NCTSN The National Child Traumatic Stress Network

IMPACT

SUMMER 2011

Inside this issue...

A QUARTERLY PUBLICATION OF THE NATIONAL CHILD TRAUMATIC STRESS NETWORK

For "Rare and Precious" Network, a Decade of Progress and Vision of the Future

This year marks the 10th anniversary of the founding of the Donald J. Cohen National Child Traumatic Stress Initiative, through which the NCTSN was created. The co-directors of the National Center for Child Traumatic Stress (NCCTS) took the opportunity at the NCTSN All-Network Conference to acknowledge all that the Network has accomplished since its inception and share their perspectives on the future.

John Fairbank, Maryann Robinson, and Bob Pynoos discuss the ten-year anniversary of the Network

"Ten years ago," John Fairbank, PhD, NCCTS Co-Director, said, "many of us in the field of child traumatic stress were working exclusively with a single type of trauma in a single type of setting." He recalled that there was little public understanding of the impact of children's exposure to a wide range of traumas, and very little awareness of the effects of cumulative exposure. Research on treatment was in its infancy, and training opportunities were few. "Child trauma providers were underfunded," Fairbank said, "and systems were at a loss about what to do with children who had experienced serious traumatic events."

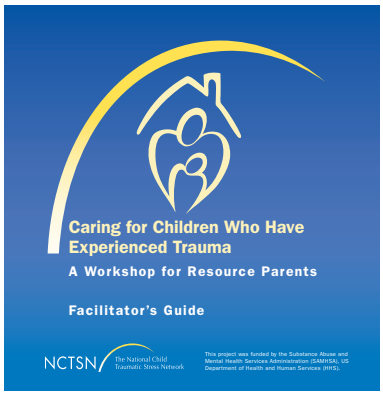
Ten years later, the field has changed dramatically. "With the launch of the NCTSN, we have experienced something new under the sun that is rare and precious," Fairbank said. "Thanks to the Congressionally-mandated Network, we no longer work in silos; we collaborate. Our work is deeply informed by the experience of other providers, other researchers, and the families themselves. Training is much more widely available on how to treat different forms of child traumatic stress, different age groups, in different service settings. We are disseminating our knowledge through partners in all child-serving systems. We have developed over 175 products related to child trauma. Evidence-based practices are reaching hundreds of thousands of children."

>>> *cont'd on pg. 2*

Resource Parents Credit Training for Profound, Transformative Impact

Without the Resource Parent Curriculum, Shannon Reagan-Shaw says she would not have felt able to be an effective long-term foster parent for her children, let alone their adoptive parent. The NCTSN training, she says, gave her the tools she needed to understand and work with the two foster kids who eventually became part of her permanent family.

Children with severe trauma often have destructive and aggressive behaviors; her children had thrown feces and urinated on the carpets. "We were desperate for a tool that would help us be better parents to these kids," Reagan-Shaw told her workshop audience at the NCTSN All-Network Conference in March.



>>> *cont'd on pg. 3*

This project was funded by the Substance Abuse and Mental Health Services Administration (SAMHSA), U.S. Department of Health and Human Services (HHS). The views, policies, and opinions expressed are those of the authors and do not necessarily reflect those of SAMHSA or HHS.

For "Rare and Precious" Network, a Decade of Progress and Vision of the Future

cont'd from pg. 1

Fairbank said that it typically takes 15-20 years for evidence-based treatments to become established in health care and other service settings. The NCTSN has expedited the transfer of knowledge through its collaborative approach to training, intervention development, and creation of new resources. He enumerated the tangible successes of the collaborative model, including comprehensive learning collaboratives that change systems; the national responses to the disastrous hurricanes Rita and Katrina; the development of Psychological First Aid in several formats and languages; and adaptations of proven treatments like Trauma-Focused Cognitive Behavioral Therapy.

Also speaking at the conference, Robert Pynoos, MD, Co-Director of the NCCTS, observed that the goal of the NCTSN was "to bring child trauma out of the shadows. And that has happened." He said that the reality of child trauma and its solutions is now part of mainstream research and clinical and family discussions. Pynoos said that, going forward, "because there is a palpable momentum for providing the best trauma care, the Network will continue to have a profound impact on the field. We are poised for shaping graduate education in a variety of disciplines to include trauma training as part of the regular curriculum. The Network continues to support those in the field and foster the growth of new leaders as well."

> ***"Thanks to the Congressionally-mandated Network, we no longer work in silos; we collaborate. Our work is deeply informed by the experience of other providers, other researchers, and the families themselves."***
>
> *JOHN FAIRBANK, PhD, NCCTS Co-Director*

Pynoos concluded by describing the Network as "a large, protective and supportive shield over the growth of our field…We have to find a way for that not to be weakened so that the work can continue, and children and families can receive the best possible care for years to come."

Constructing Trauma Narratives: Insights from the Experts

Alicia Lieberman and Judy Cohen presented on the value of constructing a trauma narrative

Judith Cohen, MD, and Alicia Lieberman, PhD, the lead developers of Trauma-Focused Cognitive Behavioral Therapy and Child Parent Psychotherapy, respectively, both say that construction of a trauma narrative is a key component of their treatment approaches. How these experts use trauma narratives similarly and differently was the subject of a workshop at the All-Network Conference in March. The two colleagues stressed that their approaches are not in competition with each other.

In Cohen's treatment modality, the trauma narrative is constructed with the child; Lieberman constructs the narrative with the child and parent together. "For most children, what the mother believes shapes the child," Lieberman said, explaining her position with respect to parents. In the process of constructing the narrative, she pointed out, "the mother is the conductor, the therapist is second violin."

Lieberman said that because "progress favors the prepared clinician," therapists should prepare the ground with mother and child and "extend" and connect "the strands" of the trauma narrative.

At her clinic in San Francisco, children under age five average six or more trauma types and their mothers average 13-22 trauma types. Helping the mother understand her trauma will better enable her to understand how trauma impacts her child, Lieberman said. When the mother believes that the child doesn't understand an event or crisis, "the child is cut off from the one person they want to talk with and want understanding from." The child may be more ready than the parent, so the therapist should work to increase the parent's ability to withstand the retelling of the trauma. "The mother has an opportunity to 're-do' her experience of being a child."

>>> cont'd on pg. 4

Resource Parents Credit Training for Profound, Transformative Impact

cont'd from pg. 1

The Resource Parent Curriculum, known as *Caring for Children Who Have Experienced Trauma: a Workshop for Resource Parents*, taught Reagan-Shaw to "think about kids' behavior differently," she said. "We were able to look at the root problem. The children were acting out in the only way they knew how." With knowledge gained from the training, she continued, "we had an opportunity for real change and healing."

Reagan-Shaw took her training in Madison, WI, through the Adolescent Trauma Treatment Project of the Mental Health Center of Dane County, a Network affiliate. Another training participant, Scott Dunahee, joined Reagan-Shaw in speaking at the All-Network meeting in Baltimore and in a subsequent taped interview that will be shown to other resource parents.

> ***"At the core, if a kid does not feel safe and secure, behaviors will not change."***
>
> *SCOTT DUNAHEE, Training Participant*

In the interview, Dunahee recounted how his foster daughter was up for hours every night with night terrors that did not resolve with rational conversation. "At the core, if a kid does not feel safe and secure, behaviors will not change," Dunahee said. With the training, he learned concrete ways to "de-escalate" situations and help his son feel more secure.

"This is a profound set of teachings," Dunahee remarked, adding that he especially appreciated his training following a "meltdown" that his son, seven years old, experienced after a visit from his birth mother. "These kids are not attacking us. It is not about us…and the behaviors are not the child," he said. "The problem-solving sessions of the training helped me personally."

Reagan-Shaw said that each module of the Resource Parent Curriculum helped her, but not until she completed the whole curriculum did she experience "profound change" in the way she parents. It helped her to see how trauma informs her children's behavior, and to then use that knowledge in day-to-day interactions with the children.

Dunahee is in the process of adopting his 7-year old boy and the boy's 9-year-old brother, along with an 11-year-old girl who has been his foster daughter. He returns again and again to the information gained from the training, so that he can reconsider what is happening with his kids and find more effective ways to work with them. "Kids have to feel safe, not just be safe," he said.

Scott Dunahee and Shannon Reagan-Shaw, both resource parents, described how the Resource Parent Curriculum has made a profound impact on each of their families' growth.

Chris Foreman, MSSW, an individual affiliate of the NCTSN, has been using the Resource Parent Curriculum for several years to train Dane County foster parents. Foreman said that in her experience, the training "truly results in increased placement stability and helps improve child well-being. There are dozens of children in our community who are doing well directly because of their caregiver's dedication to learning and implementing a trauma lens in their parenting."

Foreman and colleague Elizabeth Sharda, MSW, of Bethany Christian Services in Grand Rapids, MI, an NCTSN site, helped organize the workshop at the All-Network meeting so that Network members could discuss how to break down the barriers to full implementation of the curriculum. One barrier is the once-weekly, six-week commitment to the training, which can seem daunting for busy foster parents. It is that particular obstacle that Tripp Ake, PhD, Assistant Director of Training at the Center for Child and Family Health in Durham, NC, said he hopes to overcome with showings of the videotaped interview with Reagan-Shaw and Dunahee. The interview, he said, will reveal to foster parents why it is worth their effort to attend the full training.

Constructing Trauma Narratives: Insights from the Experts *cont'd from pg. 2*

Although parents can contribute meaning to the traumatic event for the child, they can also be trauma reminders. "One danger in the co-created narrative is that the mother can undermine the child's perspective," Lieberman pointed out. So, the therapist sometimes has to act as a translator for the mother and child to increase their mutual understanding. The therapist should work to actively bridge and validate both the child's and parents' perspectives.

The trauma narrative can be expressed in words, in somatic re-experiencing of events, or in symbolic behavior and play. It will be fragmented, imperfect, and evolving; indeed, disorganization of the trauma narrative may be a necessary stage in its development, according to Lieberman.

Cohen said she agreed, adding that sometimes a lack of coherence in the narrative "is important in itself." She also mentioned that about 85% of youth treated with Trauma-Focused Cognitive Behavioral Therapy name the trauma narrative as their favorite part of treatment.

Cohen described key steps for the therapist in constructing a trauma narrative:

1. Look for the underlying theme to the child's story and build on it. Lack of protection or fear of abandonment are examples of underlying themes.
2. Add thoughts and feelings—as much as the child is willing to add—to validate the child's subjective experience.
3. Address the maladaptive beliefs that follow from distorted premises, such as the child's notion that he or she should have been able to stop a traumatic event from happening.
4. Help the child make meaning of events. Statements about "what I have learned, how I have changed, and what I would tell other kids" assist children in that effort. It is effective at this stage to engage a child's altruism in helping other children prevent or cope with similar events.

Cohen said this approach to narrative construction typically takes from 12 to 22 sessions. Lieberman said the "more leisurely" approach of her model is important because "we want to promote an approach to life." On that note, Cohen quoted the philosopher Jean Paul Sartre, who said, "Freedom is what you do with what is done to you." The trauma narrative, she emphasized, helps children regain their freedom.

A Seminal Researcher Reviews Resilience

The goal of resilience work is to support adaptive systems in children and families, given that the greatest danger to children occurs when these systems are damaged or destroyed, Ann Masten, PhD, said at the opening plenary of the NCTSN All-Network Conference in Baltimore.

But even when adaptive systems are faulty, children's own executive functioning skills are malleable through focused treatment and training, and these interventions positively impact the children's brain functioning. Masten pointed out that the basic methods of fostering resilience in children and families include risk reduction, increasing or restoring resources, and nurturing the families' adaptive systems.

> ***"...helping parents function well through a crisis has a protective impact on the children."***
>
> *ANN MASTEN, PhD, Distinguished McKnight University Professor, University of Minnesota*

Masten, Distinguished McKnight University Professor at the University of Minnesota, is the author of "Ordinary Magic: Resilience Processes in Development," first published in *The American Psychologist* in 2001. Her article upended conventional wisdom about children and traumatic events by pointing out that resilience is common among children rather than extraordinary. Masten recently co-edited a special section of the journal *Child Development* (July/August 2010) devoted to children's resilience and recovery following disasters around the world.

Since it began more than 40 years ago, research in resilience has cumulatively shown that children who are most affected by trauma may also benefit the most from interventions, Masten said in Baltimore. She also emphasized that parents are at the top of nearly every "short list for resilience" in young people. "Parenting quality modulates risk. As risks rise higher and higher, parents have a bigger and bigger impact." So, helping parents function well through a crisis has a protective impact on the children.

Network Members Ask: How do we Define Trauma-Informed Systems?

After working to assure that their own agencies, their community partners, and entire child-serving systems are providing children with trauma-informed care, members of the NCTSN are now seeking a shared definition of trauma-informed systems.

At the All-Network Conference in Baltimore, laying the foundation for such a definition was a foremost topic in a discussion led by members of the Trauma-Informed Systems Collaborative Group.

Susan Ko, PhD, who is co-managing the National Center for Child Traumatic Stress at UCLA and helping to coordinate the collaborative group, said the Network's approach has always been to work in multiple child-serving systems at the same time. Because the various entities have differing definitions of 'trauma-informed systems,' it is appropriate for the NCTSN to play a role in defining these systems for its members and partners. Ko said the central issue is about "infusing the trauma perspective into existing systems."

Lisa Conradi, PsyD, Project Manager/Psychologist at Rady Children's Hospital in San Diego, commented that the importance of trauma-informed care is now clear. "In the past," she said, "the mental health diagnoses that kids were getting weren't fully explaining what was going on. The literature on child trauma best explains how and why children and parents behave the way they do. So, we now try to integrate that understanding into everything we do."

Charles Wilson, MSSW, Executive Director of the Chadwick Center at Rady, added that "Trauma, with a 'capital T', is the kind of event that creates a traumatic stress reaction. Trauma-informed systems are aware of how we as providers can help or make it worse."

Other members of the collaborative group said that trauma-informed systems are defined by their recognition of the following beliefs:

- That parents are often trauma survivors themselves. They may need help recognizing the signs and symptoms of traumatic stress and learning to manage their own reactions, as well as those of their child.
- That culture influences in how trauma is expressed and treated.
- That trauma-informed systems are grounded in human experience.
- That work with child-serving systems calls for adding to their knowledge in the language they use.

Sometimes it helps to approach a positive definition from its negative, said Ginny Sprang, PhD, Buckhorn Professor of Child Welfare and Children's Mental Health at the University of Kentucky. Accordingly, "Avoidance of the emotional experience of traumatized children is a hallmark of systems that are not trauma-informed."

The Trauma-informed Systems Collaborative Group expects to spend the next year incorporating its ideas into a working definition. "As we start seeing more research on trauma-informed systems," Charles Wilson reaffirmed, "we have to be clear that we are comparing apples to apples."

Professional Self-Care: How to Avoid and Manage Secondary Trauma

Professionals who help children cope with their traumatic stress reactions are at risk of experiencing secondary trauma. Like their clients, professionals might then experience alterations in their thinking about the world, their relationships, and their lives.

Preventing and addressing secondary traumatic stress was the subject of the workshop "Caring for the Caretaker" at the NCTSN All-Network Conference in Baltimore.

While burnout stems from a heavy workload and inadequate institutional support, secondary stress (sometimes called vicarious trauma) stems from exposure to children's trauma. Therapists' emotional gifts—like empathy—can leave them especially vulnerable, said Judith Cohen, MD, Medical Director of the Center for Traumatic Stress in Children and Adolescents of Allegheny General Hospital, Pittsburgh.

From left to right: Judy Cohen, Leslie Ross, Ginny Sprang, Erika Tullberg

>>> cont'd on pg. 6

"A Light Went On:" CWLA Chief Affirms Trauma Focus and Commitment

The Child Welfare League of America is committed to becoming trauma-informed, said Christine James-Brown, the league's president and CEO, in an interview with the NCTSN. The CWLA is a strategic partner of the Network and an active collaborator on multiple projects.

"This is not the 'flavor of the week,'" James-Brown said of her organization's engagement with child trauma issues. "It is important for us to learn from the NCTSN and take that knowledge and spread it, and embed it in our policies and practice parameters."

James-Brown recalled that when Network representatives spoke at a CWLA conference three years ago, "a light went on: there are words for what was going on with workers and the kids, including secondary trauma." She said that CWLA's focus on child trauma has had notable secondary effects. For one, child welfare workers are now considered to be first responders. In addition, the trauma focus is helping to unify the efforts of public and private child services agencies.

CWLA
Together, Making Children and Families a National Priority

Professional Self-Care: How to Avoid and Manage Secondary Trauma *cont'd from pg. 5*

"What makes us good therapists is also what puts us at risk." Yet, Cohen pointed out that every factor that can stress a clinician can also be a source of compassion, making the clinician even more effective.

Stresses weighing on clinicians can arise from their clients' experiences (such as early, severe interpersonal trauma and loss), agency factors (such as heavy caseloads and less time for supervision and consultation), and personal factors (such as the therapist's own trauma history and recent family events). Cohen said that the greater the frequency and intensity of exposure to secondary traumas, the greater the clinician's risk for secondary traumatic stress. "Taking care of ourselves is necessary for optimal client care," she said, adding that one method of clinician self-care is to actively seek and offer support to and with peers.

Cohen recommended that clinicians know both the signs of secondary trauma—such as irritability, not wanting to go to work, illness, and compassion fatigue—and the triggers of it. To minimize exposure to their trauma triggers, some therapists might limit the types of clients or traumas they work with. Others seek increased help from supervisors when working with challenging clients. (Cohen emphasized that "you cannot help others if you do not feel safe. Do not stay at an agency that does not value your safety.") Working from a therapeutic model that is proven to benefit children can also help reduce therapists' stress. Those therapists who use evidence-based practices report lower levels of secondary traumatic stress.

> ***"What makes us good therapists is also what puts us at risk."***
>
> *JUDITH COHEN, MD, Medical Director of the Center for Traumatic Stress in Children and Adolescents of Allegheny General Hospital, Pittsburgh*

Leslie Anne Ross, PsyD, Vice President of the Leadership Center at Children's Institute, Los Angeles, said her organization is working to promote resilience and wellness among its providers. She recommended that organizations ask who in the agency is accountable for staff well-being; how self-care is integrated into supervision; whether policies are in place regarding staff safety; and whether the agency provides training to staff on managing secondary traumatic stress.

Ross said that staff can also take matters in their own hands by forming and participating in a group with which they can share successes and solutions for managing secondary trauma. Providers can also "find a buddy and hold each other accountable for self-care," she said.

Active self-care is just as important for supervisors as line clinicians, said Ginny Sprang, PhD, Director of the Center for the Study of Violence Against Children at the University of Kentucky. "Supervisors may be carrying around hundreds of cases in their heads."

Spotlight on Culture: Implementing Cultural Competence

Therapy is always the interaction of two or more cultural identities, a concept that makes cultural competence an essential part of providing effective therapy. With a focus on enhancing cultural competence in the treatment setting, we are introducing *Spotlight on Culture*, an initiative of the NCTSN Culture Consortium Collaborative Group. Our goal is to share with professionals the many ways that NCTSN members are approaching and implementing cultural competence. For this we invited firsthand accounts from members about their experiences and projects.

The first contribution comes from Marta I. Casas, MA, a therapist from the Latin American Health Institute (LHI), a Network member since 2007. The Institute's main goal has been to adapt, implement, and evaluate Trauma-Focused Cognitive Behavioral Therapy (TF-CBT) to meet the treatment needs of Latino children in the Boston area. The LHI has implemented culturally-sensitive adaptations of TF-CBT that are appropriate for recent immigrants, unaccompanied migrant children, children with low levels of acculturation, and children whose caregivers adhere to certain cultural practices regardless of their degree of acculturation. The adaptations also consider regional variations of cultural practices in Latin American countries. They have been found to improve treatment engagement and to empower children and families.

Marta Casas offered the following examples of the linguistic and cultural adaptations that LHI staff have implemented:

- ***Adjusting to literacy and language issues***. Many parents and children who have recently arrived in the United Sates have limited literacy, even in their native language. They need much more time to understand and complete standard forms related to their care. We have overcome this obstacle by administering the forms in interview format.
- ***Use of folk tales in psychoeducation***. We use Latin American folk tales as a platform for providing psychoeducation about posttraumatic symptoms and

>>> *cont'd on pg. 8*

Inside Trauma-Informed Systems: Ideas and Models for a Resilient Staff

Organizations may take excellent care of children with traumatic stress but often less successful at taking care of their providers. At the All-Network Conference in Baltimore, this was the theme of a discussion of the interplay among agencies, staff, and clients in trauma-organized systems.

"Organizations are organisms," said Brian Farragher, MSW, Chief Operating Officer of the Andrus Children's Center in Yonkers, NY. "We are as susceptible to stress, strain, and trauma as the people we serve." When trauma therapists experience secondary stress, agencies may be faced with very high rates of staff attrition and turnover, which is wasteful of valuable human resources and costly in rehiring and training time. Farragher said that therapists may be especially vulnerable to secondary trauma when they are managing highly traumatic cases, such as those involving the death of a child. They may be rendered emotionally numb, unavailable, or distracted in carrying out their work.

Farragher counsels agencies to "pay attention to the collective unconscious of an organization, of all that is happening under the surface," that could be impacting the care children receive. "These kids need people around them who believe in change and who can model change," he said. "If you don't have hope that things can be better, where are our clients going to get that hope?"

The Sanctuary Model

Joe Benamati, MSW, EdD, of the Sanctuary Institute at Andrus Children's Center in Westchester County, NY, described the supportive practices of the institute's staff.

>>> *cont'd on pg. 8*

Spotlight on Culture

cont'd from pg. 7

reactions. An example of this is the use of the legend of "La Llorona" (The Crying Woman), a figure from the folklore of several Central and South American countries. La Llorona drowns her children and is later condemned to perpetually cry at the sound of water, which reminds her of her loss. The story helps us to illustrate the concept of triggers and how they function as reminders of traumatic experiences.

- ***Identifying culturally appropriate ways to describe distress***. We help parents identify regional idioms of distress. The goal is to "translate" their folk expressions of trauma into shared concepts, so that the caregiver and child can speak in a common language about the trauma sequelae.
- ***Use of folk art***. Folk art, such as *Alebrijes, Vejigantes, and Mascaras de Diablo Cajuelo*, helps to illustrate aspects of affect regulation by encouraging the exploration and identification of feelings.
- ***Creating a life story***. Children create a rich narrative, which we call a "Roots Scrapbook," using poems and images. The narrative begins from their place of birth and includes traumatic memories, survival responses, as well as positive experiences that have helped them to cope. This approach promotes the telling of a more complete story within the context of their culture of origin.

Marta reminded us that culture is always present in the therapy room, regardless of the client's and therapist's ethnicity, race, nationality, and other cultural characteristics. Exercising cultural competence in treatment can help children and families more successfully interpret, manifest, and cope with distress, and ultimately overcome their traumatic experiences.

Inside Trauma-Informed Systems: Ideas and Models for a Resilient Staff

cont'd from pg. 7

He said that every morning and afternoon, the staff have a meeting that starts with the question, "How are you feeling today?" Every staff member answers and together they create a holding environment for each others' experiences.

> ***"Organizations are organisms. We are as susceptible to stress, strain, and trauma as the people we serve."***
>
> *BRIAN FARRAGHER, MSW, Chief Operating Officer, Andrus Children's Center, Yonkers, NY*

The Andrus Center is part of the Trauma Consortium of Westchester, an NCTSN affiliate site. The center's implementation of the Sanctuary model of trauma-informed residential care has been fundamental to its work. The model looks at trauma holistically, said Sarah Yanosy, LCSW, Director of the Sanctuary Institute. "It is not an intervention with clients only. It is also about how you interact with stakeholders." Understanding of trauma is applied to coworkers in an effort to create a trauma-informed culture for the agency as well as for clients. "We are really good at looking at clients," said Yanosy. "We need practice looking at ourselves from different perspectives."

The underlying philosophy of the Sanctuary model is that "trauma happens" but that people can recover, Yanosy said. The model is based on seven values: nonviolence; open communication; emotional intelligence; social learning; democracy (which counters helplessness); social responsibility (which counters a victim mentality), and growth and change (which counter "getting stuck" in the past).

Landa Harrison, MEd, acting Assistant Director of the Institute, called these values "the framework for building the culture and organization we want." She said that after adopting the Sanctuary model, staff members have felt more supported and the center has become much more collaborative in its efforts. "We no longer work in silos," she said.

Sanctuary Model Makes Impact in Juvenile Justice

A longitudinal study of new employees in the New York state juvenile justice system suggests the importance of permeating systems with trauma-informed care.

A survey of new cadets in 20 different classes revealed that 42% of these future juvenile justice workers experienced psychological abuse, 39% experience physical abuse, and 20% experienced sexual abuse as children. Histories of physical and emotional neglect were similarly prevalent, and many cadets reported more than one adverse childhood experience (18% had six or seven such experiences).

"You have to educate staff about what is going on with them," said Joseph Benamati, MSW, EdD, of the Sanctuary Institute at Andrus Children's Center in Yonkers, NY. The goal is to help prevent them from inadvertently re-enacting a childhood trauma. Benamati said that following staff training in the Sanctuary model and the principles of Dialectical Behavior Therapy, there has been a reduction in the use of restraints in facilities in the state juvenile justice system.

Have You Heard?

Elissa Brown, PhD, Professor of Psychology and Executive Director of the **PARTNERS Program** at St. John's University, recently received a 4-year, $1 million federal grant to adapt best practices in mental health for multicultural communities in the Queens, NY area. Selected as one of 10 sites chosen from a field of 200 national applicants, the PARTNERS Program will receive funding provided by **the Office of Juvenile Justice and Delinquency Prevention's Safe Start Initiative**. Dr. Brown and her PARTNERS team will deliver their nationally-recognized program of mental health services to children and families exposed to domestic violence, dating violence, sexual assault, and physical abuse. Over the four years of the grant, hundreds of families will receive state-of-the-art therapies and then be studied for two years to monitor their progress and connect them with other needed services. Dr. Brown's project will not only help families in Queens, but will be a national model for fighting the intergenerational transmission of family violence.

Bryan Samuels, Commissioner of the **Federal Administration on Children, Youth and Families**, reports that in the past 14 years the nation's child welfare system has shrunk by 25%. Speaking at the All-Network meeting in Baltimore on March 1, Samuels said that the system now serves half as many African American youth and has higher rates of adoption than it did in 1997. Youth in the system also have shorter average lengths of stay.

Glenn Saxe, MD, Chair and Clinical Professor of Child and Adolescent Psychiatry at New York University and director of the Child Study Center, appeared in his professional capacity on a taped comedy segment on the **Colbert Report** on February 14. He was interviewed for a video called "The Enemy Within—Toddler Edition," inspired by news of a New York judge ruling that a four-year-old child could be sued for negligent behavior. After Saxe asserted that jail was inappropriate for children, Colbert called him a "toddler coddler."

A recent review of research by the **US Department of Justice** confirms the prevalence of traumatic experiences among youth in juvenile justice systems and the high value of addressing those traumas in children and families, according to **Phelan Wyrick, PhD**, Senior Advisor in the Office of Justice Programs. Wyrick said DOJ's research review shows the importance of: intervening with both the child and the parent; combining home-based and center-based approaches to treatment; and, screening for poly-victimization and recognizing the full range of violence exposure. Wyrick spoke at the opening plenary of the NCTSN All Network Meeting, March 1, 2011 in Baltimore.

Do you want to receive future IMPACT newsletters?
Email: newsletter@nctsn.org

Did You Know?

The Resilience Alliance intervention is a project of the Children's Trauma Institute, a Network member formed by New York City's Administration for Children's Services and the Mount Sinai School of Medicine. The intervention was developed to address secondary traumatic stress and reduce attrition among the city's child welfare workers and supervisors. By strengthening the workers' resiliency skills and social supports, the intervention seeks to

- Improve attitudes, optimism, and self-efficacy to offset negativity of recurrent stress
- Support the mastery of skills to manage traumatic stress reactions
- Enhance collaboration among workers, supervisors, and clients

Four years ago, the pilot Resilience Alliance training project in Manhattan showed that participating child welfare workers (new workers and supervisors) had significantly greater optimism, more job satisfaction, improved ability to handle stress, less burnout, decreased attrition, and fewer overdue cases. Following the success of the pilot, the resilience intervention has been extended to veteran staff.

About IMPACT

IMPACT is a publication of the National Child Traumatic Stress Network (NCTSN). It is produced quarterly by the National Center for Child Traumatic Stress (NCCTS), co-located at UCLA and Duke University. The NCCTS serves as the coordinating body for NCTSN member sites, providing ongoing technical assistance and support.

Managing Editor: Patrick Cody
Consulting Editor: Melissa Culverwell
Design & Layout: Sue Oh Design

Established by Congress in 2000, the NCTSN is a unique collaboration of academic and community-based service centers whose mission is to raise the standard of care and increase access to services for traumatized children and their families across the United States. Combining knowledge of child development, expertise in the full range of child traumatic experiences, and attention to cultural perspectives, the NCTSN serves as a national resource for developing and disseminating evidence-based interventions, trauma-informed services, and public and professional education.