4	1
Books for children	2 (5)		2	
Policy briefs	2 (5)			2
Reading lists	1 (3)			1
TOTAL	43 (100)	3	19	21

One in five projects (19 percent) focused on developing brief information materials summarizing information on the causes, consequences, and treatment of trauma for parents and a wide variety of other audiences; six of these have been completed, two are being finalized.

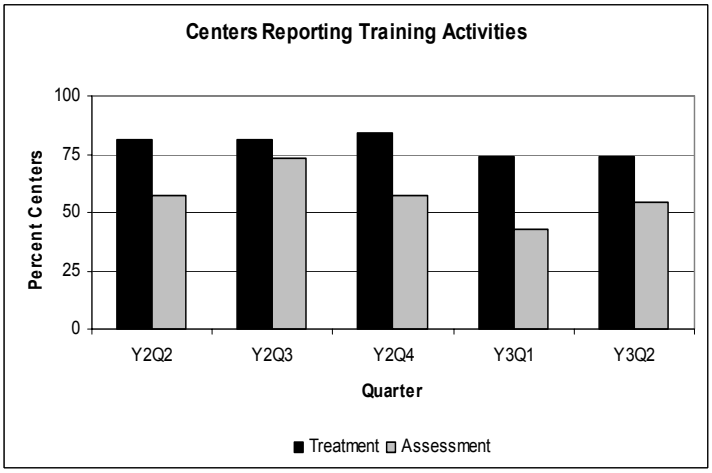
Practice guidelines and manuals make up another six (16 percent) of the products. These provide information for professionals on appropriate therapeutic responses for addressing the needs of traumatized youth and their families, but are generally not as detailed or skill-focused as training materials. Four of these have been completed. Additional information about specific collaborative groups and products is located in Appendix B.

TRAINING

Training Activities

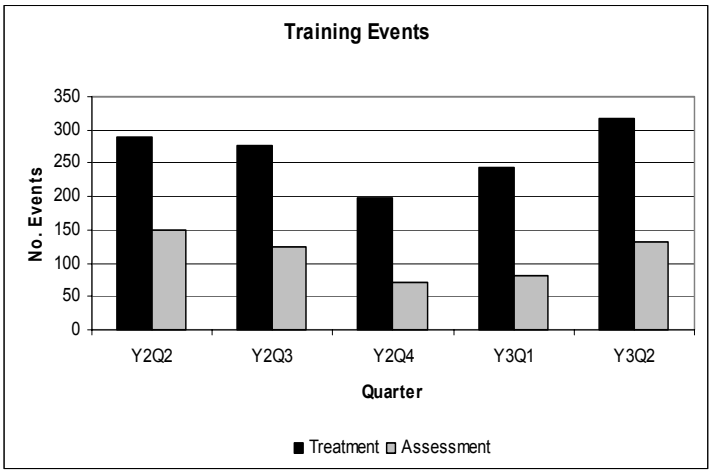
Number of Centers. The proportion of Network centers reporting training events focused on the treatment of traumatic stress this quarter was the same as last quarter (74 percent), but slightly lower than last year during the same period (81 percent).

There was a slight increase in the proportion of centers reporting assessment-focused events compared to last quarter (54 versus 43 percent). The proportion of centers reporting these types of events this quarter, however, is comparable to the same period last year (57 percent).

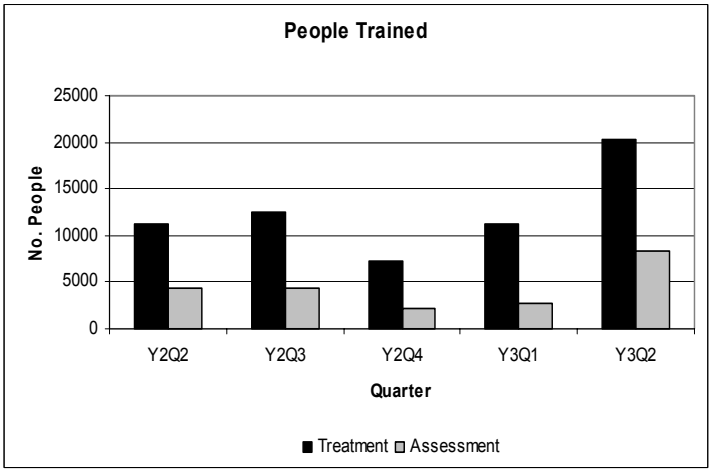


Number of Events. Centers reported a total of 317 events focused primarily on the treatment of traumatic stress this quarter. This represents a 30 percent increase over last quarter and a 9 percent increase compared to this quarter last year.

A total of 133 events focused on assessment methods were also reported this quarter. This is a 66 percent rise over last quarter, but an 11 percent decrease relative to this period last year.



Number of People Trained. The number of people attending trainings on treatment (20,342) increased appreciably compared to both the previous quarter and the same quarter last year. Attendance at treatment-focused events was approximately 80 percent higher than either last quarter or the same period last year. Attendance at events focused on assessment methods (8,412) is nearly quadruple relative to last quarter (2,633) and nearly double compared to last year at this time (4,421).



Categories of People Trained. Mental health, health care, and child welfare professionals continue to be the groups most often trained by Network centers to treat and assess traumatic stress. This quarter, three out of four (74 percent) centers trained mental health professionals to treat traumatic stress and half of all centers (50 percent) trained them to assess traumatic stress.

	Categories of Trainees							
	Treatment % Centers				Assessment % Centers			
	Y2Q3	Y2Q4	Y3Q1	Y3Q2	Y2Q3	Y2Q4	Y3Q1	Y3Q2
Mental health	81	78	69	74	68	49	41	50
Health care	35	43	39	35	35	30	19	26
Child welfare	35	41	35	44	30	14	15	24
School professionals	38	43	33	44	24	22	7	17
Legal system	30	11	20	37	14	8	7	19
Child care	27	30	28	35	19	11	9	13
Parent/family	19	11	9	20	3	3	2	7
Dom. violence shelter staff	22	16	11	19	16	5	6	7
Faith-based groups	14	5	11	11	0	0	2	6
Government	14	8	9	11	8	5	6	4
Consumers	11	0	6	13	3	0	0	4
Fire/emergency personnel	5	0	2	6	0	0	0	2

Examples of Activities

Seventeen Network centers and the Training Committee reported working to develop new and innovative curricula and to plan training activities in cooperation with service systems and extra-Network organizations. In addition, the following training activities were also reported:

- Staff at the **Center for Pediatric Traumatic Stress, Children's Hospital of Philadelphia**, developed an interactive case-based educational program for the assessment and treatment of pediatric traumatic stress in intensive care units. They also trained more than 50 trauma, emergency medicine, and critical care physicians and nurses on traumatic stress and PTSD in injured children, and conducted a case conference attended by approximately 15 intensive care physicians and nurses.

- **De Pelchin Children's Center Child Traumatic Stress Program, Houston, TX**, conducted a workshop on behavior management for Montgomery Youth Services and the parent-teacher organization at St Thomas Moore School.

- **Intermountain West Primary Children's Medical Center Safe and Healthy Families, Salt Lake, UT**, continues to develop and foster the CTTN-IW, a network of over 150 mental health professionals in seven intermountain states who are organized into 18 teams, each with a designated leader and 2-10 members per team. Teams meet monthly on issues regarding the treatment of child abuse and neglect. Several methods of training are being used including collaboration with national experts by telephone, direct training, manuals, videotapes and peer review during team meetings. On-going response from several of the teams indicates that the specialized training has increased their utilization of empirically supported treatments for abused children.

- During this quarter, the **Trauma Treatment Replication Center, Cincinnati, OH**, trained prosecuting attorneys on what doctors can and can not testify on.

- **Wendt Center for Loss and Healing, Washington, DC**, continues training members of the DC Metropolitan Police Department Family Liaison Specialist (FLS) Unit on how to work with children and families affected by a traumatic death. They also provided training on play therapy techniques for grieving children at conferences in Kansas City and Baltimore.

DISSEMINATION OF INFORMATION AND PUBLIC AWARENESS

An important goal of the National Child Traumatic Stress Network is to make professionals and the public more aware of the causes and prevalence of child traumatic stress and to inform them of the availability of effective services that can help children and their families. Some of the vehicles used by the Network to accomplish this are its website, presentations at conferences or to individual local, state, national, and international groups, publications in professional journals, NCTSN materials linked to websites of other organizations, and media events.

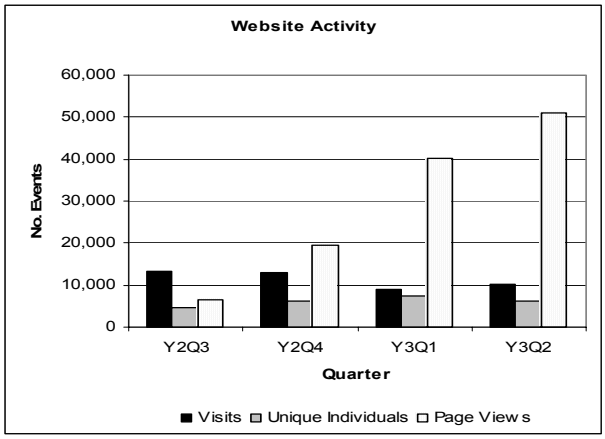
National Resource Center (NRC)

The National Resource Center (NRC) supports the mission of the Network by disseminating relevant, practical information and resources to professionals and the public. Audiences include the media, policy makers, and all those who serve children as well as survivors of childhood trauma and their families. The NRC is continuing to format and catalog the many materials that have been produced by Network centers and collaborative groups so that these have a uniform style and tone.

NCTSN Website

One vehicle which the Network uses to distribute information is the Network website – www.NCTSNet.org. A committee has been established that meets regularly to review the site and to identify areas for expansion or improvement. During this quarter, the existing section for schools was revised. This section will include information on the effects of trauma on learning; crisis planning, response, and recovery; intervention services resources; and checklists for school personnel to use in responding to crises and disasters. Plans were also made to revise materials for the families section and to add resources and materials related to cultural competency to the website.

Website Activity. The graph to the right includes three different measures of website activity – visits, unique individuals, and page views.[3] The number of visits to the website is a general estimate of the overall use of the website. It is a count of the total number of visits to the website regardless of how many times any one particular person visited. There were approximately 10,000 visits to the website this quarter, an amount similar to last quarter.



A second way to gauge the use of the website is in terms of the number of different people, or "unique individuals", who visit the site. Technically, this is a count of the number of unique IP addresses accessing the site rather than unique people. This quarter, the number of "unique individuals" was slightly lower than last, but comparable to or higher than earlier quarters.

The third measure of website use is the number of page views. This measure provides a sense of how much material visitors are exploring once they access the site. The number of page views per quarter has increased consistently across the past four quarters.

[3] Data for each website activity measure were missing for a two-week period in the current reporting period. Weekly average rates were used to estimate the value of these missing data.

Taken together, these data suggest that there is some variability in the quarterly use of the website and in the number of people exposed to the site, but that visitors to the site are increasingly viewing larger amounts of materials on the site.

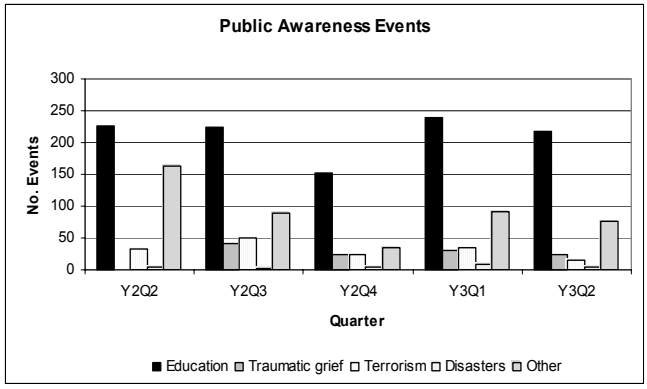
Top Ten Downloads. Nine of the ten most frequently downloaded files this quarter were products developed by Network groups. Among the most popular were materials developed by the National Center's Terrorism and Disaster Branch and School Crisis and Intervention Unit as part of the School and Family Preparedness Initiative. These were also among the most frequently downloaded files last quarter. Other files debuted among the top ten downloads this quarter. These included materials developed by Network collaborative groups concerning the mental health of children who are refugees and childhood traumatic grief.

Document	# Times Downloaded
Family Preparedness Wallet Card*	126
Trauma Information Pamphlet for Parents*	119
"Family Preparedness: Thinking Ahead"*	103
Child Traumatic Grief Educational Material*	79
Trauma Information Pamphlet for Teachers*	75
Checklist for School Personnel…Crisis and emergency Plan*	75
In the Wake of Childhood Maltreatment	68
Tips for Media Covering Traumatic Events*	62
Review of Child and Adolescent Refugee Mental Health*	60
In-Depth General Information Guide to Childhood Traumatic Grief*	54

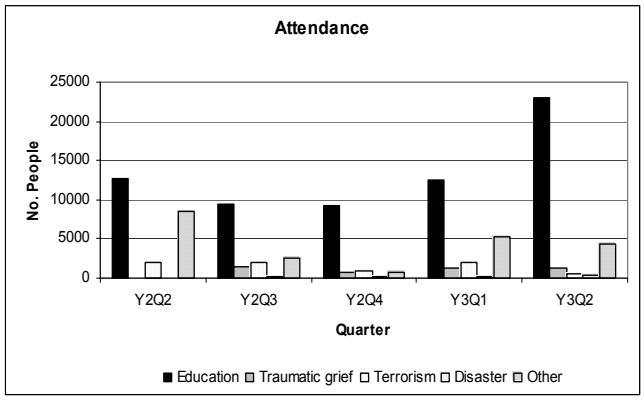
* Network publication

Public Awareness Events[4]

Number of Events. A total of 339 public awareness events were reported this quarter, a decrease of 19 percent compared to last quarter and 25 percent compared to the same quarter last year. The most common focus of the events held this quarter, as in all previous quarters, was general information on traumatic stress (64 percent of all reported events).



Attendance. While there were fewer events, a total of 29,439 people attended Network public awareness events this quarter; an 81 percent increase over the previous quarter, and a 52 percent increase over the same quarter last year. This increase is largely due to an increase in the number of people attending events providing general education on traumatic stress.



[4] Y2Q1 N=29 Y2Q2 thru Y2Q4=36 Y3Q1/Q2 N=54

Categories of Attendees. The table immediately below lists the proportions of centers that reached different categories of individuals with general information about traumatic stress (Education) and other mental health topics (Other). In the case of events focused on educating individuals about traumatic stress, there were appreciable increases this quarter in the proportion of centers reaching mental health professionals, child welfare workers, and parents/family members. The proportion of centers reaching audiences with information on other mental health topics increased for all categories except child care workers.

	Education				Other			
	Y2Q3 %	Y2Q4 %	Y3Q1 %	Y3Q2 %	Y2Q3 %	Y2Q4 %	Y3Q1 %	Y3Q2 %
Mental health professionals	68	57	50	63	50	27	26	35
Child welfare workers	49	30	22	43	16	19	11	20
School personnel	49	49	39	39	13	14	11	19
Child care workers	34	22	13	35	11	11	9	7
Health care professionals	38	35	30	31	24	24	19	22
Parent/family	37	16	13	22	3	5	6	13
Law enforcement/juv. justice	32	22	15	20	11	14	7	17
Consumers	16	5	6	15	0	3	0	7
Faith based	21	16	9	13	13	5	4	9
Domestic violence shelter staff	24	24	11	11	0	11	4	9
Government	16	16	6	7	11	11	4	6
Fire/emergency	3	5	4	4	16	0	0	0
Other	21	16	7	13	0	3	4	9

The next table describes the proportion of centers reaching different audiences with information about more specialized trauma-related topics (i.e., terrorism, disasters, and traumatic grief). Among the notable differences this quarter are increases in the proportion of centers that provided information on traumatic bereavement to law enforcement/juvenile justice professionals and members of faith-based groups.

	Terrorism/War				Natural/Man-made Disaster				Traumatic Bereavement			
	Y2Q3 %	Y2Q4 %	Y3Q1 %	Y3Q2 %	Y2Q3 %	Y2Q4 %	Y3Q1 %	Y3Q2 %	Y2Q3 %	Y2Q4 %	Y3Q1 %	Y3Q2 %
Mental health professionals	9	24	17	15	3	8	6	7	24	24	11	15
Health care professionals	6	5	11	11	3	3	6	6	13	22	7	7
School personnel	4	11	9	9	3	5	7	7	5	11	11	7
Law enforcement/juv. justice	5	0	6	7	0	0	0	4	5	5	2	9
Government	3	3	6	7	0	3	2	4	3	5	2	4
Fire/emergency	2	0	2	7	0	3	0	2	0	0	0	4
Child welfare workers	3	8	9	2	3	3	2	2	3	14	6	7
Parent/family	2	5	0	2	0	5	0	0	0	11	4	7
Child care workers	3	5	6	4	3	0	2	0	5	11	6	4
Domestic violence shelter staff	0	0	0	4	3	0	0	2	3	3	4	2
Faith based	1	5	2	4	0	8	0	2	0	0	2	13
Consumers	1	0	0	2	3	0	0	0	0	0	0	4
Other	2	3	2	4	3	11	2	2	0	8	2	2

Outreach Activity

In addition to reaching people with information about traumatic stress through training and public awareness events, Network centers are also involved with a wide range of individuals and organizations in other ways such as face-to-face meetings with members of local, state, and national organizations. The systems/organizations most frequently targeted by centers' outreach activities were schools, the legal system, mental health, and child welfare.

	Outreach Activities			
	Y2Q3 %	Y2Q4 %	Y3Q1 %	Y3Q2 %
Legal system	43	57	50	54
Schools	38	59	54	52
Mental health	35	54	52	48
Child welfare	19	49	44	43
Government	16	27	30	35
Health care	68	38	30	31
Parent/family	16	32	22	30
Faith-based groups	24	24	24	30
Child care	38	35	26	22
Domestic violence shelters	51	19	15	22
Consumers	24	11	24	20
Fire/emergency	27	8	7	15
Other	38	22	17	19

Media Activity

Network centers reported a total of 150 media events this quarter. As in the previous quarter, the most common type of media activity was local print media (72 events) followed by local television (26), and radio (19). Among items in the media this quarter were references and referrals to the Network in "Psychiatric Times", "The Enterprise" (Brockton, MA), and the CDC "Health Advisory" as well as articles by Network representatives in "Mental Health Weekly", "Desert Exposure" (Grant Co., NM), and on the Child Welfare League of America website.

	Media Events			
	Y2Q3 No. Events	Y2Q4 No. Events	Y3Q1 No. Events	Y3Q2 No. Events
Local				
Print	27	81	85	72
Radio	4	20	18	19
Television	8	49	37	26
State				
Print	10	4	9	8
Radio	2	1	2	1
Television	17	1	7	0
National				
Print	16	11	13	16
Radio	4	4	3	6
Television	4	4	6	10
TOTAL	92	175	180	158

Examples of Public Awareness Activities

- **Boston University, Adolescent Traumatic Stress and Substance Abuse Treatment**, disseminated information about their project via a poster presentation at the annual conference of the Anxiety Disorders Association of America.

- **Chadwick Center for Children and Families Trauma Counseling Program, San Diego, CA**, continued a series of presentations within the community in both English and Spanish to educate the public about child trauma, domestic violence, and child maltreatment.

- **Louisiana Rural Trauma Services Center, New Orleans, LA**, made a number of presentations to local, national, and international audiences, including audiences in Australia, Slovakia, Puerto Rico, Florida, and Connecticut. Staff also addressed the Senate and House at congressional briefings on the Court Teams Project in Washington, DC.

- **Mid-Maine Child Trauma Network, Augusta, ME**, developed a brochure for parents, "ABC's of Helping Your Child Cope with Stress/Trauma." They also participated in a resource fair for parents of children receiving special education and presented information on trauma in a developmental context at a regional conference for primary care providers.

- NCCTS staff monitored national media and responded to reporters' inquiries. They developed press releases, letters to the editor, and op editorials, and successfully assisted Network centers with media, including **Open Arms, Inc**. (GA), the **Center for Child and Family Health** (NC), **Intermountain West** (UT), and the **Mississippi Child Trauma Therapeutic Services Center**. National Center staff participated on a panel providing information to SAMHSA staff on trauma across the lifespan.

- The **National Children's Advocacy Center** offered live streaming video broadcasts of six workshops from the 20th National Symposium on Child Abuse. These workshops focused on the interface between trauma and child welfare and forensic assessment and exam.

- Among the topics covered in presentations made this quarter by staff of **North Shore University Hospital Adolescent Trauma Treatment Development Center, Manhasset, NY**, were how domestic violence impacts preschoolers, how trauma impacts memory, and how to intervene with traumatized children and adolescents.

Selected Publications by NCTSN Members

Kassam-Adams N., & Winston, F. (2004). Predicting PTSD: The relationship between ASD and PTSD in injured children. *Journal of the American Academy of Child & Adolescent Psychiatry, 43*(4), 403-411.

North, C. S., & Pfefferbaum, B. (2004). The state of research on the mental health effects of terrorism. *Epidemiologia e Psichiatria Sociale*, *13*(1), 4-9.

Pynoos, R. S., Steinberg, A. M., Dyb, G., Goenjian, A. K., Chen, S. H., & Brymer, M. J. (2004). Reverberations of danger, trauma, and PTSD on group dynamics. In B. Sklarew, S. W. Twemlow, & S. M. Wilkinson (Eds.), *Analysts in the Trenches: Streets, Schools, War Zones* (pp. 1-22). Hillsdale New Jersey: The Analytic Press.

Silva, R. R. (2004). *Handbook for Post Traumatic Stress Disorder in Children and Adolescents*. NY: Norton Medical Publication.

Steinberg, A. M., Brymer M. J., Decker, K. B., Pynoos, R. S. (2004). The University of California at Los Angeles Posttraumatic Stress Disorder Reaction Index. *Current Psychiatry Reports, 6*(2), 96-100.

NCCTS OPERATIONS

Network and Collaborative Group Development

The National Center continues to support the integration of the latest cohort of centers by responding to inquiries and facilitating connections. SAMHSA received positive comments from centers such as:

"The National Center continues to be an excellent resource and extremely responsive to [our] needs and concerns."

"The National Center has built a wonderful alliance of professional, supportive, and dedicated personnel and centers. Everyone has been supportive, giving of useful information, and generous with their time".

Support for collaborative activities is also ongoing. NCCTS staff are engaged in appropriate collaborative groups and working on expanding and consolidating membership in collaborative groups. During this quarter, NCCTS staff continued to support planning and project implementation by the Adolescent Consortium (formerly the Adolescent Network). Staff also worked with ESI to organize a meeting of individuals working on the Domestic Violence/First Responder group.

NCCTS staff also visited new and earlier-cohort centers this quarter including the National Children's Advocacy Center (AL), De Pelchin Children's Center Child Traumatic Stress Program (TX), Chadwick Center for Children and Families Trauma Counseling Program, (CA), the Childhood Trauma Intervention Center (TN), Children's Institute International (CA), the Mississippi Child Trauma Therapeutic Services Center, Open Arms, Inc. (GA), Children's Crisis Treatment Center, Project Tamaa (PA), Center for Pediatric Traumatic Stress (PA), and the Kennedy Krieger Family Center Trauma Intervention Program (MD).

Finally, during this quarter, staff worked with an independent evaluator (Abt Associates) who conducted an exploratory study of collaboration in the Network. This study was phase I of a two phase contract. The evaluators conducted almost 30 interviews with a broad spectrum of members of the NCTSN in order to elicit their perceptions of the nature, extent, and effectiveness of collaboration across the Network.

Steering Committee

The National Center organized a transparent nominating process to fill two vacancies on the Steering Committee. The Steering Committee held its annual meeting on March 12th and 13th in Durham, North Carolina. Twelve members of the Steering Committee attended along with 17 observers, which included staff from the NCCTS. Among the agenda items were discussions of the Network's core structure and strategic planning for the future of the Network. Brief progress reports were delivered by representatives from the Service Systems Core, the Policy Core, the Liaison and Project Management Team, Monitoring and Evaluation, and the NCTSN Advisory Board selection group.

Sustainability

Work continues on developing a long-range sustainability plan. Center staff are working closely with SAMHSA to address Network sustainability at the federal level. Also, exploratory meetings were organized with foundations and potential corporate donors.

APPENDIX A. NCTSN Centers

Category I National Center for Child Traumatic Stress (NCCTS)

State	City	Cong. District	Center
CA	Los Angeles	29	National Center for Child Traumatic Stress -- UCLA
NC	Durham	4	National Center for Child Traumatic Stress – Duke University

Category II Intervention Development and Evaluation Centers

State	City	Cong. District	Center
AL	Huntsville	5	National Children's Advocacy Center
CA	San Diego	49	Chadwick Center for Children and Families Trauma Counseling Program
CA	S. Francisco	8	Early Trauma Treatment Network
CT	New Haven	3	Childhood Violent Trauma Center
ID	Pocatello	2	Center for Rural, Frontier, and Tribal Child Traumatic Stress Intervention
MA	Boston	8	Boston University, Adolescent Traumatic Stress & Substance Abuse Treatment
MA	Boston	9	Center for Medical and Refugee Trauma, Boston University Medical Center
MA	Newton Centre	4	National Collaborative for Homeless Children and Trauma
NY	New York	14	The Institute for Trauma and Stress, NYU Child Study Center
NY	Manhasset	5	North Shore Univ. Hosp. Adolescent Trauma Treatment Development Center
OH	Cincinnati	1	Trauma Treatment Replication Center
OK	Oklahoma City	5	Indian Country Child Trauma Center
PA	Pittsburgh	14	Allegheny General Hospital Center for Traumatic Stress in Children & Adolescents
PA	Philadelphia	2	Center for Pediatric Traumatic Stress
SC	Charleston	1	Medical University of South Carolina, Crime Victims Center

Category III Community Treatment and Service Centers

State	City	Cong. District	Center
CA	Long Beach	37	Miller Children's Abuse and Violence Intervention Center
CA	Los Angeles	30	Children's Institute International, Central L.A. Child Trauma Treatment Center
CA	Los Angeles	24	Los Angeles Unified School District
CO	Aurora	6	Aurora Mental Health Center
CO	Denver	1	Mental Health Corporation of Denver's Family Trauma Treatment Program
DC	Washington	DC	La Clinica del Pueblo, Inc.
DC	Washington	DC	Wendt Center for Loss and Healing
FL	Clearwater	9	Healing the Hurt, Directions for Mental Health, Inc.
GA	Albany	2&8	Open Arms, Inc.
IL	Chicago	9	Family, Adolescent, & Child Enhancement Services (FACES)
LA	New Orleans	2	Louisiana Rural Trauma Services Center
MA	Allston	8	The Trauma Center, Massachusetts Mental Health Institute
MD	Baltimore	7	Kennedy Krieger Family Center Trauma Intervention Program
ME	Augusta	1	Mid-Maine Child Trauma Network
MI	Kalamazoo	6	Southwest Michigan Children's Trauma Assessment Center
MO	Kansas City	5	Kansas City Metropolitan Child Traumatic Stress Program
MO	St. Louis	1	The Greater St. Louis Child Traumatic Stress Program

Category III Community Treatment and Service Centers (continued)

State	City	Cong. District	Center
MS	Jackson	4	Mississippi Child Trauma Therapeutic Services Center
MT	Missoula	1	Montana Center for the Investigation and Treatment of Childhood Trauma
NC	Durham	4	Center for Child and Family Health
NJ	Stratford	1	University of New Jersey Center for Children's Support
NM	Santa Fe	3	New Mexico Alliance for Children with Traumatic Stress
NY	Albany	21	Parson's Child and Family Center
NY	New York	8	Safe Horizon-Saint Vincent's Child Trauma Care Initiative
NY	New York	14	Jewish Board of Family & Children's Services, Center for Trauma Program Innovation
NY	New York	14	Mount Sinai Adolescent Health Center
NY	Valhalla	18	Children's Trauma Consortium of Westchester
OH	Cleveland	10	The Children Who Witness Violence Program
OH	Toledo	9	Cullen Center for Children, Adolescents, and Families
OK	Tulsa	1	Oklahoma Community Treatment & Service Center
OR	Portland	1	Intercultural Child Traumatic Stress Center of Oregon
PA	Philadelphia	2	Children's Crisis Treatment Center, Project Tamaa
TN	Nashville	5	Childhood Trauma Intervention Center
TX	Houston	18	De Pelchin Children's Center Child Traumatic Stress Program
UT	Salt Lake	2	Intermountain West Primary Children's Medical Center Safe & Healthy Families
VA	Falls Church	8	International C.H.I.L.D., Center for Multicultural Human Services (CMHS)
WA	Seattle	7	Harborview Center for Sexual Assault and Traumatic Stress
WI	Madison	2	Mental Health Services of Dane County, Inc., Adolescent Trauma Treatment Project

APPENDIX B. NCTSN Collaborative Projects and Products

Needs Assessments

Collaborative Group	Project	Stage of Completion
Adolescent Consortium	Map of the field of adolescent trauma (survey of mental health and primary care services so that trauma focused assessments and interventions can be developed and implemented).	2
Complex Trauma Work Group	Survey of complex trauma among youth treated by Network clinicians	3
	Secondary analysis of MHCD data for use in further development and validation of the CANS-TEA child trauma information integration measure and to continue efforts of the NCTSN Complex Trauma Working Group to delineate a developmental trauma disorder for children exposed to multiple and/or prolonged traumatic events	2
Family Interventions Working Group	Survey of family interventions used by Network centers	3
Forensic Medical Exam Working Group	Survey of 100 forensic medical exam providers	3
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	3
Measures Committee	Survey of centers' needs for assessment tools	2
Policy Committee	Survey of Network centers to determine policy concerns	3
	Survey of groups external to the Network to determine policy concerns	1
Refugee Trauma Work Group	Survey of Network centers treating refugees	3
Residential Treatment Work Group	National survey of residential treatment centers, their present level of trauma-informed assessments and treatment, scope of practice, demographics, etc. in order to inform the field and make recommendations for change.	2
Rural Consortium	Survey of resources and needs	1
Service System Integration WG	SIG survey summary – data analysis completed	3
	National survey regarding systems integration in treating children traumatized by crime related activities, best practices, and what parts of the system work well and which work poorly.	2
Sexual Abuse Work Group	Survey 250 NCTSN therapists about knowledge of and attitudes toward manualized, evidence-based treatments – data analysis completed	3
	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
	Survey of centers' training needs – data analysis completed	3
Traumatic Grief Work Group	Study of epidemiology/comorbidity of traumatic grief	2

Reviews of the Field

Collaborative Group	Project	Stage of Completion
Adolescent Consortium	Literature review on the effectiveness of mentors who work with traumatized adolescents	3
	Literature review examining biological and development differences between traumatized and non-traumatized adolescents	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
	Identify common elements across multiple treatments for trauma	2
Psychopharmacology	Literature review of pharmacological treatments for stress related disorders in child and adolescent populations	3
	Survey of prescribing practices with respect to traumatized children	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 Group	Product	Code	Stage of Completion
Adapted Treatment Standards for Children with Disabilities WG	Information sheets on trauma among children who are developmentally disabled and methods for adapting treatment	BIM	3
	Information sheets on trauma among children who are deaf and methods for adapting treatment	BIM	2
	Info for clinicians on providing culturally-affirming mental health treatments to children who are deaf	PGL/M	2
	Policy brief for legislators highlighting some of the most important issues in treating traumatized children who are deaf	WP	2
Adolescent Consortium	Fact sheet describing different types of mentoring and their benefits and caveats	BIM	2
American Indian Working Group	Information package on trauma resources	BIM	3
	Medicine wheel for healing trauma	PGL/M	1
	Comic book or children's book on trauma	BK	2
Complex Trauma Work Group	White paper on clinical issues relating to complex trauma	WP	2
	Curriculum for training on complex trauma	TM	3
	Policy brief on issues relating to complex trauma	WP	2
	Clinical case book	TM	2
	Educational videos	TM	2
	Treatment development and dissemination project	Other	1
Data Operation Committee	Establish and operate Network data repository	Other	2
Forensic Medical Exam Working Group	Study of the effect that providing info to caregiver of sexually abused child about child's needs has on caregiver accessing services	Other	1
Juvenile Justice Work Group	Compendium of readings on juvenile justice and trauma	RL	3
	Fact sheets on prevalence of trauma among youth in jj system	BIM	3
	Reference sheets on assessments, interventions, and various other topics affecting traumatized youth in jj system	BIM	3
	Review of guidelines for delinquency courts working with traumatized youth	PGL/M	3
Kauffman Best Practices Project	"Closing the Quality Chasm in Child Abuse Treatment: Identifying and Disseminating Best Practices"	WP	3
LRCP Advisory Group	Manual development monograph	Other	2
Policy Committee	Policy brief	PB	3
Refugee Trauma Work Group	Policy brief on refugee trauma ("Refugee Children's Mental Health")	PB	3
	White paper II "Refugee Mental Health Interventions	WP	2
	Survey to assess treatment approaches across Centers' to treatment of refugees.	Other	3
	Develop patient data intake form to be used as a research tool to work in the Core Data Set.	Other	1
School Intervention Work Group	9/11 anniversary products in conjunction with TDB and School Crisis and Intervention Unit	BIM	3
	Crisis response educational materials	TM	3
Service System Integration WG	Guideline recommendations for model programs that focus on child trauma and the interaction of systems	PGL/M	3
Sexual Abuse Work Group	Training manual on trauma focused-CBT	TM	3
	Video taped trainings (2) on trauma-focused CBT	TM	3

Training Committee	Training video for Trauma-Symptom Checklist for Children	TM	3
Traumatic Grief Work Group	Information sheets on traumatic grief	BIM	3
	Guidelines for treatment of traumatic grief in pre-schoolers	PGL/M	3
	Manuals on the treatment of traumatic grief in school-aged children and adolescents	PGL/M	3
	Video taped trainings on traumatic grief	TM	3
	Book for children on traumatic grief	BK	2

1= Planned 2= In progress 3=Completed
BIM= Brief information materials; BK=Book; PGL/M= Practice guidelines or manual; RL=Reading list; TM=Training materials; WP= White paper