NCTSN

The National Child Traumatic Stress Network

IMPACT

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From the NCTSN Co-Directors: An Invitation to Explore the Network's Data and Evaluation Initiatives

Welcome to this special edition of *IMPACT*, in which we focus on the multifaceted role of data in improving the quality of care for children who have experienced trauma.

Systematic collection and scientific analysis of data have always been integral to the mission of the National Child Traumatic Stress Network (NCTSN). We have built an infrastructure to collect child-level behavioral health data to improve the care of the children served by the NCTSN; use organizational-level indicators and metrics to assess performance; and evaluate NCTSN programs and products. These data and evaluation initiatives are used to advance trauma-informed care and support our core values of accountability and sustainability.

Our early efforts led to the creation of two shared data systems. With the first system, the NCTSN Core Data Set (CDS), we collected child-level treatment data from more than 19,000 children and adolescents served by 72 NCTSN centers, as part of overall program evaluation activities. By analyzing these data, we have come to understand in greater depth the impact of trauma on children and adolescents.

(L to R): Robert S. Pynoos, MD, MPH, Co-Director, UCLA Neuropsychiatric Institute, and John A. Fairbank, PhD, Co-Director, Duke University Medical Center.

We have disseminated the findings to key stakeholders and reported them in more than 35 publications. With the second system, the electronic Service Utilization Form (e-SUF), we utilized organizational-level data to answer key questions about how we were functioning as a Network. We were able to document the delivery of trauma-informed training by NCTSN members to hundreds of thousands of professionals on topics that supported workforce development across all child service systems, including child welfare, juvenile justice, and schools, and for populations including military families, refugees, and domestic violence survivors. The National Center for Child Traumatic Stress (NCCTS) provided technical assistance, consultation, and the infrastructure necessary to refine the data systems and support the use of standardized outcome measures, evidence-based interventions, and best practices for children and families exposed to trauma.

Throughout this issue, Network members describe their experiences using these data and evaluation initiatives for their intended purposes: to transform the delivery of clinical care, improve staff training, and raise awareness.

Additionally, two new NCTSN data efforts are highlighted: the Clinical Improvement through Measurement Initiative (CIMI) and the Collaborative Change Project (CoCaP). Building on the CDS, CIMI provides an innovative technology platform for enhancing clinical practice and outcomes. Similar to the e-SUF, CoCaP is a continuous quality-improvement effort that uses organizational data to track and monitor program

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>
> *ROBERT S. PYNOOS, MD, MPH, and JOHN A. FAIRBANK, PHD, NCTSN Co-Directors*

outcomes across the Network. The goal with CIMI, CoCaP, and our other data and evaluation efforts is to discover and share the most effective ways to help children and families.

As we begin the Network's 16th year, we are pleased to share with you some of the ways we hold ourselves accountable through our data collection and evaluation efforts. We would especially like to thank our sites and the thousands of children and families who have contributed to the success of these efforts. We hope that this issue will inspire you to learn more about how data and evaluation can be used to transform clinical care for our most vulnerable youth.

Sincerely,

Robert S. Pynoos, MD, MPH
Co-Director, UCLA Neuropsychiatric Institute

John A. Fairbank, PhD
Co-Director, Duke University Medical Center

The Key to Successful Use of Data: Partnering With Foster Parents

Collection and evaluation of assessment and treatment data can make a difference for foster children who have experienced trauma, say two foster parents who have helped steer the design of the NCTSN data collection efforts. Both parents emphasized that to engage foster families in the process, clinicians must be able to communicate the utility of gathering this sensitive information, and show how it relates to treatment plans.

Mandy Taylor and her husband live in Grand Rapids, MI, and have fostered 13 youth, four of whom they adopted. Completing the Child Assessment of Needs and Strengths (CANS) and Family Assessment of Needs and Strengths (FANS) tools is required for all children entering the state's foster care system. This screening provides information intended to help set the goals of care. The Taylors have often sought counseling and other mental health services for their children who have emotional and cognitive impairment issues. But many times, Taylor did not receive feedback on the information she had furnished about her kids at intake. That communication gap, Taylor said, makes foster parents "feel like we want to shut down and not give some of that vulnerable information the next time." She added, "You [clinicians] have a lot of information you need to gather, and if you're not asking questions in a friendly way toward the family member, you're not going to get the right answers. When you're not getting the right answers, you're not setting the right goals, and then you're not achieving goals in an effective way. It all starts with needing to talk to a family in the way that they're going to understand and respond to."

Mandy Taylor, Grand Rapids, MI, foster parent and family advocate.

> "If you're not asking questions in a friendly way toward the family member, you're not going to get the right answers."
>
> *MANDY TAYLOR, Family Advocate*

These messages resonated powerfully with Network members when Taylor participated as a family advocate in a yearlong Breakthrough Series on Assessment and the NCTSN Core Curriculum. Lisa Conradi, PsyD, a clinical psychologist and Director of Clinical Operations at the Chadwick Center for Children and Families at Rady Children's Hospital, San Diego, CA, was one of the faculty members in the Breakthrough Series. Treating foster parents as partners, and sharing collected information with them, were messages that rang true for Conradi. "For me, this solidified the importance of being highly intentional and specific, as we work with clients, about why we're doing these measures," she said.

And – here's the key step – sharing the collected information with clients can help them see how their experiences compare with those of others. That was the missing piece, Taylor said, whenever she was required to fill out assessment measures for her foster children. Real-time reports can be used to provide critical feedback.

Guidance for Clinicians

Taylor has been on the faculty of a Breakthrough Series on *The Meaningful Use of the CANS-Trauma and FANS-Trauma with Youth and Families*. Clinicians can use the screening and assessment process to engage parents and build trust, she said. If clinicians clarify that reassessments are being done to measure progress, and use the results as a springboard to look at strengths as well as areas of struggle, parents will be more likely to engage. "If you don't give these reasons," Taylor said, "parents may interpret the re-test as a sign that they (and the child) are 'failing' at therapy." Conversely, the ability to show, in a graphic presentation, how measures on a particular scale have changed, can make parents and their children feel included instead of being subjected to an arbitrary process.

Data-Driven Improvements

Foster parent Shannon Reagan Shaw and her husband, who live in Sun Prairie, WI, have fostered 25 children and adopted two out of foster care. Reagan Shaw discovered the usefulness of the NCTSN Resource Parent Curriculum (RPC) early during her foster parent years. She quickly became a co-facilitator and then a facilitator, and has since been active as a disseminator of the curriculum. She founded and continues to participate with *It's Not About You*, an RPC support group focused on using the curriculum's trauma-focused information to change parenting practices.

Shannon Reagan Shaw, Sun Prairie, WI, foster parent and member of Child Welfare Practice Lab.

With a graduate degree in cellular biology, Reagan Shaw saw research as a natural direction to pursue, and she became involved in the Child Welfare Practice Lab early in its development. "We had lots of anecdotal evidence that the RPC helped keep kids in stable placement, but we wanted to explore the reasons behind positive outcomes," she noted. "The first piece we had to figure out was, what research questions are we trying to answer?" The RPC focuses on education and on explaining the thoughts/feelings/behaviors of children who have experienced trauma, so the evaluation efforts looked at those areas. The

collaborative evaluation approach addressed a key question: To what degree does the RPC influence the trauma-informed perspective of parents attending the workshop? Reagan Shaw explained: "We measured changes in parenting self-efficacy, attribution (the reason the child is behaving in a particular way), as well as retention (the intention to remain a foster or kinship care provider). Further, we attempted to ascertain if any variation in implementation approaches could be responsible for any measured changes."

Reagan Shaw said that the data collected from the Practice Lab "expanded our knowledge base on local implementation of this popular NCTSN product, which informs the dissemination of this trauma-informed workshop throughout the child welfare system. Children, families, and the child welfare team all benefit from participation in the Lab itself, and from improvements at a local and national level with this type of partnership." For example, using data from the Practice Lab, Reagan Shaw has now updated the mandatory foster-parent training curriculum for Wisconsin.

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>
> *SHANNON REAGAN SHAW, Child Welfare Practice Lab*

Conradi praised the Data and Evaluation Program at the National Center for Child Traumatic Stress for their guidance on making assessment useful for clients and clinicians. Going forward, the assessment categories have been broadened to include younger children and cultural components of trauma. This is the direct result of the give-and-take of the Core Data Set (CDS) to the Clinical Improvement through Measurement Initiative (CIMI) development process.

Conradi said that feedback from resource parents and former foster youth has proved invaluable to the design of measures that will engage clients. "For so long in the mental health field," she observed, "we've relied on the notion that if we ask the right questions and gather information, then that's enough [to help clients]. We didn't necessarily see data as being important in that process."

Lisa Conradi, PsyD, Director of Clinical Operations at the Chadwick Center for Children and Families at Rady Children's Hospital, San Diego, CA.

Taylor and Reagan Shaw are optimistic about the progress being made for foster and adoptive parents and their kids. They agreed that with the CANS, Child Welfare Practice Lab, and other measures and innovations in CIMI, there have been "huge strides" in the ability to help clinicians understand the work from the family point of view. ∎

CoCaP
Collaborative Change Project

The NCTSN Collaborative Change Project (CoCaP) is a shared measurement system that uses organizational-level data from a common set of indicators to answer important questions about the NCTSN. CoCaP provides the NCTSN with a mechanism to document its scale and to define its influence on raising the standard of care for children and families who have experienced trauma. The project increases our ability to benefit from collaboration – a hallmark of the NCTSN.

CoCaP enables us to answer key questions that are important to stakeholders, such as

- **How many children is the NCTSN serving?**

- **How many mental health providers, professionals, and paraprofessionals does the Network train?**

- **What service systems are being reached by the NCTSN? How does this change over time?**

- **What role does the NCTSN play in response to highly publicized catastrophic events?**

CoCaP data from July 2015 to June 2016 show that in the area of education, NCTSN centers

- **Delivered 22,400 hours of instruction, on topics such as clinical interventions, assessment methodologies, and general trauma education, to 182,200 contacts**

- **Engaged participants in *all* child serving systems – mental health, child welfare, juvenile justice, school, and medical settings.**

Center for Trauma Recovery and Juvenile Justice Utilizes Core Data Set to Explore Trauma Patterns

While it is well-known that adverse childhood experiences (ACEs) often do not occur as isolated events, less is known about how patterns of co-occurring ACEs and trauma might change across development, and how these might influence the emergence of psychological health problems and impairment such as posttraumatic stress disorder (PTSD) and juvenile justice involvement. Director and Principal Investigator Julian D. Ford, PhD, of the Center for Trauma Recovery and Juvenile Justice, and his colleague Damion J. Grasso, PhD, Assistant Professor of Psychiatry, UConn Health in Farmington, CT, saw an opportunity with the NCTSN Core Data Set (CDS) to begin to address these questions.

The Initial Study and Findings

To carry out their study,* Grasso, Ford, and colleagues Dierkhising, Branson, and Lee accessed de-identified data collected between 2004 and 2010 from 3,485 youth receiving services at 56 different NCTSN centers. The CDS used

several measures to delineate the number and types of ACEs and trauma experienced by the youth, including the Trauma History Profile, the UCLA PTSD Reaction Index, the Child Behavior Checklist, and Service Utilization/Juvenile Justice Involvement. Responses to these measures came in retrospective reports from the participating youth, and furnished rich layers of detail. Analysis of trauma profiles in the CDS was informed by the authors' own research on polyvictimization in populations

Julian D. Ford, PhD, Director, Center for Trauma Recovery and Juvenile Justice, UConn Health, Farmington, CT.

of youth involved in juvenile justice and child welfare; as well as by the work of others in the field, including David Finkelhor and colleagues, investigators for the National Survey of Victimization of Children and Youth.

Grasso and colleagues grouped the retrospective reports of traumatic events from the CDS into three developmental epochs: early childhood, from 0 to 5 years old; middle childhood, from 6 to 12 years old; and adolescence, from 13 to 18 years old. They chose a sophisticated statistical method for identifying unique profiles of youth based on their reported exposure to patterns or constellations of traumatic events. This approach yielded subgroups of youth with patterns of trauma exposure characteristic of polyvictimization.

In the early childhood epoch, 22% of children showed patterns of polyvictimization – exposed to an average of 5 types of trauma out of the 19 examined by the researchers. "Being exposed to five types of traumatic stressors is an enormous amount for a kid in the first five years of life," Ford noted. "We didn't expect that almost one in four of the kids at this

age would be polyvictims." Polyvictimization during early childhood was largely defined by trauma occurring within a caregiving environment, including family violence, which is not a surprising finding given that young children are dependent on their caregivers, Grasso pointed out.

Types of trauma exposure tend to change as children move into different developmental epochs. For example, during middle childhood, children, especially girls, may face greater risk for sexual abuse. Other traumatic stressors, such as bullying, also may occur at higher rates because children in this developmental stage are spending more time in school and environments outside of the home. During middle childhood, 14% of the sample showed patterns of polyvictimization – exposed to 6 types of trauma on average. The greatest number and variety of trauma types was seen in the adolescent period, where polyvictims reported an average of 7 trauma types including violence in the home, as well as other forms of violence and trauma occurring outside of the home.

Predictive Value of Polyvictimization

In a second study in preparation, Grasso and his colleagues combined their analyses of the three developmental epochs to look at how trauma patterns in one developmental period may

predict exposure in subsequent periods. "We found that about 87% of kids in early childhood with patterns of polyvictimization also went on to experience polyvictimization in middle childhood," Grasso said. "It's as if victimization experienced within the caregiving environment in early childhood serves as a gateway to exposure to multiple other forms of trauma and adversity in middle childhood and adolescence."

Damion J. Grasso, PhD, Assistant Professor of Psychiatry, UConn Health in Farmington, CT.

Interestingly, Ford and Grasso emphasized that some of the children identified as polyvictims in early childhood did not continue to experience polyvictimization in later years. Why is that? Ford said that these children may have benefited from positive changes in family and life circumstances. Or, they may have received good treatment or support services. In further research, Ford and Grasso will be exploring additional questions, such as, what helps children to become resilient, and how is polyvictimization in later years avoided.

*Grasso, D. J., Dierkhising, C. B., Branson, C. E., Ford, J. D., & Lee, R. (2016). Developmental patterns of adverse childhood experiences and current symptoms and impairment in youth referred for trauma-specific services. *Journal of Abnormal Child Psychology, 44*(5), 871-886. http://link.springer.com/article/10.1007/s10802-015-0086-8

Chaddock Continues CDS Efforts Forged as Grantee

As a Network member during the 2008-2012 grant cycle, Chaddock implemented the NCTSN Core Data Set (CDS) with such success that the agency has since incorporated standardized assessments into its three-year strategic plan, said Angel Knoverek, PhD, LCPC, ACS, Director of Program Consultation and Evaluation. The agency's ongoing participation in efforts such as the NCTSN Clinical Improvement through Measurement Initiative (CIMI) is even more impressive given the fact that Chaddock continues this work as an Affiliate member and not a current NCTSN grantee.

Chaddock providers were no strangers to compliance-based assessments, especially with Medicaid and Department of Child and Family Services clients, who are among the 17,000 children who annually receive trauma-informed and attachment-based services at the Quincy, IL, campus and at rural and school sites in the surrounding tri-state area (Illinois, Iowa, and Missouri). "Our clinicians were very busy trying to juggle many different assessments," Knoverek recalled. Adding another layer of data collection could have been daunting, but the infrastructure support from the National Center for Child Traumatic Stress – for institutional review board approvals, for training, and for implementation of the CDS – allowed Chaddock to create an assessment process that went beyond compliance to become a comprehensive system that worked for the benefit of clinicians and families. "It is awesome to have the technology to provide access to assessments and timely reports," she said, "and to improve the accuracy of the specific feedback provided by clinicians to parents and children."

The CDS implementation team at Chaddock realized that clinicians needed quick-tip sheets, flow charts, and guidance for managing their data collection. "If the process is not user-friendly," Knoverek said, "then chances are it is not going to be used to full capacity." Chaddock created a data repository so that clinicians could revisit treatment decisions and monitor clients' progress. The agency also created a Clinical Support Manager position for Kelly Green, who is now the go-to person for technical questions.

The CDS assessment process, which included charts and graphs, helped clinicians more quickly develop therapeutic rapport with clients. A graphic representation of the client's score on, for instance, the UCLA PTSD Reaction Index, is useful for both clinicians and clients, Knoverek noted. "The use of the CDS assessments does not replace or trump a clinical interview," she said. "But it gives us more information to either confirm what our clinical impressions are, or to present contradictions that offer an opportunity to explore what else might be going on for the client."

For her doctoral thesis, Knoverek examined a small subset of the youth represented in the CDS to assess the feasibility of implementing SPARCS (Structured Psychotherapy for Adolescents Responding to Chronic Stress) with younger children (http://gradworks.umi.com/35/10/3510564.html). Knoverek was also able to work on a mini-grant project that raised important questions about which services work best for whom among chronically trauma-exposed children accessing intensive services.

Chaddock is currently participating in CIMI, which takes advantage of mobile technology to enable data entry and real-time reporting in a manner that supports measurement-based care and enhances the quality of services. Knoverek said that use of the CDS, and now CIMI, has "helped us improve fidelity and make certain that all of the key elements of trauma- and attachment-focused treatment are still being implemented." ∎

Clinician Angel Knoverek, PhD, LCPC, ACS, engages children in a therapeutic group activity at Chaddock in Quincy, IL.

Exploring Trauma Patterns *cont'd from pg. 4*

Implications for Early Intervention

"We know that exposure in that early childhood period predicts exposure in subsequent periods," Grasso summed up. "Now we need to know what we can do to prevent subsequent exposure. I think the no-brainer here is to focus on those modifiable family factors that are putting the child and the family at risk. We can look at ways to address impaired caregiving, whether it is alcohol and substance abuse, domestic violence, or other mental health problems. We know that there's this intergenerational transmission of trauma-related risk, so how can we interrupt that transmission?"

Ford noted that the results of their analyses using the CDS provide clear evidence that early intervention may help to interrupt the trauma cycle. "Rather than waiting until these kids are having serious problems in later childhood or adolescence," Ford said, "this highlights the importance of early childhood interventions." Collaborations with Alicia Lieberman, PhD, the originator of Child-Parent Psychotherapy and the Early Trauma Treatment Network, are now part of the center's initiatives. Other collaborations will include work with Marlene Wong, whose Category II center focuses on school-age children to help keep them out of the juvenile justice system. The CDS analyses have established, Ford said, that "indeed there are polyvictims who may be stranded in polyvictimization unless we help them." ∎

Data Collection Offers Opportunities for Unpacking the Refugee Experience

Discovering best practices for reaching and helping traumatized refugee children involves collaborations between mental health providers and communities, according to providers from the Refugee Trauma and Resilience Center at Boston Children's Hospital, and The Children's Center in Salt Lake City, UT. Their work with the NCTSN Core Data Set (CDS) and other data sets has convinced them of the enormous potential of data collection to inform the delivery of services.

For example, in 2012, Theresa S. Betancourt, ScD, MA, Director of the Harvard School of Public Health's Research Program on Children and Global Adversity, and other NCTSN colleagues, participated in an NCTSN mini-grant project which used the CDS to examine the trauma profiles of refugee children served by participating Network sites.[1] Their study found that many of the 60 war-affected refugee children in the database had high rates of probable PTSD, generalized anxiety, somatization, traumatic grief, and general behavioral problems. Exposure to war or political violence outside the United States frequently co-occurred with forced displacement, traumatic loss, bereavement or separation, exposure to community violence, and exposure to domestic violence. Academic problems and behavioral difficulties were prevalent, but criminal activity, alcohol or drug use, and self-harm were rare. These findings highlight the complex trauma profiles, comorbid conditions, and functional problems that are important considerations for providers of mental health interventions for refugee children and adolescents. Given the difficulties associated with access to mental health services for refugees, both preventive and community-based interventions within family, school, and peer systems hold particular promise, Betancourt noted.

A follow-up validation study of the children in the CDS,[2] currently in press, "speaks to the fact that refugees are being supported more often by in-home counseling, and special classes or school, than U.S.-origin youth," she said. These findings highlight the importance of treatment modalities that are being offered by service providers in the NCTSN. Heidi Ellis, PhD, Director of the Refugee Trauma and Resilience Center at Boston Children's, noted that the CDS findings corroborated what she has observed in her extensive work with Somali refugees in Massachusetts. Among these populations, "there are very low rates of treatment engagement with what we think of as standard mental health services," she said. "Other pathways, like seeking support and services through school or community centers, are much more palatable."

The results of Ellis's longitudinal studies underscore the importance of using community advisory boards and other approaches to ensure that the voices of community members are heard. In addition, cultural brokers can help to discern the nuances of language used in the community to refer to mental health issues. These community perspectives are invaluable for the design and delivery of appropriate mental health services for refugees.

Somali refugee girls in Auburn, ME, participate in a group activity. Photo courtesy of the Refugee Trauma and Resilience Center, Boston, MA.

The findings from the CDS studies also affirmed that much more research is needed to understand the particular types of trauma and needs of refugee clients. "Given the diversity of refugee settlement in the U.S., there's really an opportunity to do something more broad-based," Betancourt observed. "Working with the Core Data Set has really helped us think through some of those design and methodological issues." According to the Data and Evaluation Program staff, Betancourt and Ellis were instrumental in enhancing the content of the Clinical Improvement through Measurement Initiative (CIMI). Their expertise, lessons learned from their studies, and feedback from their consumers and partners directly informed the new Refugee and Immigrant Families module. These changes have enhanced the quality of the information collected.

Currently, Betancourt and her team linked to the Refugee Trauma and Resilience Center are leading an initiative supported by the National Institute for Minority Health and Health Disparities. The initiative emphasizes community-based participatory research to develop and evaluate family home-visiting programs that may help refugee families succeed in navigating their adjustment to life in the United States.

Additional Considerations

Devon Musson Rose, LCSW, Director of Clinical Services at The Children's Center in Salt Lake City, sees a diverse range of refugees at her center. Now an Affiliate member, The Children's Center continues its trauma-focused work and collaborates with refugee settlement groups and other refugee-serving agencies. Over the years, the center has served refugee and immigrant families from Iraq, Bhutan, Syria, Afghanistan, Burma, Somalia, and the Democratic Republic of Congo, as well as Latino and Hispanic immigrants. Musson Rose pointed out a distinct difference between

Data Collection and the Refugee Experience

"immigrant" and "refugee" clients. The latter have been granted legal refugee status, which is usually accompanied by a package of discrete but time-limited support services. Undocumented economic migrants, or those fleeing their country of origin to escape violence, face an array of different challenges. Whether clients are refugees or immigrants, sensitivity to confidentiality is paramount. Because language is often a barrier, interpreters must be available. Musson Rose recalled one Burmese mother who did not feel safe to disclose her exposure to domestic violence until she was assured that an out-of-state interpreter would assist her. Musson Rose explained, "The Burmese community is very tight-knit, and she was concerned that through a local interpreter, her information might get back to her ex-partner."

The Refugee Trauma and Resilience Center has now built bridges across language and other barriers to service by employing community members as cultural brokers. In addition, Betancourt and her team are training refugee team members to collect data on tablets programmed in Nepali for use by Bhutanese refugees, as well as in Maay Maay for Somali Bantu refugees.

Making standardized assessments available in the preferred language of clients is a feature made possible by CIMI. The Children's Center, a pilot site for the initiative, has been a "great resource" for thinking about how to use measurement-based care with refugee and immigrant populations, according to staff at the National Center for Child Traumatic Stress. Ellis and Betancourt acknowledged that measurement can often be perceived by clinicians as overwhelming. But they urged new NCTSN grantees and other Category III sites to avail themselves of tools and shared measurement systems, such as those available in CIMI, to help in the process. In that way, more can be learned about the best ways to serve these vulnerable populations. ■

[1]Betancourt, T. S., Newnham, E. A., Layne, C. M., Kim, S., Steinberg, A. M., Ellis, H., & Birman, D. (2012). Trauma history and psychopathology in war-affected refugee children referred for trauma-related mental health services in the United States. *Journal of Traumatic Stress, 25*(6), 682-690.

[2]Betancourt, T. S., Newnham, E. A., Birman, D., Lee, R., et al. (2017). Comparing trauma exposure, mental health needs, and service utilization across clinical samples of refugee, immigrant, and U.S.-origin children. *Journal of Traumatic Stress.* In press.

Kentucky Researchers Find CIMI Enhances Measurement-Based Care

Launching the CDS at the University of Kentucky's Center on Trauma and Children was a natural fit in 2007, said Ginny Sprang, PhD, Executive Director of the Center on Trauma and Children and Principal Investigator of the Child and Adolescent Trauma Treatment and Training Institute, funded by SAMHSA's National Child Traumatic Stress Initiative. "The whole measurement-based care perspective has just been the way we do business." When applications opened in 2014 soliciting pilot sites for the NCTSN Clinical Improvement through Measurement Initiative (CIMI), "we saw this as an opportunity to further enhance our measurement-based care process."

CIMI allows for clinicians to enter data in real time and to obtain immediate scoring on client measures. The center's transition to tablet data entry dovetailed nicely with the CIMI pilot study. The process, Sprang said, "cut out the middle man – that is, the data clerk does not have to score the measures under time pressure." Jessica G. Eslinger, PhD, LCSW, a clinician at the Center on Trauma and Children, added that the ability to share scores in a graph or printout with caregivers and clients has an extra bonus. Clinicians are clear about the reasons for collecting data, and as a result, "Clients respond well to seeing that there is objective data that will be used to make treatment decisions," she said.

The introduction of CIMI coincided with the yearly clinical training for the center's interns, students, and residents. Learning the CIMI protocol became "the way they learn to do their job," said Sprang. Eslinger, the center's Clinical Research Protocol Manager, guided the training process. "The CIMI forms look a little overwhelming at first," she said, "so we

have learned over time to stagger the training sessions. After we initially present the information, we repeat training at 30 days, then at 6 weeks and at 8 weeks. This helps clinicians better digest the material." Demonstrations and role-playing supplement instruction.

Ensuring sustainability requires consistent monitoring by supervisors in addition to solid training support, Sprang said. "If you want someone to use data to make clinical decisions, then every time you are advising the clinician, you must ask, 'what does the data show?'" Eslinger praised Sprang's leadership regarding the CIMI rollout: "When someone has a vision, as Dr. Sprang does, there's a trickle-down effect that generates excitement about the ability to use measurement-based care to increase better outcomes for the families with whom we are working. The completion of psychometric information really provides such a richness in terms of the care we can provide our families."

Sprang has also tapped into the richness of the CDS to further explore treatment issues. She collaborated with other NCTSN colleagues to study commercial sexual exploitation of youth, using comparisons within the CDS. Their findings were published in 2014 in the *Journal of Interpersonal Violence.* A second study, published in 2012 in *Traumatology*, found that, among other factors, African American race, placement in state custody, and PTSD contribute to treatment attrition. After replicating those results at the center, Sprang applied for SAMHSA funding to create a dropout management program, which has become one of the key elements designed to reduce health disparities in the current funding cycle. ■

Have You Heard?

Diane Elmore, PhD, MPH, Director of the Policy Program for the **UCLA-Duke University National Center for Child Traumatic Stress**, has received the Public Advocacy Award of the International Society for Traumatic Stress Studies (ISTSS). Each year the ISTSS recognizes the efforts and achievements of its members and others dedicated to the study of traumatic stress. The Awards Committee seeks nominations from the ISTSS community and recognizes the commitment of students and professionals in research, patient care settings, media, and advocacy. Elmore was honored for her outstanding and fundamental contributions to advancing social understanding of trauma. Thank you, Diane, for your hard work!

The ARC Web site has launched! The ARC site provides resources for understanding the Attachment, Regulation, and Competency (ARC) framework, along with information about traumatic stress, adversity, resilience, and health. The site is divided into categories that support provider navigation; however, parents may find useful information on the provider page, and agencies may find useful information on the child and adolescent page. Congratulations to **Margaret Blaustein, PhD**, of the **Trauma Center at Justice Resource Institute**; and **Kristine Kinniburgh, LICSW**, of **JRI** for this great accomplishment. Visit the ARC Web site today at http://arcframework.org/

The Department of Justice has awarded grants to state, local, and tribal jurisdictions, law enforcement agencies, and victim service providers to combat human trafficking across the United States. Three Network Centers are among the grant recipients: **Baystate Health**, in Springfield, MA; **Georgia Center for Child Advocacy**, Atlanta; and **Dee Norton Lowcountry Children's Center**, Charleston, SC. These awards include funding to provide comprehensive and specialized services for human trafficking victims; support task forces that investigate and prosecute human trafficking cases; assist child victims of sex trafficking; and support research to improve understanding of the nature of human trafficking crimes and development of best practices to prevent and respond to them.

Brown University's **Children & Youth Cabinet (Providence)**, a NCTSN Category III center in Rhode Island, sponsored an event at Roger Williams Middle School in Providence for teachers and school professionals. The event was a theatrical performance by youth and young adults with the Everett Company Stage School, the center's partner. During the event artists told stories of youth trauma and crisis, and then held a 30-minute talkback session with the adults in attendance. In sharing their stories of trauma and resilience, the youth and adults made deep connections. All teachers and administrators left with a package filled with tools about strategies, signs, and self-care items.

Did You Know?

The American Academy of Child and Adolescent Psychiatry (AACAP) recently honored **Lisa Amaya-Jackson, MD, MPH**, as an AACAP Distinguished Fellow. Amaya-Jackson received the award at the AACAP's 63rd annual meeting, held October 24-29, 2016, in New York City.

Dr. Amaya-Jackson is a leader in research, treatment, and training in child and adolescent psychological trauma and exposure to violence. She spearheads the NCTSN child trauma programs as Director of Training at the Center for Child and Family Health, Co-Director of the NC Child Treatment Program, and Associate Director of the UCLA-Duke University National Center for Child Traumatic Stress, all in Durham, NC. Heartfelt congratulations!

Lisa Amaya-Jackson, MD, MPH, Associate Director of the UCLA-Duke University National Center for Child Traumatic Stress, Durham, NC.

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