DEPARTMENT OF HEALTH AND HUMAN SERVICES

Substance Abuse and Mental Health Services Administration
Center for Mental Health Services

Request for Applications (RFA) No. SM-03-012
Part I - Programmatic Guidance

Cooperative Agreements to Expand the National Child Traumatic Stress Initiative

Short Title: Child Traumatic Stress Initiative Community Treatment and Services Centers

Application Due Date:
August 7, 2003

Gail P. Hutchings, M.P.A.
Acting Director, Center for Mental Health Services
Substance Abuse and Mental Health
Services Administration

Charles G. Curie, M.A., A.C.S.W.
Administrator
Substance Abuse and Mental Health
Services Administration

Date of Issuance: June 2003

Catalog of Federal Domestic Assistance (CFDA) No. 93.243
Authority: Section: 582 of the Public Health Service Act, as amended and subject to the availability of funds

Table of Contents

Agency

Department of Health and Human Services (DHHS), Substance Abuse and Mental Health Services Administration (SAMHSA).

Purpose of This Announcement

The Substance Abuse and Mental Health Services Administration (SAMHSA), Center for Mental Health Services (CMHS), is accepting applications for fiscal year 2003 cooperative agreements to expand the National Child Traumatic Stress Initiative (NCTSI). It is expected that approximately **$4.8 million** will be available to fund **12** new Community Treatment and Services centers to participate in the National Child Traumatic Stress Network (NCTSN). Annual awards may be up to $400,000 in total costs (direct and indirect costs) for each year for up to 4 years. **Cost sharing is not required in this program.** Actual funding levels will depend on the availability of funds. Second, third, and fourth project year funding may be supplemented by SAMHSA for activities that fall within the scope and intent of this RFA.

Applications with proposed budgets that exceed $400,000 in any year of the project will be returned without review.

Applicants **must** request support for 4 years and provide a separate budget for each year. Although SAMHSA's intent for this program is to fund the full 4-year period requested, continued funding is contingent on availability of funds.

The purpose of the NCTSI is to improve treatment and services for all children and adolescents in the United States who have experienced traumatic events or have witnessed such events. A network of centers, the NCTSN, has been established to promote the development and use of effective treatments and services; to develop resources on trauma for professionals, consumers, and the public; and to develop trauma-focused public education, professional training, and other field development activities.

Who Can Apply?

The following domestic public and private nonprofit entities are eligible to apply:

- Community-based and faith-based organizations
- Outpatient clinics
- Public or private universities
- Psychiatric or general hospitals
- Units of State or local governments
- Indian tribes and tribal organizations
- Partnerships of multiple clinical centers, programs, and/or community service providers applying as a single center (in which case one of the participating organizations must be designated as the applicant organization).

It is SAMHSA's intent to ensure the broadest possible distribution of NCTSI grant funds across the United States. Therefore, applicant organizations from the following States will be given priority consideration for grant awards for the Community Treatment and Services center program because they do not currently have an NCTSI center: Alaska, Arizona, Arkansas, Delaware, Georgia, Hawaii, Idaho, Indiana, Iowa, Kansas, Kentucky, Louisiana, Maryland, Michigan, Minnesota, Mississippi, Montana, Nebraska, Nevada, New Hampshire, New Jersey, North

Carolina, North Dakota, Oklahoma, Rhode Island, South Carolina, South Dakota, Tennessee, Texas, Vermont, West Virginia, Wisconsin, and Wyoming.

Applicant organizations from one of the above States are permitted to partner with other centers or programs from States not included in the list. Applicants from States that are not listed will receive consideration for funding only if there are not enough highly qualified applicants from the listed States.

Applicant organizations may apply for the Community Treatment and Services Centers (this RFA) and/or the Intervention Development and Evaluations Centers (RFA SM-03-011). A separate, complete application is required for each category. An organization that is selected for funding in both grant programs will receive funding only for its proposed Intervention Development and Evaluation Center.

Organizations that are currently grantees of the NCTSI are not eligible to apply as the applicant organization under this RFA.

Application Kit

SAMHSA application kits include the following:

1. PHS 5161-1 - *(revised July 2000)* **-** Includes the Face Page, Budget Forms, Assurances, Certifications, and Checklist.

2. PART I - of the Request for Applications (RFA) includes instructions for the specific grant or cooperative agreement application. **This document is Part I.**

3. PART II - of the Request for Applications (RFA) provides general guidance and policies for SAMHSA grant applications. The policies in Part II that apply to this program are listed in this document under "Special Considerations and Requirements."

You must use all of the above documents of the kit in completing your application.

How to Get an Application Kit:

To get a complete application kit, including Parts I and II, you can:

- Call the SAMHSA Mental Health Information Center at (800) 789-2647
  Monday through Friday, 8:30 A.M. to 5:00 P.M., EST
  TDD: (301) 443-9006
  Fax: (301) 984-8796
  P.O. Box 42490
  Washington, DC 20015

- Download **Part I, Part II, and the PHS 5161-1** of the application kit from the SAMHSA web site at www.samhsa.gov. Click on "Grant Opportunities" and then "Current Grant Funding Opportunities."

Where to Send the Application

Send the signed original and two copies of your grant application to:

Mr. Ray Lucero, Review Branch
Substance Abuse and Mental Health Services Administration
Parklawn Building, Room 17-89
5600 Fishers Lane
Rockville, MD 20857
ATTN: Announcement SM03-012

All applications MUST be sent via a recognized commercial or governmental carrier. Hand-carried, faxed, or e-mailed applications will not be accepted. You will be notified by letter that your application has been received.

Be sure to type: "SM-03-012, National Child Traumatic Stress Initiative: Community Treatment and Services Center Program" in Item Number 10 on the face page of the application form.

If you require a phone number for delivery, you may use (301) 443-9917.

Application Due Date

Your application must be received by August 7, 2003. Applications received after this date must have a proof-of-mailing date from the carrier seven days before the due date.

Private metered postmarks are not acceptable as proof of timely mailing. Late applications will be returned without review.

It is anticipated that funding decisions related to this RFA will not be made before September 2003.

How to Get Help

For questions on program issues, contact:

Christine Guthrie, M.P.H.
Division of Prevention, Traumatic Stress, and Special Programs, Room 17C-25
Center for Mental Health Services
SAMHSA
5600 Fishers Lane
Rockville, MD 20857
(301) 443-0691
E-Mail: cguthrie@samhsa.gov

For questions on grants management issues, contact:

Stephen Hudak
Division of Grants Management
Substance Abuse and Mental Health Services Administration
Rockwall II, 6th Floor
5600 Fishers Lane
Rockville, MD 20857
(301) 443-9666
E-Mail: shudak@samhsa.gov

Cooperative Agreements

These awards are being made as cooperative agreements because they may require substantial Federal staff involvement.

Awardees Must:

- Comply with the terms of the cooperative agreement award as specified in the requirements of this RFA and the Notice of Grant Award

- ❑ Participate in collaborative activities with other NCTSN centers and other collaborative network activities
- ❑ Participate in grantees' meetings
- ❑ Accept guidance and respond to requests for data from CMHS
- ❑ Participate in policy steering groups and other work groups to help accomplish project goals
- ❑ As appropriate, author or co-author publications on project results for use by the field
- ❑ Participate in post-award, cross-site process and outcome evaluation activities
- ❑ Implement specified activities, data collection, and quality control, and complete required SAMHSA reports.

SAMHSA Staff Will:

- ❑ Consult with the National Center, Intervention Development and Evaluation Centers, and Community Treatment and Services Centers Project Directors on all phases of the project to ensure accomplishment of the goals of the Initiative
- ❑ Review critical project activities for conformity to the goals of the NCTSI
- ❑ Have overall responsibility for monitoring the conduct and progress of the NCTSI programs
- ❑ Make recommendations regarding continued funding
- ❑ Provide feedback on project design and components
- ❑ Participate in selected policy and steering groups or related work groups
- ❑ Review quarterly reports and conduct site visits, if warranted
- ❑ Provide support services or recommend outside consultants, if needed
- ❑ Author or co-author publications on program findings
- ❑ Provide technical assistance on ways to help disseminate and implement products of collaborative activities.

Award Criteria

Decisions to fund a grant are based on:

1. The strengths and weaknesses of the application as indicated by a Peer Review Committee and approved by the CMHS National Advisory Council

2. Availability of funds

3. Geographic location of the applicant organization as indicated in the "**Who Can Apply?"** section of this RFA.

Post-Award Requirements

1. Reports Required
   - ♦ Quarterly progress reports (the Government Project Officer [GPO] will suggest the format for these reports)
   - ♦ Annual report (in place of fourth quarterly report)
   - ♦ Final report at the end of the project period summarizing project progress, accomplishments, problems, alterations in approaches utilized, and lessons learned.

2. Grantees must inform the Project Officer of any publications based on the grant project.

3. Grantees must provide information needed by SAMHSA to comply with the Government Performance and Results Act (GPRA) reporting requirements.

GPRA mandates accountability and performance-based management by Federal agencies, focusing on results or outcomes in evaluating the effectiveness of Federal activities and on measuring progress toward achieving national goals and objectives. Grantees must comply with GPRA data collection and reporting requirements.

GPRA measures related to this RFA are not yet determined. Post-award, SAMHSA will be working with grantees to finalize the GPRA measures and obtain necessary clearances.

Grantee Meetings:

All awardees must attend an annual 3-day meeting of the centers funded under this Initiative. Costs related to this requirement must be provided for in the project budget. All NCTSI awardees should plan for three project staff to attend.

Program Overview

The overall goals of the NCTSI are to:

- Improve the quality, effectiveness, provision, and availability of therapeutic services delivered to all children and adolescents who experience traumatic events.

- Develop a national network of centers, programs, and constituencies dedicated to improving the identification of, assessment of, treatment of, and services to children and adolescents who have experienced traumatic events.

- Further the understanding of the impact on individuals, families, and communities of child and adolescent traumatic stress and of effective therapeutic interventions to prevent the occurrence of serious negative consequences of childhood and adolescent trauma.

- Reduce the frequency and severity of negative consequences of traumatic events on children and adolescents through greater public recognition and understanding of the sequelae of childhood trauma, and support improved prevention and treatment services.

The NCTSI consists of three types of centers: the National Center for Child Traumatic Stress, Intervention Development and Evaluation Centers, and Community Treatment and Services Centers. **This RFA solicits applications for new Community Treatment and Service Centers.**

Each type of center has primary responsibility for a set of functions under the Initiative. **It is critical to the success of the NCTSI that the NCTSN of collaborative centers develop effective ways of engaging in substantial joint activities to achieve the goals of treatment/services improvements for children and adolescents who have experienced trauma.** All centers are expected to collaborate with other centers in the NCTSN and perform other Network-related activities deemed essential to achieve the goals of the Initiative. Descriptions of the component centers, organizational structure, and collaborative activities of the NCTSN are provided in the appendices of this RFA.

National Center for Child Traumatic Stress

The National Center provides the vision, national leadership, and overall organizing and coordinating expertise to move the NCTSI toward its goals by:

- providing leadership for a national network of centers for knowledge development and treatment and clinical services improvement and evaluation in the area of child traumatic stress
- establishing a national capacity for training and technical assistance in implementing effective treatment and service delivery
- supporting collaboration and coordination within the NCTSI and providing technical assistance to participating centers
- developing a National Child Traumatic Stress Resource Center to develop and disseminate informational resources and other products on child and adolescent traumatic stress to professionals, policy makers, and the public.

Intervention Development and Evaluation Centers

Intervention Development and Evaluation Centers are responsible for the development, delivery, and evaluation of improved treatment approaches and service delivery models within the NCTSI by:

- using their specialized expertise to identify and evaluate existing therapeutic approaches and develop more effective approaches
- developing the NCTSN as a national network of treatment and service centers and providing their expertise in support of the NCTSN establishing a specialized capacity for training, evaluation, and technical assistance to support effective treatment and services for traumatized children and their families
- utilizing clinical and service information on child trauma cases that will improve understanding of treatment and service needs; treatment and service delivery effectiveness; and availability, access, and disparity in service delivery; and to inform planning and decision making of the NCTSI centers
- participating in the development of a national child traumatic stress resource center, by serving as a nationally recognized expert resource in specific areas of child traumatic stress. In their defined area of national expertise, IDE centers would serve as a resource for training, consultation, and technical assistance on effective treatment and services
- providing expertise in support of the NCTSI Resource Center's publication and electronic dissemination of information to professionals and the public on those child trauma issues.

Community Treatment and Service Centers

Community Treatment and Service Centers are service organizations or programs that primarily provide treatment and services in their community or in specialty child service settings for children and their families who have experienced trauma. They are

expected to help the NCTSI achieve its goals by:

- collaborating with other NCTSI centers to identify, improve, develop, and implement improved child trauma services and treatments that are effective in their community or in different specialty service contexts that they have access to, which might include hospitals, schools, inpatient psychiatric treatment centers, juvenile justice detention facilities, refugee centers, or child welfare/child protective service systems

- participating in Network efforts to develop protocols for collecting information on client characteristics, services received, and treatment outcomes for children and adolescents who receive trauma services that the NCTSN deems necessary to fulfill the Network's goals

- expanding identification, assessment, treatment, and services for traumatized children and adolescents in the local community or in child and adolescent service sectors, and improvement of trauma-focused services and outreach activities

- participating in activities to develop knowledge regarding the availability of and access to effective child trauma services in communities and in child and adolescent specialty service settings

- providing training, consultation, and other outreach efforts to local service sectors or service providers that can identify and/or provide access or services to children and adolescents who have experienced trauma

- establishing liaison with some of the local service systems that provide services to children and adolescents who have experienced trauma. Such systems might include school systems, state/county mental health services, child welfare, protective services, rehabilitative services for children with physical and developmental problems, juvenile justice system, emergency medical services, disaster services, and refugee services.

Organizations applying to participate as one of the component centers under this Initiative will be required to document their intention of collaborating within the NCTSI Network in developing and evaluating treatment and services.

Collaborative Framework

The National Center 1) has developed the framework and organizational procedures for communication and collaboration among NCTSI-funded centers; (2) is supporting Network efforts to develop procedures to document and monitor collective activities and experiences; and (3) is providing support for joint center activities to achieve the goals of treatment/services improvements for children.

The National Center chairs a **Steering Committee** representing all the NCTSI centers. The Steering Committee will provide leadership for the activities of the NCTSN; prioritize efforts by the centers in identifying, implementing, improving, and/or developing child and adolescent trauma treatment and services, finalize plans for NCTSI-wide activities, reports, protocols, and standards; and will establish an **NCTSI Advisory Board**.

The Advisory Board may include representatives from the corporate community, foundations, parent and consumer groups, media and advertising, education, and State and Federal government, as well as leaders from the broader scientific community. It will help create positive public awareness for the issue of child traumatic stress, establish priorities related to NCTSI financial stability and sustainability, and provide and promote access to political and business leaders.

What to Include in Your Application

In order for your application to be complete and eligible, it must include the following in the order listed. Check off areas as you complete them for your application.

❑ **1. FACE PAGE**

Use Standard Form 424. Follow instructions contained in Appendix A, Part II, rather than the instructions that accompany the form itself. In signing the face page of the application, you are agreeing that the information is accurate and complete.

❑ **2. ABSTRACT**

Your total abstract should be no longer than 35 lines. In the first 5 lines or less of your abstract, write a summary of your project that can be used in publications, reporting to Congress, or press releases. The abstract should summarize the major goals of the project, the type(s) of trauma or populations of child trauma victims that are the focus of project efforts, types of treatment and service approaches to be used (if applicable), and the major actions or activities to be engaged in.

❑ **3. TABLE OF CONTENTS**

Include page numbers for each of the major sections of your application and for each appendix.

❑ **4. BUDGET FORM**

Standard Form (SF) 424A, which is part of the PHS 5161-1, is to be used for the budget. Fill out sections B, C, and E of the SF 424A. Follow instructions in Appendix B of Part II of the RFA.

❑ **5. PROJECT NARRATIVE AND SUPPORTING DOCUMENTATION**

These sections describe your project. The program narrative is made up of Sections A through D. Sections A-D **may be no longer than 30 pages.**

The sections in the Project Narrative are:

- ❑ **Section A** - Organizational Qualifications and Experience
- ❑ **Section B** - Implementation Plan
- ❑ **Section C** - Monitoring/Evaluation
- ❑ **Section D** - Project Management

Section A of your project must receive a score of at least 25 points by the peer review committee to be considered for priority funding. This means that only proposed centers with sufficient prior expertise and experience in child traumatic stress are likely to be eligible for funding under this cooperative agreement. Applicants that score below 25 points in

Section A may be considered for funding based on the needs of the NCTSI and the availability of funds.

The Supporting Documentation section of your application provides additional information necessary for the review of your application. This Supporting Documentation should be provided immediately following your Project Narrative in Sections E through H. There are no page limits for these sections, except for Section G, the Biographical Sketches/Job Descriptions.

❑ **Section E** - Literature Citations
This section must contain complete citations, including titles and all authors, for any literature you cite in your application.

❑ **Section F** - Budget Justification, Existing Resources, Other Support

You **must** provide a narrative justification of the items included in your proposed budget, as well as a description of existing resources and other supports you expect to receive for the proposed project. **(See Part II of the RFA, Grant Announcement, Example A, Justification).**

❑ **Section G** - Biographical Sketches and Job Descriptions

- Include a biographical sketch for the project director and for other key positions. Each sketch should be no longer than **2 pages**. If the person has not been hired, include a letter of commitment from the individual with a current biographical sketch.

- Include job descriptions for key personnel. They should be no longer than **1 page**.

- **Sample sketches and job descriptions are listed on page 22, Item 6 in the Program Narrative section of the PHS 5161-1.**

? **Section H** - SAMHSA's Participant Protection

The elements you need to address in this section are outlined after the Project Narrative description in this document.

❑ **6. APPENDICES 1 THROUGH 4**

- Use only the appendices listed below.

- **Do not** use appendices to extend or replace any of the sections of the Project Narrative unless specifically required in this RFA (reviewers will not consider them if you do).

- **Do not** use more than **30** pages (plus all instruments) for the appendices.

Appendix 1:
Schedules and Time Lines of Activities, Reports, and Products

Appendix 2:
Letters of Agreement, Memoranda of Understanding, or other documentation of collaboration with other potential centers or programs

Appendix 3:
Letter to Single State Agency

Appendix 4:
Sample Consent Forms

❑ **7. ASSURANCES**
Non-Construction Programs. Use Standard Form 424B found in PHS 5161-1. See Part II, page 9.

❑ **8. CERTIFICATIONS**
See Part II, page 9. A list of certifications is included in the PHS Form 5161-1. See Part II, page 9.

❑ **9. DISCLOSURE OF LOBBYING ACTIVITIES (See form in PHS 5161-1)**

Appropriated funds, other than for normal and recognized executive-legislative relationships, may not be used for lobbying the Congress or State legislatures. Federal law prohibits the use of appropriated funds for publicity or propaganda purposes or for the preparation, distribution, or use of information designed to support or defeat legislation pending before the Congress or State legislatures. This includes "grass roots" lobbying, which consists of appeals to members of the public suggesting that they contact their elected representatives to indicate their support for or opposition to pending legislation or to urge those representatives to vote in a particular way. (Please read Part II of the RFA, General Policies and Procedures for all SAMHSA applications for additional details.)

❑ **10. CHECKLIST** (Found in the PHS 5161)

You must complete the Checklist. See Part II, Appendix C, of the RFA for detailed instructions.

Project Narrative
Sections A through D

In developing your application, use the instructions below that have been tailored to this program. These are to be used in lieu of the "Program Narrative" instructions found in the PHS 5161 on page 21.

Sections A through D are the Project Narrative of your application. These sections describe your organization and what you intend to do with your project. Below you will find detailed information on how to respond to Sections A through D. Sections A through D may not be longer than ***30*** pages.

- **Your application will be reviewed and scored against the requirements described below for Sections A through D. These sections also function as review criteria**.
- A peer review committee will assign a point value to your application based on how well you address **each** of these sections.
- The number of points after each main heading shows the maximum number of points a review committee may assign to that category.
- Bullet statements do not have points assigned to them; they are provided to invite attention to important areas within the criterion.
- Reviewers will also be looking for evidence of cultural competence **in each section** of the Project Narrative. Points will be assigned based on how well you address cultural competency aspects of the review criteria. SAMHSA's guidelines for cultural competence are included in Part II of the RFA, Appendix D.

NOTE: Although the budget for the proposed project is not a review criterion, the Review Group will be asked to comment on the appropriateness of the budget after

the merits of the application have been considered.

Community Treatment and Services Center Project Requirements

Section A: Organizational Qualifications and Experience (35 points)

Section A of your project must receive a score of at least 25 points by the peer review committee to be considered for priority funding. This means that only proposed centers with sufficient prior expertise and experience in child traumatic stress are likely to be eligible for funding under this cooperative agreement. Applicants that score below 25 points in Section A may be considered for funding based on the needs of the NCTSI and the availability of funds.

1. Operational and Collaborative Experience (25 points)

Operational

- Briefly describe the types of clinical and other trauma relevant services provided by your organization/program with respect to:
  - Clinical interventions, supportive services, training, education, and consultation.
  - The settings in which you provide services (e.g., outpatient, inpatient, hospital, school, or juvenile justice settings).
  - Indicate the number of children who receive intervention services from your organization each month or who directly and substantially benefit via service programs for which you provide training, consultation, or other trauma-focused or mental health-oriented assistance.
  - Describe the evidence base for the interventions that you use (outcome assessments, clinical follow-up, use of empirically supported standardized intervention models, use of interventions endorsed by authoritative clinical guidelines or best practice reviews, etc.).
  - Discuss the types of clinical information that is currently collected at your center and how is it used.

- Discuss how your organization reaches out to the community in the areas of:
  - Identifying and providing trauma services to children and families who do not seek services.
  - Training community providers in child trauma services.
  - Developing or monitoring trauma services appropriate to the race/ethnicity/culture/age of the community's service population.
  - Educating the community on child trauma issues.
  - Educating and training staff in specialty child service systems, such as juvenile justice, emergency medical services, or child protective services.
  - Describe the specific tangible products (e.g., publications--scientific or otherwise, screening or assessment instruments, training manuals, white papers, manualized treatments, and information systems for trauma-related services) of these outreach efforts.

- Describe the results of multisite evaluation or outcome studies in which your organization has participated, such

as evaluation reports, published articles, or other summaries of findings.

- Describe current involvement of consumer constituencies, especially child and adolescent trauma victims and their families, in activities at your center (e.g., service provision, training, community education and outreach).

Collaborative

- Describe the extent to which your organization is:
  - Collaborating with other treatment/service providers or referral sources.
  - Collaborating with local child service systems, such as schools, primary health care, protective service, child welfare, and juvenile justice.
  - Establishing coordination and linkages with other service providers in service provision or other endeavors.
  - Developing linkages with professional and client groups in the community.
  - Developing community-wide initiatives.
  - Provide documentation of any formal collaborative arrangements (e.g., Letters of Agreement) in Appendix 2.

- Describe the concrete results or products of these collaborations.

2. Personnel (10 points)

- Identify the individual who will function as Project Director (i.e., the individual with primary oversight for the development of project goals and objectives and responsibility for ensuring success of the project) and describe his/her qualifications in terms of:
  - Training and experience in child trauma interventions.
  - Prior leadership and collaboration experience.
  - Familiarity with the community and its subpopulations.
  - Connection to key community leaders, service providers, and child service sector personnel.

- Experience indicates that Project Directors will need to devote significant time and effort to this project in order to both direct site-specific activities and participate in network collaborative activities. Please indicate the FTE of the Project Director for your proposed project.

- Identify a minimum of three additional staff or consultants who will participate at least 0.2 FTE in the activities of your CTS Center.
  - Describe their qualifications and experience in mental health service delivery and child traumatic stress.
  - Describe their involvement with national/regional/State organizations and programs that provide or advocate for child traumatic stress and mental health programs.
  - Describe their experience in interacting with or providing services in specialized child service sectors, such as schools, juvenile justice, child health, child welfare, rehabilitation, or protective services.

Section B: Implementation Plan (35 points)

In this section you are asked to describe your plans for activities in your community

of concern and how you will translate your success into lessons and benefits for the larger community (county, State, Nation). Please make sure to address each function thoroughly and label your narrative responses under separate headings that match the function headings. To adequately address some of the requirements in this section, it is important to be familiar with current NCTSN centers and collaborative activities. This information can be obtained in the Appendices to this RFA, the NCTSI website (www.nctsnet.org), and contact you might have with NCTSN centers, which are listed in Appendix D. As a CTS Center, you will concentrate your efforts both on activities that you can carry out with your partners and populations locally and on activities that you will undertake in association with the resources and partners of the NCTSN.

1. Network Participation

- Provide a statement indicating the willingness of your organization and its staff to participate in the following NCTSI activities:
  - Participating in NCTSN committees, workgroups, and taskforces
  - Implementing consensus decisions made by the NCTSI Steering Committee
  - Collaborating with other NCTSN centers in a) multisite treatment/services studies; and b) development of clinical data and evaluation data collection protocols
  - Serving as a resource for the NCTSI and the National Resource Center for Child Traumatic Stress (NRC-CTS) in aspects of community treatment/service delivery, intervention development and evaluation
  - Working with the NCTSN and NRC-CTS to ensure that effective treatment or services at your center can be documented, standardized, evaluated, and disseminated to other service programs outside your community.

- Describe the unique strengths, such as expertise or experience with certain types of trauma or target population, treatment or service approaches, or service provision with child service systems, that your center could provide to the existing NCTSN. Indicate the non-NCTSN treatment/service programs, constituencies, and resources that your organization could recruit for participation in the Network.

- Describe how your current clinical and services data collection could be adapted to incorporate a NCTSN-wide clinical and services data protocol (See Appendix J) that has the aim of collecting information across NCTSN centers on client characteristics and services provided.

- The NCTSN currently conducts network activity through a number of venues (committees, workgroups, and taskforces) (see Appendix I).
  - Identify the existing venues that staff at your center have the experience and expertise to participate in.
  - Propose any potential new committees that are relevant to your expertise and interest in child and adolescent trauma services in RTF areas, if applicable.

- Given your knowledge of the NCTSN and its member centers obtained from the Appendices, the NCTSN website, or other contact with NCTSN centers, outline a brief preliminary plan for

participating in the structure and function of the NCTSN and in efforts to improve its effectiveness.
- o Describe a set of activities (no more than four) to carry out the plan.
- o Identify the main obstacles to the success of your plan.
- o Describe the means for overcoming the obstacles you have described.

2. Community Engagement

- ♦ Outline your plan to improve access to and quality of treatment and services for children and adolescents exposed to traumatic events in your community with NCTSI grant resources.
  - o Describe a set of objectives and activities to carry out the plan. These objectives should be feasible and practical to evaluate.
  - o In your plan, identify the number of children who will receive services or will directly and substantially benefit via service programs for which you provide training, consultation, or other trauma-focused assistance.
  - o Discuss how the race/ethnicity/cultural diversity of children and their families and the developmental stage of children will be addressed in your plan.
  - o Describe the tangible products of these activities (e.g., publications--scientific or otherwise, screening or assessment instruments, training manuals, white papers, manualized treatments, and information systems for trauma-related services, etc.).
  - o Describe how collaborating with other NCTSI centers or using the resources of the NCTSN will enhance the success of your proposed community activities.
  - o Discuss how what you do in your community will contribute to the overall NCTSI goals of improving the quality of and access to treatment and services throughout the Nation for children and adolescents who experience trauma.

- ♦ Describe activities your center will implement to promote trauma-informed treatment and services in specialty child service sectors in your community, such as schools, hospitals, law enforcement, juvenile justice, and/or child welfare. Describe the products of these activities.

- ♦ Describe the process your center will follow in implementing additional new, potentially effective child trauma treatment and service approaches developed or used by other NCTSI Centers that could improve access to and quality of child and adolescent trauma services that currently exist at your center.

3. Network Collaboration

- ♦ Given your knowledge of the NCTSN and its member centers obtained from the Appendices, the NCTSN website, or other contact with NCTSN centers, outline your preliminary plan(s) to engage in joint activities to improve access to and quality of treatment and services for children and adolescents exposed to traumatic events.
  - o Describe a set of objectives and activities to carry out the plan. These objectives should be feasible and practical to evaluate.
  - o Describe how achievement of these objectives may impact the child trauma field with respect to trauma type, service settings, target population or type of interventions,

or other aspects of the field you believe will be bettered.
- Describe resources in your center that will be devoted to these collaborative activities. Describe how the plan will make effective use of the human and other resources of the NCTSN. Identify the indicators you will you use to assess your collaboration.
- Identify the products that will result from achievement of these objectives that will support the overall goals of the NCTSI.

(Note: It is expected that this preliminary plan may be modified during the course of the project because of additional input from NCTSN partners, outcomes of implemented activities and programs, and other events and situations that arise within the project or the Network. Funded projects can make changes to their plans with prior approval from the Government Project Officer assigned to oversee their grant.)

- Given your knowledge of the NCTSN and its member centers, outline a brief preliminary plan for strengthening your linking, networking, collaborating, and coordinating with other NCTSN partners to improve traumatic stress treatment and increase access to services for traumatized children.
  - Describe a set of objectives and associated activities (no more than four) to carry out the plan.
  - Identify the main obstacles to the success of your plan.
  - Describe the means for overcoming the obstacles you have described.

Section C: Monitoring/Evaluation (15 points)

Community Treatment and Service Centers must budget a minimum of 10% and a maximum of 15% of total costs for monitoring/evaluation activities.

- Provide a preliminary plan to evaluate the functioning of your Community Treatment and Services Center in achieving goals stated for each functional area in the Implementation Plan (Section B) of your project proposal. Please specify:
  - A proposed set of indicators for completion or success of activities under each function.
  - Methods that will be used to collect data on indicators of activities; both qualitative and quantitative methods may be used.
  - How results of the evaluation will be used in goal setting, decision making, activity planning, and monitoring.

- Describe a timetable for evaluation reports and outline the structure and content of such reports.

- Describe the qualifications and experience of the project's evaluation staff. If the evaluation staff has not yet been selected, position description(s) listing the minimum qualifications and experience requirements should be attached in Section G.

- Describe procedures to obtain input from consumer constituencies, especially youth and families, in developing the evaluation plans, collecting data, and reporting results.

Section D: Project Management - Organizational, Equipment/ Facilities, Other Support and Sustainability (15 points)

- Provide a project schedule and an activity-centered time line to reflect the 4-year project length. Please attach as Appendix 1.

- Describe a staffing pattern that is appropriate and adequate for the project.

- Describe the extent to which the staffing and management plans, project organization, and other resources are appropriate for carrying out all aspects of the proposed project; reflective of the diversity of the target population; and sensitive to age, gender, race/ethnicity, and other cultural factors related to the target population and to the community to be served.

- Provide information about the adequacy and availability of facilities and equipment.

- Describe the key components of your plan for sustaining your proposed activities beyond or supplementing NCTSI grant funding (consider components such as resource mapping activities, financing strategies, coalitions/partnerships with other child-serving agencies to improve resource availability or access to funding streams, key stakeholders and community support, use of outcomes evaluation data to inform potential funders or to mobilize key constituent support, and marketing plans).
  - Discuss aspects of your project that you would wish to sustain in the long term.
  - Describe your short- and long-term approach for this.
  - Discuss how intra-NCTSN partnerships could provide opportunities for funding and sustainability.

SAMHSA's Participant Protection Requirements

Part II of the PA/RFA provides a description of SAMHSA's Participant Protection Requirements and the Protection of Human Subjects Regulations.

The evaluation requirements as described in the "Project Narrative" section of this RFA are subject to the SAMHSA Participant Protection (SPP) provisions. However, applicants who propose to implement more in-depth evaluation activities may be subject to the Federal provisions at 45 CFR Part 46 (Protection of Human Subjects). In accordance with these provisions, evaluation approaches designed to conduct the systematic collection of data on individual clients require review and approval by an Institutional Review Board (IRB). These requirements apply whether SAMSHA funds or funds from other sources are used to carry out the evaluation activities.

SAMHSA will place restrictions on the use of funds until all participant protection issues are resolved. Problems with participant protection identified during peer review of your application may result in the delay of funding. See Part II of the RFA for more information on participant protection.

You must address each element regarding participant protection in your supporting documentation. If one or more of the elements is not relevant to your project, you must document the reasons that the element(s) does not apply.

This information will:

1. Reveal if the protection of participants is adequate or if more protection is needed.

2. Be considered when making funding decisions.

Projects may expose people to risks in many different ways. In this section of your application, you will need to:

- Identify and report any possible risks for participants in your project.

- State how you plan to protect participants from those risks.

- Discuss how each type of risk will be dealt with, or why it does not apply to the project.

Each of the following elements must be discussed:

Protect Clients and Staff from Potential Risks

- Identify and describe any foreseeable physical, medical, psychological, social, legal, or other risks or adverse affects.

- Discuss risks that are due either to participation in the project itself, or to the evaluation activities.

- Describe the procedures that will be followed to minimize or protect participants against potential risks, including risks to confidentiality.

- Give plans to provide help if there are adverse effects to participants.

- Where appropriate, describe alternative treatments and procedures that may be beneficial to the participants. If you do not decide to use these other beneficial treatments, provide the reasons for not using them.

Fair Selection of Participants

- Describe the target population(s) for the proposed project. Include age, gender, and racial/ethnic background, and note if the population includes homeless youth, foster children, children of substance abusers, pregnant women, or other groups.

- Explain the reasons for including groups of pregnant women, children, people with mental disabilities, people in institutions, prisoners, or others who are likely to be vulnerable to HIV/AIDS.

- Explain the reasons for including or excluding participants.

- Explain how you will recruit and select participants. Identify who will select participants.

Absence of Coercion

- Explain if participation in the project is voluntary or required. Identify possible reasons why it may be required: for example, court orders requiring people to participate in a program.

- If you plan to pay participants, state how participants will be awarded money or gifts.

- State how volunteer participants will be told that they may receive services even if they do not complete the study.

Data Collection

- Identify from whom you will collect data: participants themselves, family members, teachers, others. Describe the data collection procedure and specify the sources for obtaining data: school records, interviews, psychological assessments, questionnaires, observation, or other sources. Where data are to be collected through observational techniques, questionnaires, interviews, or other direct means, describe the data collection setting.

- Identify what type of specimens (e.g., urine, blood) will be used, if any. State if the material will be used just for evaluation or if other use(s) will be made. Also, if needed, describe how the material will be monitored to ensure the safety of participants.

- Provide in Appendix 4, "Data Collection Instruments/Interview Protocols," copies of all available data collection instruments and interview protocols that you plan to use.

Privacy and Confidentiality

- Explain how you will ensure privacy and confidentiality. Include who will collect data and how it will be collected.

- Describe:
  - How you will use data collection instruments.
  - Where data will be stored.
  - Who will or will not have access to information.
  - How the identity: of participants will be kept private: through the use of a coding system on data records, limiting access to records, or storing identifiers separately from data.

NOTE: If applicable, grantees must agree to maintain the confidentiality of alcohol and drug abuse client records according to the provisions of **Title 42 of the Code of Federal Regulations, Part II.**

Adequate Consent Procedures

- List what information will be given to people who participate in the project. Include the type and purpose of their participation. Include how the data will be used and how you will keep the data private.

- State:
  - Whether or not their participation is voluntary
  - Their right to leave the project at any time without problems
  - Possible risks from participation in the project
  - Plans to protect clients from these risks.

- Explain how you will get consent for youth, the elderly, people with limited reading skills, and people who do not use English as their first language.

NOTE: If the project poses potential physical, medical, psychological, legal, social or other risks, you **must** get written informed consent.

- Indicate if you will get informed consent from participants or from their parents or legal guardians. Describe how the consent will be documented. For example: Will you read the consent forms? Will you ask prospective participants questions to be sure they understand the forms? Will you give them copies of what they sign?

- Include sample consent forms in your Appendix 4, titled "Sample Consent Forms." If needed, give English translations.

NOTE: Never imply that the participant waives or appears to waive any legal rights, may not end involvement with the project, or releases your project or its agents from liability for negligence.

- Describe if separate consents will be obtained for different stages or parts of the project. For example, will they be needed for both participant protection in treatment intervention and for the collection and use of data?

- Additionally, if other consents (e.g., consents to release information to others or gather information from others) will be used in your project, provide a description of the consents. Will individuals who do not consent to having individually identifiable data collected for evaluation purposes be allowed to participate in the project?

Risk/Benefit Discussion

Discuss why the risks are reasonable compared to expected benefits and importance of the knowledge from the project.

Special Considerations and Requirements

SAMHSA's policies, special considerations, and requirements related to grants and cooperative agreements are found in **Part II** of the RFA/PA. The only policies and special considerations that apply to this program are:

- Population Inclusion Requirement
- Government Performance Monitoring
- Healthy People 2000
- Consumer Bill of Rights and Responsibilities
- Promoting Nonuse of Tobacco
- Supplantation of Existing Funds
- Single State Agency (SSA) Coordination
- Intergovernmental Review (E.O. 12372)
- Public Health System Reporting Requirements
- Confidentiality/SAMHSA Participant and Human Subject Protection

APPENDIX A

Background

The term "trauma" has both a medical and a psychiatric definition. Medically, trauma refers to a serious or critical "bodily injury, wound, or shock" (Neufeldt, 1988). In psychological terms, trauma assumes a different meaning, referring to a "painful emotional experience, or shock, often producing a lasting psychic effect" (Neufeldt, 1988).

Various adverse events experienced in childhood and adolescence can have a detrimental effect on the health, well-being, and development of affected children and adolescents (Brooks-Gunn and Duncan, 1997; Rutter, 1999). Traumatic events often involve a life-threat, severe physical injury, threat to psychological control or physical or psychological integrity, loss of a primary caretaker, or loss of one's community or social environment. Traumatic events may occur as episodes of (a) physical and sexual abuse or assault; (b) natural or man-made disasters and catastrophes; (c) physical injuries or incapacitation, such as from motor vehicle or bicycle accidents, animal attacks, or other serious accidents; (d) chronic, severe, or painful medical conditions or invasive or painful medical procedures; (e) witnessing or experiencing family or community violence; (f) traumatic loss of family members, friends, and other significant attachment figures; and (g) exposure to war, terrorism, kidnappings, political oppression, and forced displacement. Traumatic events can be single or repeated events or chronic exposure to or experience of a condition. Many types of trauma include both acute and longer-term components (e.g., acute physical injuries, such as burns) that result in chronic pain, disfigurement, or disability, or repeated episodes of childhood abuse.

Exposure to traumatic events is common in children and adolescents. In 1998 an estimated 200,000 children were victims of physical child abuse, 100,000 were victims of sexual abuse, and 225,000 were victims of multiple forms of child maltreatment (U.S. Department of Health and Human Services, 2000a). Each year approximately 140,000 children and adolescents receive treatment for bicycle-related head injuries; almost 20,000 children are hospitalized because of burns, and 5 of every 100,000 children aged 0-10 are hospitalized for dog bites (Sosin et al., 1996; Sacks, Kresnow, and Houston, 1996; Quinlan and Sacks, 1999).

During the event and its immediate aftermath, traumatic events can produce feelings of panic, helplessness, and uncontrollable fear or terror and lead to a range of both acute and chronic traumatic stress reactions. The American Psychiatric Association's *Diagnostic and Statistical Manual for Mental Disorders* (DSM-IV) recognizes a number of psychiatric syndromes associated with exposure to stressful and traumatic events, including Post-Traumatic Stress Disorder, Acute Stress Disorder, and Adjustment Disorder. The impact of trauma on the functioning of children and adolescents can be pervasive. Effects of trauma can include dysphoric emotional states and emotional dysregulation, such as depression, anxiety, and chronic or impulsive outbursts of anger; suicide attempts; behavior problems, such as antisocial behavior and substance abuse; cognitive and motivational distortions, including hopelessness, chronic shame, or guilt; learning and academic problems resulting from learning, memory, and attentional difficulties; and interpersonal problems (Leavitt and Fox, 1993; Briere et al., 1996;

Eckenrode, Laird, and Doris, 1993; Gunnar, 2000; Perry and Pollard, 1998; Pollack, Cicchetti, and Klorman, 1998; Shonk and Cicchetti, 2001; Trickett and Schellenbach, 1998). A number of other serious syndromes and pervasive personality distortions are associated with exposure to serious or chronic stress and trauma, including Dissociative Disorders and Borderline Personality Disorder. And yet, many children and adolescents are able to cope effectively with the aftereffects of their trauma exposure through their own resilience, and with support of family and others, and may even derive positive benefits from their experiences.

The severity and chronicity of the stress reactions following exposure to traumatic events can vary greatly. Of particular significance to children and adolescents are the effects on development (Cichetti and Toth, 1997; Kaufman and Henrich, 2000; Garbarino, Eckenrode, and Powers, 1997; Pynoos et al., 1999). Exposure to trauma can delay, distort, or arrest normal developmental processes in children and adolescents. Developmental effects are a function of the age at which a child is exposed to traumatic events, the developmental issues that they are addressing at the time, the significance of the type of trauma for current and later developmental stages, and how this exposure may affect resources needed for later developmental tasks.

Considerable progress has been made in understanding the prevalence, characteristics, risk factors, and consequences of trauma in children and adolescents. However, knowledge is unevenly developed across areas of child trauma and many fundamental questions have not been adequately addressed, such as which children will experience the most detrimental effects of trauma exposure, the impact of trauma on developmental processes across the stages of development, and determination of the underlying biological, psychological, and social processes that must be targeted by effective interventions (Pfefferbaum, 1997).

Intervention in the aftermath of trauma is one of the most significant clinical issue in child and adolescent mental health. Promising interventions for child trauma have been identified (James, 1989; Cohen, Berliner, and March, 2000; Deblinger and Heflin, 1996; March et al., 1998; Lieberman, Silverman and Pawl, 2000; Marmar, Weiss, and Pynoos, 1995; Pynoos et al., 1998), but much needs to be done to provide these services to children and their families. The scientific evidence base is not strong on many critical intervention issues, such as what types of interventions maximize trauma recovery, which children and which types of trauma exposure are effectively treated by different types of intervention approaches, and how intervention approaches should best address developmental issues.

Of particular concern for receipt of intervention services are children in child service systems with high rates of trauma exposures, such as the child welfare and child protective services systems, the juvenile justice system, hospitals and emergency clinics, child rehabilitation services, and service systems for refugee children (Rosenfeld et al., 1997; Dubner and Motta, 1999; Clausen et al., 1998; Crimmins et al., 2000; Erwin et al., 2000). These systems provide services to large numbers of children. In 1998, more than 1.8 million reports of child abuse and neglect were investigated by child protective services and 900,000 children were categorized as victims of abuse and/or neglect or at risk for maltreatment (U.S. Department of Health and Human Services, 2000a). Every day in the U.S. nearly 600,000 children and adolescents are in the child welfare system -- with almost half in non-relative foster care and almost 10 percent in institutional care (U.S. Department of Health and Human Services, 2000b). In 1997

approximately 125,000 juveniles were in detention (Gallagher, 1999). Approximately 100,000 refugees are admitted into the U.S. every year; many are families arriving from war zones, fleeing political oppression or victims of torture (U.S. Department of Health and Human Services, 2000c).

In addition to these specialty child service systems, schools are the largest child service system, and in every school there will be children whose ability to perform competently is compromised by unrecognized and untreated traumatic stress. Some progress has been made in developing procedures to identify children affected by exposure to traumatic events and provide trauma-focused treatment in school settings (Muris, et al., 2000; McNally, 1996; March et al., 1998). Development and implementation of effective identification, assessment, and treatment approaches in these child service settings would have a significant impact on the mental health of children.

The National Child Traumatic Stress Initiative is designed to address these child trauma issues by providing Federal support for a national effort to improve treatment and services for child trauma, to expand availability and accessibility of effective community services, and to promote better understanding of clinical and research issues relevant to providing effective interventions for children and adolescents exposed to traumatic events.

APPENDIX B

References and Resources

Briere, J., Berliner, L., Bulkley, J.A., Jenny, C., and Reid, T. (1996) The APSAC Handbook on Child Maltreatment. Thousand Oaks, CA: Sage Publications.

Brooks-Gunn, J. and Duncan,G. J. (1997) The effects of poverty on children. Future of Children, 7, 55-71.

Cicchetti, D. and Toth, S. L. (Eds.) (1997) Developmental Perspectives on Trauma: Theory, Research, and Intervention. Rochester, NY: University of Rochester Press.

Clausen, J. M., Landsverk, J., Ganger, W., Chadwick, D., and Litrownik, A. Mental health problems of children in foster care. Journal of Child and Family Studies, 7, 283-296.

Cohen, J. A., Berliner, L. and March, J. S. (2000) Treatment of children and adolescents. In E. B. Foa, T. M. Keane, et al. (Eds.) Effective Treatments for PTSD: Practice Guidelines from the International Society for Traumatic Stress Studies. New York: Guilford, 330-332.

Crimmins, S. M., Cleary, S. D., Brownstein, H. H., Spunt, B. J., and Warley, R. M. (2000) Trauma, drugs and violence among juvenile offenders. Journal of Psychoactive Drugs, 32, 43-54.

Deblinger, E. and Heflin, A. H. (1996) Treating Sexually Abused Children and Their Nonoffending Parents: a Cognitive Behavioral Approach. Thousand Oaks, CA: Sage Publications.

Dubner, A. E. and Motta, R. W. (1999) Sexually and physically abused foster care children and posttraumatic stress disorder. Journal of Consulting and Clinical Psychology, 67, 367-373.

Eckenrode, J., Laird, M., and Doris, J. (1993) School performance and disciplinary problems among abused and neglected children. Developmental Psychology, 29, 53-62.

Erwin, B. A., Newman, E., McMackin, R. A., Morrissey, C. and Kaloupek, D. G. (2000) PTSD, malevolent environment, and criminality among criminally involved male adolescents. Criminal Justice and Behavior, 27, 196-215.

Gallagher, C.A. (1999) Juvenile Offenders in Residential Placement, 1997. Washington, D.C.: U.S. Department of Justice, Office of Juvenile Justice and Delinquency Prevention, OJJDP Fact Sheet #96.

Garbarino, J., Eckenrode, J., and Powers, J. L. (1997) The maltreatment of youth. In J. Garbarino and J. Eckenrode (Eds) Understanding Abusive Families: an Ecological Approach to Theory and Practice. San Francisco: Jossey-Bass, 145-165.

Gunnar, M. R. (2000) Early adversity and the development of stress reactivity and regulation. In C.A. Nelson (Ed) The Minnesota Symposia on Child Psychology, Vol 31: The Effects of Early Adversity on Neurobehavioral Development. Minnesota Symposia on Child Psychology; V. 31. Mahwah, N.J.: Erlbaum, 163-200

James, B. (1989). Treating Traumatized Children: New Insights and Creative Interventions.

Lexington, MA: Lexington Books/D. C. Heath.

Kaufman, J. and Henrich, C. (2000) Exposure to violence and early childhood trauma. In C.H Zeanah, (Ed). Handbook of Infant Mental Health. Second Edition. New York: Guilford Press, 195-207.

Leavitt, L. A. and Fox, N. A. (1993) The Psychological Effects of War and Violence on Children. Hillsdale, NJ: Erlbaum.

Lieberman, A. F., Silverman, R., and Pawl, J. (2000) Infant-parent psychotherapy: Core concepts and current approaches. In C.H Zeanah, (Ed). Handbook of Infant Mental Health. Second Edition. New York: Guilford Press, 472-484.

March, J. S., Amaya-Jackson, L., Murray, M. C., and Schulte, A. (1998) Cognitive-behavioral psychotherapy for children and adolescents with posttraumatic stress disorder after a single-incident stressor. Journal of the American Academy of Child and Adolescent Psychiatry, 37, 585-593.

Marmar, C. R., Weiss, D. S., and Pynoos, R. S. (1995) Dynamic psychotherapy of post-traumatic stress disorder. In M. J. Friedman, J. Matthew , D. S. Charney, et al. Neurobiological and Clinical Consequences of Stress: From Normal Adaptation to Post-traumatic Stress Disorder. Philadelphia: Lippincott Williams & Wilkins, 495-506.

McNally, R. J. (1996) Assessment of posttraumatic stress disorder in children and adolescents. Journal of School Psychology, 34, 147-161.

Muris, P., Merckelbach, H., Koerver, P. and Meesters, C. (2000) Screening for trauma in children and adolescents: The validity of the Traumatic Stress Disorder scale of the Screen for Child Anxiety Related Emotional Disorders. Journal of Clinical Child Psychology, 29, 406-413.

Perry, B. D. and Pollard, R. H. (1998) Homeostasis, stress, trauma, and adaptation: A neurodevelopmental view of childhood trauma. Child and Adolescent Psychiatric Clinics of North America, 7, 33-51.

Pfefferbaum, B. P. (1997) Posttraumatic stress disorder in children: A review of the past 10 years. Journal of the American Academy of Child and Adolescent Psychiatry, 36, 1503-1511.

Pollak, S., Cicchetti, D., and Klorman, R. (1998) Stress, memory, and emotion: Developmental considerations from the study of child maltreatment. Development and Psychopathology, 10, 811-828.

Pynoos, R. S., Goenjian, A. K., and Steinberg, A. M. (1998) A public mental health approach to the postdisaster treatment of children and adolescents. Child and Adolescent Psychiatric Clinics of North America, 7, 195-210.

Pynoos, R.S., Steinberg, A. M., and Piacentini, J.C. (1999) A developmental psychopathology model of childhood traumatic stress and intersection with anxiety disorders. Biological Psychiatry, 46, 1542-1554.

Quinlan, K. P. and Sacks, J. J. (1999) Hospitalizations for dog bite injuries [letter] Journal of the American Medical Association, 28, 232-233.

Rosenfeld, A.A., Pilowsky, D.J., Fine, P., et al. (1997) Foster care: An update. Journal of the American Academy of Child and Adolescent Psychiatry, 36, 448-457.

Rutter, M. L. (1999) Psychosocial adversity and child psychopathology. British Journal of Psychiatry, 174, 480-493.

Shonk, S. M. and Cicchetti, D. (2001) Maltreatment, competency deficits, and risk for academic and behavioral maladjustment. Developmental Psychology, 37, 3-17.

Singer, M.I., Anglin, T.M., Song, L., and Lunghofer, L. (1995) Adolescents' exposure to violence and associated symptoms of psychological trauma. Journal of the American Medical Association, 273, 477-482.

Sosin, D. M., Sacks, J. J., and Webb, K. W. (1996) Pediatric head injuries and deaths from bicycling in the United States. Pediatrics, 98, 868-70.

Sacks, J. J., Kresnow, M., and Houston B. (1996) Dog bites: how big a problem? Injury Prevention, 2, 52-4.

Trickett, P. K. and Schellenbach, C. J. (1998) Violence Against Children in the Family and the Community. Washington, D.C.: American Psychological Association.

U. S. Department of Health and Human Services, Children's Bureau. (2000a) Child Maltreatment 1998: Reports from the States to the National Child Abuse and Neglect Data System.

U. S. Department of Health and Human Services, Children's Bureau. (2000b) Adoption and Foster Care Analyis and Reporting System: Report Number 4.

U. S. Department of Health and Human Services, Office of Refugee Resettlement. (2000c) Fact Sheet.

ADDITIONAL RESOURCES AVAILABLE AT:
http://www.nctsnet.org

APPENDIX C

National Child Traumatic Stress Network:
Background, structure, and mission of the National Child Traumatic Stress Network

Treatment centers from all over the United States have come together to form a new coalition, the National Child Traumatic Stress Network (NCTSN). The Network, which is currently composed of 37 centers, is being funded by the Center for Mental Health Services, Substance Abuse and Mental Health Services Administration, US Department of Health and Human Services, through a Congressional initiative, the Donald J. Cohen National Child Traumatic Stress Initiative. This Congressional initiative recognizes the profound, destructive, and widespread impact of trauma on American children's lives. Its purpose is to improve the quality, effectiveness, provision, and availability of therapeutic services delivered to all children and adolescents experiencing traumatic events. The Network will develop and disseminate effective, evidence-based treatments; collect data for systematic study; and help to educate professionals and the public about the effects of trauma on children.

Over the past 20 years significant advances have been made in the field of child traumatic stress. This Network is a groundbreaking effort that blends the academic best practices of the clinical research community with the wisdom of front-line community service providers. The work of Network members ranges across settings, disciplines, age groups, and trauma types, delivering high-quality services to large numbers of children and their families. The Network is committed to addressing the full spectrum of child trauma from a developmental and family-centered perspective and to helping children from every ethnic, socio-cultural, and economic background.

The Network is made up of three components:

National Center for Child Traumatic Stress (Category I)

Designated to lead the NCTSN as the National Center for Child Traumatic Stress (NCCTS), the UCLA David Geffen School of Medicine and the Duke University School of Medicine have individually and collectively provided leadership in the developmental understanding of child traumatic stress; have pioneered evaluation and treatment of children, families, and communities; and are at the forefront in developing public mental health strategies to reach the large population of children, families, and communities affected by traumatic events. The National Center for Child Traumatic Stress, as a joint program of UCLA and Duke University, is supported by the vast resources of two of the country's preeminent learning institutions, their medical schools, and departments of psychiatry and university-level programs.

Intervention Development and Evaluation Centers (Category II)

Intervention Development and Evaluation (IDE) Centers are charged with identifying, supporting, improving, and developing treatment and service approaches for different types of child and adolescent traumatic events. IDE Centers emphasize developmentally appropriate trauma evaluation and intervention for children and adolescents of all ages, as well as the identification, assessment, and appropriate treatment of children in specialty child service sectors, such as schools, the juvenile justice system, the refugee service system, and the child welfare and protective service systems.

Community Treatment and Services Centers (Category III)

The third category of grantees, Community Treatment and Services Centers, will implement and evaluate effective treatment and services in community settings; collect clinical data on traumatized children receiving treatment; develop expertise related to effective practices, financing, and other service issues; and provide leadership and training on child trauma for service providers in the community and staff in a range of child service sectors.

NCTSN Mission

To raise the standard of care and improve access to services for traumatized children, their families, and communities throughout the United States.

NCTSN Vision

- The NCTSN will raise public awareness of the scope and serious impact of child traumatic stress on the safety and healthy development of our Nation's children and families.

- We will improve the standard of care by integrating developmental and cultural knowledge to advance a broad range of effective services and interventions that will preserve and restore the future of our Nation's traumatized children.

- We will work with established systems of care, including the health, mental health, education, law enforcement, child welfare, and juvenile justice systems, to ensure that there is a comprehensive continuum of care available and accessible to all traumatized children and their families.

- We will be a community dedicated to collaboration within and beyond the Network to ensure that widely shared knowledge and skills create a national resource to address the problem of child traumatic stress.

web site link: http://www.nctsnet.org/nccts/nav.do?pid=abt_main

APPENDIX D

National Child Traumatic Stress Network Center Descriptions

Alabama

National Children's Advocacy Center

The National Children's Advocacy Center will focus on treatment and services for children who are victims of child abuse or neglect and their families. This will include identifying gaps in the field and the best practices and emerging practices that will meet those needs, evaluating those practices, and disseminating the information to the field through a variety of training and technical assistance methods and in collaboration with the National Child Traumatic Stress Network. As a partner of the National Child Traumatic Stress Network, the NCAC plans to develop new training and technical assistance projects for therapists new to the field of child abuse; expand and conduct research on the Family Advocate Model; expand research on the Forensic Evaluation Model, particularly for preschool child sexual abuse victims; and provide curriculum enhancements to universities that train professionals working in the field of child abuse.
Contact: JoAnn Plucker
Phone: (256) 533-0531
Email: jplucker@ncac-hsv.org
Web: http://www.NationalCAC.org

California

Chadwick Center for Children and Families Trauma Counseling Program

The Trauma Counseling Program within the Chadwick Center at Children's Hospital - San Diego is a large trauma-focused treatment program with offices throughout the County of San Diego. It will use its large and culturally diverse community service environment to explore the most effective treatment methods across childhood trauma types. The focus will be on the treatment of children. The trauma types include child abuse, witness to intimate and community violence, accident-related trauma, and painful medical procedures. The Chadwick Center will examine the most effective clinical pathways for connecting children from the initial medical and/or legal system contacts to trauma treatment. The Center will draw from its culturally diverse staff and client base and location as a border community to examine the issues of ethnicity, culture, and degrees of acculturation in the healing process. As part of the National Child Traumatic Stress Initiative, the Chadwick Center will partner with the NIMH-funded Child and Adolescent Services Research Center at Children's Hospital to support scientific integrity in its research on effective treatment methods.
Contact: Barbara Ryan
Phone: (858) 966-4011
Email: beryan@chsd.org
Web: http://www.charityadvantage.com/chadwickcenter/home.asp

Children's Institute International, Central L.A. Child Trauma Treatment Center

Children's Institute International, Central L.A. Child Trauma Treatment Center, is a community agency serving metropolitan Los Angeles in two clinic sites, as well as in schools and through home-based services. CII's mental health programs serve children who have been abused or neglected, sexually abused, and/or exposed to domestic violence as well as to violence at school or in their community. One goal of the Trauma Center is to create a Child Trauma Council in Central Los Angeles, composed of multiple agencies serving children. Another special focus will be an evaluation of their multidisciplinary approach to serving children and families in their domestic violence treatment program.
Contact: Becky Gaba
Phone: (213) 385-5100
Email: rgaba@childrensinstitute.org
Web: http://www.childrensinstitute.org

Early Trauma Treatment Network

Early Trauma Treatment Network (ETTN) is a unique collaboration between the University of California, San Francisco (UCSF), the Child Violence Exposure Program at Louisiana State University Health Sciences Center, the Child Witness to Violence Project at Boston Medical Center, and Tulane University/Jefferson Parish Human Services Authority Infant Team at Tulane University Medical Center. The ETTN is focused on providing Child-Parent Psychotherapy, a manualized, multimodal, relationship-based treatment for infants, toddlers, and preschoolers exposed to interpersonal traumas, including domestic violence, child abuse, community violence, and traumatic loss. They are implementing and evaluating this innovative treatment approach in ethnically and culturally diverse populations across the four sites.
Contact: Chandra Ghosh Ippen
Phone: (415) 206-5312
Email: chandra@itsa.ucsf.edu

L.A. Unified School District Community Practice Center

The Los Angeles Unified School District Community Practice Center is designed to expand knowledge, services, training, and education for early trauma interventions in schools, including treatment, crisis response, and seamless linkages to other community services and follow-up care. It is developing school services specifically for ethnic minority and underserved children, including immigrant populations, and doing outreach to diverse communities affected by trauma to reduce stigma and increase awareness of the impact that trauma can have on children. It is also expanding upon the cognitive-behavioral therapy treatment model it has been piloting in schools. The Center will focus on children who have been exposed to a wide range of community violence.
Contact: Marleen Wong
Phone: (818) 997-2640
Email: mwong1@lausd.k12.ca.us

Miller Children's Abuse and Violence Intervention Center

Miller Children's Abuse and Violence Intervention Center (MCAVIC) is an outpatient evaluation and treatment program in Long Beach, California. The Center collaborates closely with community agencies and schools to provide culturally sensitive, trauma-specific, and developmentally appropriate services to children, adolescents, and their families. MCAVIC provides coordinated investigative, medical, and mental health services to children, adolescents, and families who have experienced child abuse, family violence, neighborhood violence, parental substance abuse, medical trauma, and community disasters. MCAVIC provides coordination of services for immediate intervention, as well as long-term services, support, and community outreach. MCAVIC's school-based program is designed to increase the availability of evaluation and treatment services to school-age children who have experienced child abuse, domestic violence, community violence, and parental substance abuse.
Contact: Laura Benson
Phone: (562) 933-0590
Email: lbenson@memorialcare.org
Web: http://www.memorialcare.org

National Center for Child Traumatic Stress

Designated to lead the NCTSN as the National Center for Child Traumatic Stress (NCCTS), the UCLA David Geffen School of Medicine and the Duke University School of Medicine have individually and collectively provided leadership in the developmental understanding of child traumatic stress, have pioneered evaluation and treatment of children, families, and communities, and are at the forefront in developing public mental health strategies to reach the large population of children, families, and communities affected by traumatic events. The National Center for Child Traumatic Stress, as a joint program of UCLA and Duke University, is supported by the vast resources of two of the country's preeminent learning institutions, their medical schools, and departments of psychiatry and university-level programs.
Contact: Jenifer Wood
Phone: (310) 235-2633

Email: jlwood@mednet.ucla.edu
Web: http://www.nctsnet.org

Colorado

Aurora Mental Health Center

Aurora Mental Health Center is a nonprofit community mental health center that serves Aurora, Colorado, a city of 275,000 that includes parts of three counties of metropolitan Denver. Currently 315 paid employees and 82 volunteers aid more than 5000 people annually. Services are provided in eight counseling and specialized service centers, seven residential facilities, 25 public schools, two county departments of human services, homes, foster homes, and at other community locations. In 1999, the Aurora Mental Health Center was named the best community mental health center in Colorado by State Mental Health Services and has consistently ranked in the top three. The Center helps abused and neglected children and children who have witnessed interpersonal violence. The Center's Intercept program works with children with mental illness and developmental disabilities, an underserved population with an extremely high prevalence of abuse.
Contact: Frank Bennett
Phone: (303) 617-2305
Email: FrankBennett@aumhc.org
Web: http://www.aumhc.org

Mental Health Corporation of Denver's Family Trauma Treatment Program

Mental Health Corporation of Denver's Family Trauma Treatment Program provides access for low-income children and families to community mental health services through a network of more than 30 locations throughout the Denver area. The program's goal is to improve services and treatment for children who have experienced trauma by implementing and evaluating evidence-based interventions in a variety of community settings including schools, shelters, juvenile detention centers, day care centers, and neighborhood clinics.
Contact: Karen Mallah
Phone: (303) 504-6565
Email: kmallah@mhcd.com

Connecticut

Childhood Violent Trauma Center

Childhood Violent Trauma Center (CVTC) represents a collaboration between the interdisciplinary faculty and staff at the Yale Child Study Center and the University of Connecticut Health Center. Together, the CVTC seeks to develop innovative and comprehensive responses to children and adolescents who have been acutely traumatized by violence in their communities and homes, with an emphasis on collaboration with local entities, especially law enforcement.
Contact: Steven Berkowitz
Phone: (203) 785-7047
Email: steven.berkowitz@yale.edu
Web: http://www.nccev.org

District of Columbia

La Clinica del Pueblo, Inc.

La Clinica del Pueblo, Inc., is an outpatient bicultural, bilingual, nonprofit, community-based organization that provides a variety of services to an immigrant population, mainly Latino, in Washington, DC. The mission of La Clinica is: "To provide free, culturally sensitive and comprehensive health care and education services to the Latino community and any others in need. La Clinica promotes community participation and empowerment through professional care, advocacy, and a vision of health as a basic human right." La Clinica provides medical, HIV, mental health, social work, and interpreters services to nearly 6000 unduplicated clients of all ages annually. Most patients/clients speak little or no English, have no health insurance, are immigrants from Central America (mainly El Salvador), and have never completed secondary school. The child and adolescent

trauma victims seen at La Clinica suffer from exposure to domestic violence and/or substance abuse in the home, physical abuse, sexual abuse or assault, and medical trauma. Many have lost loved ones in natural disasters or through torture and the experience of being immigrants. The long-term goal of La Clinica's project is to develop a well-integrated medical/mental health model for early identification and treatment of Latino children and adolescents suffering from trauma.
Contact: Darleen Joyce
Phone: (202) 462-4788
Email: djoyce@lcdp.org
Web: http://www.lcdp.org

Wendt Center for Loss and Healing

The Wendt Center for Loss and Healing is a 28-year-old nonprofit agency that provides mental health services to children and families. The Wendt Center serves people throughout the Washington, DC, metropolitan area who have experienced the death of a loved one, or are living with life-threatening illness. Individual counseling, grief support groups, a summer grief camp for children, and training for mental health professionals are the heart of the Wendt Center services. Three years ago the Wendt Center created the only program in the United States that provides on-site grief counseling to families who must visit the city morgue to identify a body; through this work the Wendt Center has developed an expertise in working with children from families who have experienced a traumatic death.
Contact: Susan Ley
Phone: (202) 624-0010
Email: sley@lossandhealing.org
Web: http://www.lossandhealing.org

Florida

Healing the Hurt, Directions for Mental Health, Inc.

Directions for Mental Health, Inc., is a community mental health center in Clearwater, Florida currently serving children and adolescents aged 0-18 who present with mental health symptoms and a history of trauma. Healing the Hurt is a partnership with Hospice of the Florida Suncoast and Family Service Centers, two community organizations that have traditionally provided intervention to children and adolescents who have recently experienced trauma related to death or serious illness of a family member, or from sexual assault. Healing the Hurt works closely with the local school board, Safe Start Initiative, and the juvenile justice system, and participates in a replication of the Child Development-Community Policing program. The agencies will be developing protocols for our services and implementing best practices as recommended by the National Center. In addition to expanding services and improving access, Healing the Hurt will focus on increasing community awareness of the effects of trauma on children and on training other providers in the region.
Contact: Ann Kelley
Phone: (727) 547-4566
Email: ann.kelley@directionsmh.org

Illinois

Family, Adolescent, and Child Enhancement Services (FACES)

Family, Adolescent and Child Enhancement Services (FACES) is a program of Chicago Health Outreach, a community-based health organization providing services to disenfranchised individuals and families in Chicago. The program enhances the quality of life for refugee children, adolescents, and families by providing culturally and linguistically appropriate and comprehensive mental health services for individuals suffering from trauma-related distress or emotional stress exacerbated by the refugee experience. Direct services include psychiatric assessment and treatment, individual and family counseling, psychotherapy, occupational, art and dance / movement therapy, theater work, case management typically provided by a case manager from the child's country of origin, and outreach programs to sensitize the children's wider communities to their needs. All services are available in the home, school, community, and on site.
Contact: Joan Liautaud
Phone: (773) 751-4054

Email: jaywon@aol.com
Web: http://www.heartland-alliance.org

Maine

Mid-Maine Child Trauma Network

The Mid-Maine Child Trauma Network (MCTN) will strengthen the infrastructure of rural community services to children who have experienced traumatic stress and their families. Building on a successful triage assessment and outcome evaluation protocol serving physical and psychosocial needs of abused and neglected children in foster care, the MCTN will (1) identify community resources, needs, and coordination opportunities among foster care, domestic violence, emergency health care, mental health, and terrorism/disaster response services; (2) pilot triage assessment and outcome evaluation protocols in the above areas; (3) provide training and consultation to increase trauma assessment and intervention resources; (4) facilitate interagency development and coordination of child trauma services; and (5) collaborate with the National Child Traumatic Stress Network and regional networks in resource development and dissemination.
Contact: Stephen Meister
Phone: (207) 621-2304
Email: smeister@mainegeneral.org

Maryland

Substance Abuse and Mental Health Services Administration

The Center for Mental Health Services (CMHS), Substance Abuse and Mental Health Services Administration (SAMHSA), works to create an effective community-based mental health service infrastructure in the U.S. The Center's foremost goals are to improve the availability and accessibility of high-quality care for people with or at risk for mental illnesses and their families. Although the largest portion of the Center's annual appropriation supports States through the Community Mental Health Services Block Grant Program, CMHS also supports a portfolio of grant programs that develop and apply knowledge about best community-based practices to reach people at greatest risk: adults with serious mental illnesses and children with serious emotional disturbances. Issues of stigma and consumer empowerment are also on the Center's agenda. Further, the Center collects and disseminates national mental health services data, designed to help inform future services policy and program decision-making.
Contact: Robert DeMartino
Phone: (301) 443-2940
Email: nctsi@samhsa.gov
Web: http://www.samhsa.gov

Massachusetts

Center for Medical and Refugee Trauma, Boston University Medical Center

Center for Medical and Refugee Trauma, Boston University Medical Center, is working to develop and evaluate interventions and services for children and adolescents who experience medical trauma, including burns, injuries, and invasive medical procedures. The Center also has an emphasis on work with children and families who have experienced war, displacement, and resettlement stress. Activities of the Center include the investigation of risk factor profiles and the development of culturally informed, socially and ecologically valid interventions for children who have experienced trauma; examination of the impact of trauma on physical and mental health outcomes; consideration of acute preventative interventions for injured children; and improvement of interventions for pain in medically hospitalized children.
Contact: Daphne McCampbell
Phone: (617) 414-7531
Email: daphne.mccampbell@bmc.org
Web: http://www.bmc.org/childpsychiatry

The Trauma Center, Massachusetts Mental Health Institute

The Trauma Center, Massachusetts Mental Health Institute, provides community crisis intervention, trauma treatment, clinical training, and treatment outcome research for traumatized children and their caregivers. The Center focuses on specialty trauma service delivery, education, and training to assist children exposed to physical and sexual abuse, neglect, and community and political violence. It is affiliated with multiple community agencies, including clinics, universities, schools, youth groups, homeless shelters, church groups and the Boston police department, which partner with the Center to serve children in the Greater Boston area as well as in rural and remote areas of New England.
Contact: Joseph Spinazzola
Phone: (617) 782-6460
Email: spinazzola@traumacenter.org
Web: http://www.traumacenter.org

Missouri

Kansas City Metropolitan Child Traumatic Stress Center

Kansas City Metropolitan Child Traumatic Stress Program is sponsored by the University of Missouri-Kansas City. It is a partnership between the University, a multiservice children's agency called The Children's Place, and a large community collaborative of family-serving organizations in the metro-Kansas city area convened by PROCOMM and UMKC. Goals of the KC Metro program are to promote identification, assessment, and treatment for traumatized children and adolescents in the Kansas City area, and to increase public awareness and promote the utilization of trauma treatments and services to underserved populations, including those in specialty service settings. KC Metro plans to emphasize policy and advocacy at the local and State level.
Contact: Sharon Portwood
Phone: (816) 235-1064
Email: portwoods@umkc.edu

The Greater St. Louis Child Traumatic Stress Program

The Greater St. Louis Child Traumatic Stress Program is a collaborative project between the Children's Advocacy Services of Greater St. Louis and the Center for Trauma Recovery of the University of Missouri-St. Louis. The program provides assessment and therapy free of charge for children and adolescents for a variety of traumatic events, including sexual and physical abuse, assault, accidents, homicide, domestic violence, and community violence. Services include individual, family, and group therapy; forensic interviews and medical exams; abuse prevention education; research; consultation; and professional education and training programs.

http://www.umsl.edu
Contact: Jeffrey Wherry
Phone: (314) 516-7342
Email: wherry@msx.umsl.edu
Web: http://www.safekidsmo.org

New Mexico

New Mexico Alliance for Children with Traumatic Stress

New Mexico Alliance for Children with Traumatic Stress is a collaboration between nonprofit, State government, and tribal organizations committed to improving New Mexico's capacity to identify, treat, and serve children who experience traumatic stress, from diverse cultural and ethnic backgrounds, living in both urban and remote rural areas. In addition to creating a network of highly trained service providers, the Alliance also seeks to document and disseminate information to local and national audiences about promising interventions for the unique populations they serve.
Contact: Sarthak Das
Phone: (505) 603-0056
Email: newmacts@yahoo.com
Web: http://www.tacinc.org

New York

Children's Trauma Consortium of Westchester

The Children's Trauma Consortium of Westchester is a partnership between the Behavioral Health Center at Westchester Medical Center, Julia Dyckman Andrus Memorial, The Center for Preventive Psychiatry, and Fordham University Graduate School of Social Service. The Children's Trauma Consortium will provide a continuum of care for children who have experienced or been exposed to community violence, domestic violence, sexual abuse and assault, or physical abuse and assault. The focus will be on children at a high risk of being removed from their homes, schools, and communities.
Contact: Maralee Walsh
Phone: (914) 493-7071
Email: walshm1@wcmc.com

Jewish Board of Family and Children's Services - Center for Trauma Program Innovation

The Jewish Board of Family and Children's Services - Center for Trauma Program Innovation (JBFCS) will develop, improve, and systematize trauma-focused assessment and treatment services for traumatized children from low-income and racially diverse neighborhoods. Children served have been exposed to a full range of interpersonal and community violence, and present with both acute and chronic traumatic stress consequences. JBFCS is a large, decentralized network of mental health and social service programs throughout New York City. Two major goals of the Center are: 1) to develop psycho-educational modules and a treatment manual for the Sanctuary trauma treatment program; and 2) to introduce research-grade data collection and treatment protocols to screen for trauma exposure, systematize trauma assessment, and implement trauma-focused treatment approaches.
Contact: Robert Abramovitz
Phone: (212) 632-4665
Email: RAbramovitz@jbfcs.org
Web: http://www.jbfcs.org

Mount Sinai Adolescent Health Center

Mount Sinai Adolescent Health Center is dedicated to the coordinated and integrated provision of comprehensive adolescent health care services within a single setting that maintains complete patient confidentiality and provides care to adolescents regardless of their ability to pay. AHC staff work to engage adolescents in treatment, using a holistic approach and personally tailoring care to each individual's medical, mental health, family planning, and health education needs. Located in New York City, AHC serves a culturally and ethnically diverse population that has experienced a wide range of traumatic experiences including physical and sexual abuse/assault; domestic, gang, and community violence; and homelessness.
Contact: Sabina Singh
Phone: (212) 423-2900
Email: sabina.singh@msnyuhealth.org

North Shore University Hospital Adolescent Trauma Treatment Development Center

North Shore University Hospital Adolescent Trauma Center is based at a not-for-profit tertiary care hospital that has a commitment to providing mental health services to children and adolescents in the Long Island Region who have experienced physical abuse, sexual abuse, neglect, or other types of interpersonal trauma. The Center specializes in developing interventions to address and raise awareness about the unique impact of exposure to trauma during adolescence.
Contact: Victor LaBruna
Phone: (516) 562-3245
Email: vlabruna@nshs.edu

Parsons Child and Family Center

Parsons Child and Family Center provides residential treatment services to children and adolescents in Northeastern New York State. The Parsons treatment continuum includes residential and foster care, outreach to schools and day care centers, and mental health and prevention services for children who have been

physically and sexually abused and/or exposed to domestic and community violence. The Parsons Child Trauma Study Center will use its participation in NCTSN to disseminate information about best practice assessments and treatments of traumatized children and adolescents to its extensive collaborative network as well as to improve the treatment provided at Parsons' own treatment programs. Research and evaluation for the grant activities will be coordinated by Dr. John Hornik and associates at the Advocacy for Human Potential (AHP) agency.
Contact: Joseph Benamati
Email: benamaj@parsonscenter.org
Web: http://www.parsonscenter.org

Safe Horizon - St. Vincent's Child Trauma Care Initiative

Safe Horizon-St. Vincent's Child Trauma Care Initiative offers a unique and comprehensive continuum of outreach and treatment services for child trauma victims and their families. Programs range from community-based prevention to inpatient treatment and provide effective, trauma-focused care to thousands of children and youth each year. The project is the result of a collaboration between Safe Horizon, the Nation's leading nonprofit victim assistance organization, and Saint Vincent Catholic Medical Center, one of the largest behavioral healthcare providers in New York City. By pooling their resources and expertise, the Initiative creates a system of extensive outreach, services, treatment, consultation, and referrals that enables children and youth affected by trauma to access the most appropriate level of care at any given time. The overarching goal is to increase the options for and improve the quality of trauma-focused services and treatment for all youth who have experienced trauma.

http://www.svcm.org
Contact: Carrie Epstein
Phone: (212) 577-3871
Email: cepstein@safehorizon.org
Web: http://www.safehorizon.org

The Institute for Trauma and Stress, NYU Child Study Center

The Institute's specific aims are the assessment and treatment of traumatized children, as well as the development and dissemination of effective trauma treatments for children and their families. The Institute treats all types of urban trauma, including physical and sexual abuse, domestic and community violence, and traumatic bereavement and exposure to the 9-11 terrorist attack. The Institute's programs and goals include the training of clinicians in empirically based trauma assessment and treatment, the evaluation of the effectiveness of these treatments in the community, and the development of new treatments sensitive to the child and youth's trauma history, cultural, and community context. There is extensive outreach to and education of those who work regularly with children about the psychological, social, and biological impacts of traumatic events. The Institute pioneers individual, group, parent, and family cognitive-behavioral therapies, as well as psychopharmacological and medical services. Services are offered through its affiliate outpatient and inpatient clinics, as well as school-based programs and foster care.
Contact: Lena Kessler
Phone: (212) 263-2775
Email: lena.kessler@med.nyu.edu
Web: http://www.aboutourkids.org

North Carolina

National Center for Child Traumatic Stress

Designated to lead the NCTSN as the National Center for Child Traumatic Stress (NCCTS), the UCLA David Geffen School of Medicine and the Duke University School of Medicine have individually and collectively provided leadership in the developmental understanding of child traumatic stress, have pioneered evaluation and treatment of children, families, and communities, and are at the forefront in developing public mental health strategies to reach the large population of children, families, and communities affected by traumatic events. The National Center for Child Traumatic Stress, as a joint program of UCLA and Duke University, is supported by the vast resources of two of the country's preeminent learning institutions, their medical schools, and departments of psychiatry and university-level programs.

Contact: Jenifer Wood
Phone: (310) 235-2633
Email: jlwood@mednet.ucla.edu
Web: http://www.nctsnet.org

Ohio

Cullen Center for Children, Adolescents, and Families

Cullen Center for Children, Adolescents, and Families combines the treatment capabilities of the Toledo Children's Hospital and the front-end delivery strengths of the Lucas County Children's Advocacy Center. Together, both entities provide group, individual, and family counseling, advocacy, and other support services to children and teens who experience violence, abuse, and other traumatic events. Building on the Lucas County Safe Kids Safe Streets Initiative, the Center will involve the community in all project components and widely disseminate information and treatment protocols.
Contact: Kristine Buffington
Phone: (419) 291-7919
Email: Kris.Buffington@Promedica.org

The Children Who Witness Violence Program

The Children Who Witness Violence Program provides immediate 24-hour trauma response services to children and families who have been referred by police officers in participating communities in the greater Cleveland area. The program is administered by Mental Health Services, Inc. a community mental health service provider. Police officers refer families who are involved in domestic or community violence by calling the Mental Health Services crisis line. A crisis intervention specialist is assigned to the family, makes contact with them within an hour or two, and schedules an initial visit. The goals of the initial response are to 1) stabilize the crisis situation and provide immediate trauma intervention; 2) assure the safety of the child witness and the family; and 3) begin a comprehensive assessment of the child and family system. After the initial intervention and assessment phase, the child and family may be referred to an appropriate agency for up to six months of follow-up services.
Contact: Sarah McGuire
Phone: (216) 623-6555
Email: sarah@mhs-inc.org

Trauma Treatment Replication Center

The Trauma Treatment Replication Center is part of the Mayerson Center for Safe and Healthy Children, a child abuse evaluation, treatment, and research center located in Children's Hospital Medical Center, Cincinnati. The Trauma Treatment Replication Center is focused on acquiring expertise in the replication of child treatment models in community settings. Its goal is to transfer evidence-based child and adolescent trauma treatments from their developers to community-level providers.
Contact: Frank Putnam
Phone: (513) 636-7001
Email: frank.putnam@chmcc.org
Web: http://www.cincinnatichildrens.org/svc/prog/child-abuse/default.htm

Oregon

Intercultural Child Traumatic Stress Center of Oregon

The Intercultural Child Traumatic Stress Center of Oregon has two major components. The first is a six-month education program for service providers and others who work with refugee and immigrant children, focusing on the issue of child traumatic stress. The education program will train ethnic mental health counselors and school personnel, among others, to identify refugee and immigrant children who may be suffering the effects of traumatic stress. The education program will also publicize the availability of culturally appropriate treatment through the center. The second major component is direct treatment of refugee and immigrant children who suffer the effects of traumatic stress. Individual, family, and group therapy are available for children from any of the 15 or so ethnic/language groups regularly encountered by the Intercultural Psychiatric Program, with a

special emphasis on Asians and Hispanics.
Contact: Thomas Argent
Email: argentt@ohsu.edu

Pennsylvania

Allegheny General Hospital Center for Traumatic Stress in Children and Adolescents

Allegheny General Hospital Center for Traumatic Stress in Children and Adolescents is an urban, outpatient treatment program with a strong commitment to community involvement, based in Pittsburgh, PA. The Center treats children exposed to many types of trauma, but has a particular focus on developing, modifying, and disseminating effective interventions for child physical and sexual abuse, traumatic loss, and posttraumatic stress disorder. The Center has developed trauma-focused individual, group, and family cognitive behavioral interventions, and has completed several randomized trials using these interventions with abused children and adolescents. It has also recently established an NCTSN Task Force on Childhood Traumatic Bereavement.
Contact: Judith Cohen
Phone: (412) 330-4321
Email: JCohen1@wpahs.org

Center for Pediatric Traumatic Stress

The Center for Pediatric Traumatic Stress (CPTS) at The Children's Hospital of Philadelphia develops and evaluates empirically based interventions for children who have experienced traumatic stress due to medical illness or injury, and for their families. This includes developing manualized "best practice" protocols for preventing and treating traumatic stress, and establishing service delivery models to integrate prevention and treatment into health care and school-based systems. Current areas of intervention development focus on traumatic stress related to life-threatening illness, acute injury, and critical care. CPTS is guided by an experienced team of clinicians from psychology, critical care medicine, emergency medicine, nursing, oncology, pediatrics, and surgery, and collaborates with health care providers nationwide to address critical issues regarding the prevention and treatment of traumatic stress in medical and primary care health settings. CPTS is also in the process of establishing an education and training center for disseminating state-of-the art-information and protocols about traumatic stress related to pediatric illness and injury.
Contact: Stephanie Schneider
Phone: (267) 426-5205
Email: schneiderst@email.chop.edu

Children's Crisis Treatment Center's Project Tamaa

Children's Crisis Treatment Center (CcTC) intends to expand its current trauma services by developing and implementing an innovative, community-/school-based, multimodal treatment program to assist the large and growing number of West African refugee children and their parents/caregivers who have relocated to the Southwest area of Philadelphia, Pennsylvania. Our new program, entitled Project Tamaa, is designed to target and serve those West African refugees from Liberia, Guinea, and Sierra Leone who have witnessed and experienced traumatic events, such as civil war and conflict-related atrocities in their homelands and in refugee camps, and who are also struggling with acculturation issues. Project Tamaa's school-based components include children's therapy/support groups and teacher educational seminars, while the community-based components include caregiver education/support groups, case management services, and multicultural social events.
Contact: Anne Holland
Phone: (215) 496-0707 x1427
Email: Aholland@cctckids.com
Web: http://www.cctckids.com

Utah

Child Trauma Treatment Network-Intermountain West Primary Children's Medical Center

Child Trauma Treatment Network Intermountain West Primary Children's Medical Center seeks to improve treatment and services for children who experience trauma related to abuse and who live in the Intermountain

West States of Arizona, Idaho, Montana, Nevada, South Dakota, Utah, and Wyoming. The program is developing a regional network of child therapists from all seven States who will participate and collaborate in training and consultation. Teams of therapists will work to create a network of professionals to serve the Intermountain West by raising the standard of care for children traumatized by abuse and by working to ensure that underserved populations of children have access to care.
Contact: Susan Stewart
Phone: (801) 265-3180
Email: wcsstewa@ihc.com
Web: http://www.ihc.com/xp/ihc/primary

Virginia

International C.H.I.L.D., Center for Multicultural Human Services (CMHS)

The Center for Multicultural Human Services (CMHS) helps people from ethnically diverse backgrounds succeed by providing comprehensive, culturally sensitive mental health services and by conducting research and training to make such services more effective and widely available. Based in the Washington, DC, metropolitan area, this nonprofit agency provides a broad range of services through a multilingual (over 30 languages) interdisciplinary staff utilizing a social-ecological team treatment approach. Under NCTSN funding, CMHS is refining and documenting developmentally, clinically, and culturally appropriate treatment strategies for children who have experienced war, displacement, and refugee-related trauma. This past year, CMHS developed and evaluated an innovative community outreach and treatment program targeted to child survivors of war from Sierra Leone, "Leaders of Tomorrow." Thirty children, ages 7-15, participated in a 4-week intensive summer program, and those most in need of intervention and support receive ongoing case management and group tutorials. CMHS developed and performed a play entitled "Children of War" in an effort to educate the public about the impact of war, displacement, and abuse on children and to explore the therapeutic value of using trauma narratives as part of the healing process. CMHS also provided training and consultation to programs across the US on strategies for developing mental health services in refugee and immigrant communities.
Contact: Dennis Hunt
Phone: (703) 533-3302 x111
Email: dhunt@cmhsweb.org
Web: http://www.cmhsweb.org

Washington

Harborview Center for Sexual Assault and Traumatic Stress

The Harborview Child Traumatic Stress Program is located at the Center for Sexual Assault and Traumatic Stress (HCSATS), a specialty program of the Harborview Medical Center, a University of Washington teaching hospital. The Center serves children and adults affected by Child maltreatment, rape and violent crime, and other traumatic events. The Center will, as part of the NCTSN, increase capacity to deliver evidence-based interventions at HCSATS; improve mechanisms for identifying and linking affected children server within the medical center to services; create a collaboration with specialized community providers serving victims in diverse settings to increase identification, access, and the availability of cultural specific treatments ; develop and evaluate an empirical components-based treatment training program; construct and collect qualitative and quantitative data on practice, child outcomes, and systems.
Contact: Lucy Berliner
Phone: (202) 521-1800
Email: lucyb@u.washington.edu
Web: http://www.nctsnet.org/nccts/nav.do?pid=abt_ntwk

APPENDIX E

NATIONAL CHILD TRAUMATIC STRESS NETWORK

The Story of the National Child Traumatic Stress Network

The problem of child traumatic stress has been evident for many years, but recently the Federal Government elevated the problem to the national stage. The Donald J. Cohen National Child Traumatic Stress Initiative was established in 2001 to improve access to care, treatment, and services for children and adolescents exposed to traumatic events, and to encourage and promote collaboration between service providers in the field, through a series of grants totaling more than $30 million.

A series of Federal grants were awarded by the U.S. Department of Health and Human Services under the auspices of the Substance Abuse and Mental Health Services Administration (SAMHSA), and the Center for Mental Health Services (CMHS) to establish the National Child Traumatic Stress Network consisting of The National Center for Child Traumatic Stress (Category I Center) established as a joint effort of the UCLA David Geffen School of Medicine and the Duke University Medical Center to provide coordinating leadership of the National Child Traumatic Stress Network; Intervention Development and Evaluation Centers (IDE Category II Centers) that will use the grant funds to identify, support, improve, and develop effective treatment and service approaches; and Community Treatment and Service Centers (CTS Category III Centers) that will use their funds to provide direct community-level service and treatment. (Although the grants for the Network Centers were made within these guidelines, it should be noted that many organizations within the Network actually do work that crosses categorical boundaries.)

In making the announcement, Secretary of Health and Human Services Tommy G. Thompson said, “the attacks of September 11 remind us how essential these programs are to help our children deal physically and emotionally with traumatic events. We are committed to substantially improving mental health services for children and adolescents and supporting the valuable services of the grantees of the Donald J. Cohen Initiative.”

In choosing to name this initiative after Donald J. Cohen, M.D., the government honored a person who spent his entire professional career in the mental health field as a tireless advocate for children. He was a well-respected and world-renowned physician and teacher. Over the course of his career, he held many faculty positions at the Yale University School of Medicine. As Director of the Child Study Center at Yale School of Medicine, he championed traumatized children and their families, advocating that more resources be dedicated for research and service innovation. In his remarks to the Senate when he announced that this program was being named for Dr. Cohen, Senator Joseph Lieberman said, “I can think of no better tribute to this great man than to name the very program he envisioned so many years ago in his honor.”

The Scope of Child Traumatic Stress

THE PROBLEM

Trauma is woven into the fabric of daily life. Child abuse and neglect, domestic violence, community violence, medical trauma, traumatic loss, accidents, injuries, terrorism, natural disasters, and human-caused catastrophes all impact the lives of children, their families, and communities throughout the United States. The prevalence of exposure to traumatic events is alarming. In a nationally representative survey of 12-17 year-old youth, 8% reported having been sexually abused at some time in their lives, 17% were physically assaulted, and 39% had been eyewitnesses to violence. In a landmark study in North Carolina, a comprehensive child and adolescent survey indicated that fully 25% of the children and youth interviewed had experienced at least one traumatic event by age 16.

THE IMPACT

We have learned that some children who are either direct victims or witnesses of trauma experience severe and persistent post-traumatic stress reactions, such as unwelcome trauma pictures coming back to mind, not feeling as close to others, and feeling jumpy or nervous. We have also learned about the powerful influence of trauma reminders in the daily lives of children and how these reminders can affect family and peer relationships. In addition, traumatic stress can have an insidious impact, disturbing many domains of normal child development, as well as affecting a child's pro-social behavior and citizenship at school and in the community.

Biological studies among children and adolescents are demonstrating that trauma reactions may interfere with development and are rooted in the basic biology of fear and danger.

There is evidence that traumatized children show persistent alterations in their levels of stress hormones such as cortisol and disturbances in children's startle reactions, putting them chronically "on alert." These biological accompaniments of post-traumatic stress have a significant impact on academic and social functioning. Human-perpetrated violence can cause profound changes in the basic building blocks of interpersonal life, including disturbances in attachment and extreme feelings of loneliness.

Manifestations include irritability, oscillations in behavior from aggressiveness with peers and adults to excessive passivity and avoidance, reckless behavior — and in adolescence, substance abuse, high-risk sexual behavior, gang participation, disturbances in academic performance and motivation, and difficulties in moral decision-making.

Social-ecological issues are equally serious. Traumatic experiences (e.g., being shaken as a baby or surviving a motor vehicle accident) produce physical disabilities that create functional challenges to interacting with people and in completing basic tasks needed to survive. They adversely alter expectations and beliefs about interpersonal situations. The impact of traumatic events for infants and young children can be exacerbated or mitigated by the response of the parents and caregivers in the child's life. It is important to note that traumatic events often help

identify kids that are "at risk" for further trauma unless support is provided to the family. The seriousness of the problem of traumatic stress cannot be overstated. It is real and made more poignant with greater public awareness by the events of September 11th. As a result, significant additional bilateral Congressional support has extended the Network's sites to include many more communities throughout the United States. This increased support comes at a time when the field of child traumatic stress is on the cusp of major advances in improving access to services and the care of traumatized children and their families.
(Please see references in Appendix B)

The Composition of the National Child Traumatic Stress Network (Category I, II, and II Centers)

As of September 2002 the Donald J. Cohen National Child Traumatic Stress Initiative funded 37 sites of excellence, dedicated to establishing the National Child Traumatic Stress Network—NCTSN. The Network's mandate is to improve treatment and services for child trauma and to expand availability and accessibility of effective community services to children and adolescents exposed to traumatic events. The Network aims to promote better understanding of clinical and research issues relevant to providing effective interventions for use in community practice settings.

This Initiative creates a true national resource that allows many of the leaders in the field of child traumatic stress (CTS) to work individually and collectively across disciplines and settings to effect integrated and sustained change.

The Initiative is made up of three components:

CATEGORY I CENTER

Designated to lead the NCTSN as the National Center for Child Traumatic Stress (NCCTS), the UCLA David Geffen School of Medicine and the Duke University Medical Center have individually and collectively provided leadership in the developmental understanding of CTS; have pioneered evaluation and treatment of children, families, and communities, and are at the forefront in developing public mental health strategies to reach the large population of children, families, and communities affected by traumatic events.

The National Center for Child Traumatic Stress (NCCTS), as a joint program of UCLA and Duke University, is supported by the vast resources of two of the country's preeminent learning institutions, their medical schools, and departments of psychiatry and university-level programs.

THE NETWORK

Over the past 20 years significant advances have been made in the field of CTS. This Initiative and the Network marks the first time that a true integration platform has been developed to blend the academic best practices of the clinical research community with the wisdom of front-line

community service providers. The work of Network members ranges across settings, disciplines, age groups, and trauma types, delivering high-quality services to large numbers of children and their families who have experienced trauma.

CATEGORY II CENTERS--INTERVENTION DEVELOPMENT AND EVALUATION PROGRAMS

By funding the Intervention Development and Evaluation Programs (Category II Centers) in the Network, SAMHSA is funding the establishment or continuing efforts of Centers that will identify, support, improve, or develop treatment and service approaches for:

- Different types of child and adolescent traumatic events, including witnessing or experiencing interpersonal violence or life threat, traumatic loss of family, sexual assault and abuse, medical trauma including injuries from accidents and invasive procedures, natural and human-caused disasters, war and terrorism, and displacement and refugee trauma.
- Developmentally appropriate trauma evaluation and intervention for children and adolescents of all ages.
- Identification, assessment, and appropriate treatment and services for children in specialty child service sectors, such as schools, the juvenile justice system, the refugee service system, the child welfare and protective service system, and services for vulnerable children including the disabled.

CATEGORY III CENTERS--COMMUNITY TREATMENT AND SERVICE PROGRAMS

The third category of grantees, Community Treatment and Service Programs, will establish or continue community practice centers. These centers will implement and evaluate effective treatment and services in community settings, collect clinical data on traumatized children receiving treatment and services, provide expertise on effective practices, service financing and other service issues, and develop and provide leadership and training on child trauma for service providers in the community and staff in child service sectors.

The Mission of the National Child Traumatic Stress Network— NCTSN

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

The Vision of the NCTSN

The NCTSN will raise public awareness of the scope and serious impact of child traumatic stress on the safety and healthy development of our Nation's children and families. We will improve the standard of care by integrating developmental and cultural knowledge to advance a broad range of effective services and interventions that will preserve and restore the future of our Nation's traumatized children.

We will work with established systems of care, including the health, mental health, education, law enforcement, child welfare, and juvenile justice systems, to ensure that there is a comprehensive continuum of care available and accessible to all traumatized children and their families. We will be a community dedicated to collaboration within and beyond the Network to ensure that widely shared knowledge and skills create a national resource to address the problem of child traumatic stress.

The Identity of the National Child Traumatic Stress Network— NCTSN

The purpose of the Network is to unite the efforts of a wide range of independent organizations focusing on child trauma and to provide a model for expansion and growth. In no way, though, is the NCTSN being developed to supplant or supersede the identity of any individual members of the Network. It is meant, instead, to add value to the identities of all members and provide a national framework to highlight their experience, expertise, and success, which form the real strength of the Network as a whole.

Network Identity

The Network provides the unique opportunity to integrate the strengths of academic centers, dedicated to developing the most scientifically supported interventions and the people to deliver them, and community-based treatment and service centers, with their wisdom about providing effective care.

The Network can ensure the development of a comprehensive, integrated, evidence-based system of care for traumatized children, their families, and communities throughout the United States. The Network is able to look ahead to the future to ensure that all possible steps are taken to address the problem of childhood traumatic stress.

TANGIBLE BENEFITS

What does the Network offer its constituents in tangible, quantifiable terms?

- Dedicated and informed expert staff who are leaders in the field
- Reliable, state-of-the-art and state-of-the-science information
- Effective, informed educators
- Comprehensive knowledge base of best practices and emerging evidence-based protocols
- An effective networking framework
- Shared visions, values, and purpose
- The critical scale to effectively discover, design, and deliver services to children who have experienced traumatic stress, their families and communities.
- A national voice representing the members of the Network

CULTURAL IMPERATIVES

Members of the NCTSN have identified certain key imperatives that they wish to have embedded in the culture of the Network. These include:

- Respect for the individual and respect for cultural diversity
- Integrity
- Collegiality
- Collaboration
- Commitment to effective communication
- Fair dealing, balance
- Transparency
- Compassion and courage
- Expertise

NETWORK PERSONALITY

If the Network were a person, how would that person be described?

- Intelligent, Creative, Professional
- Energetic, Resourceful, Pragmatic
- Discriminating, Responsible, Trustworthy
- Compassionate, Empathetic, Responsive
- Dedicated, Competent, Resilient
- Multi-faceted, Culturally Diverse and Culturally Competent, Socially Aware
- Contemporary, Curious, Adventuresome
- Modest, Generous

NETWORK VALUES

What does the Network stand for? What does it believe in? What would it make a stand on?

- Selflessness and dedication
- Fostering the development of new generations of professionals
- Using a scientific, developmentally sound approach
- Innovation
- Responsiveness to individuals, families, and communities
- Objectivity
- Professional development, care, and support
- Respect for cultural diversity
- Recognition that the Network whole is greater than the sum of the parts and has the advantage of being able to move the field ahead to provide care to traumatized children and their families and communities more quickly than could any individual center

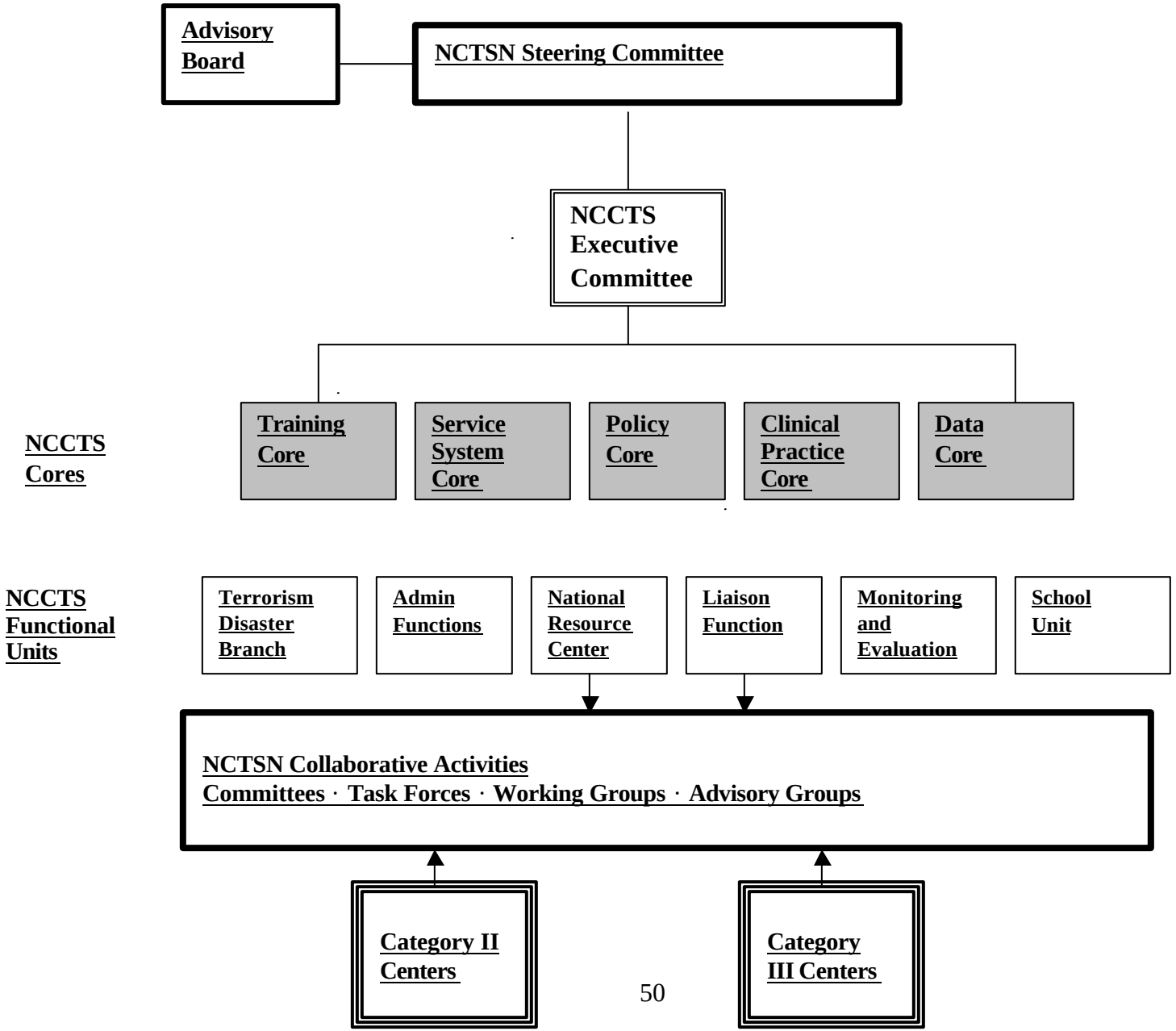
NETWORK CONDUCT

Our collective activities must be informed by a common set of principles:

- To develop and deliver services to children who have experienced traumatic events and to their families
- To give reliable, accurate information
- To encourage collaboration and collegiality

- To be consistent in presentation, tone, and manner
- To be courteous and professional
- To be respectful of diverse cultures
- To be encouraging and enthusiastic
- To be courageous and resolute
- To be dedicated to developing and inspiring future generations of caregivers for traumatized children, their families, and communities

APPENDIX F
NCTSN ORGANIZATIONAL CHART



APPENDIX G

NATIONAL CHILD TRAUMATIC STRESS NETWORK ORGANIZATION

NCTSN Steering Committee

The Steering Committee of the National Child Traumatic Stress Network (NCTSN) guides the development of a national network of centers to raise the standard of care and improve access to services for traumatized children, their families, and communities throughout the United States. Specifically, the Steering Committee provides oversight and guidance to the Network to ensure that plans and activities are consonant with the mission and vision of the NCTSN, reviews the progress of Network activities, and provides recommendations to the National Center to promote the success of NCTSN activities. Five representatives from Intervention Development and Evaluation Centers and five representatives from the Community Treatment and Services Centers are appointed to the Steering Committee for terms ranging from 1 to 3 years.

NCTSN Terrorism and Disaster Branch

The National Child Traumatic Stress Network (NCTSN) has a variety of unique resources and activities geared to improve the national and local response to children exposed to trauma. The Terrorism and Disaster Branch (TDB) is a specialized unit of the National Center for Child Traumatic Stress (NCCTS) recently established to develop models, services, and partnerships to address the impact of terrorism and disasters on the Nation's children, families, and communities and to improve care and services related to these events. The TDB's mission is to promote the well-being of children and families by strengthening our Nation's preparedness and response to terrorism and disaster. TDB staff have extensive experience responding to a range of events, including the Oklahoma City and American Embassy bombings, the September 11 attacks, mass school violence, war, earthquakes, hurricanes, tornadoes, and wildfires.

National Resource Center

Mission

The mission of the National Resource Center for Child Traumatic Stress (NRC-CTS) is to support the goals, activities, and mission of the National Child Traumatic Stress Network (NCTSN) by providing relevant, practical information and resources to members of the NCTSN, professionals in the field, and the public, including survivors of trauma, their families, and communities.

Vision

The NRC-CTS will be the leading national resource for professionals, the public, and the community of people who are affected by CTS via the acquisition, coordination, and management of existing materials in the field of child traumatic stress (CTS); the stewardship and facilitation of certain new initiatives within the NCTSN, including training, technical assistance, social marketing, and media relations; and the development of effective distribution methods of the services and products of the NCTSN.

Advisory Board

Mission

The mission of the Advisory Board of the NCTSN is to raise the national visibility of the issue of child traumatic stress and enhance the capacity of the Network to identify its priorities for action.

Purpose

The NCTSN Advisory Board (NAB) will communicate and promote across the Nation the vision, goals, programs, and accomplishments of the NCTSN, and provide independent, broad advice and counsel to the NCTSN Steering Committee related to strategic priorities and direction for the NCTSN.

Data Core

Overview

The Data Core is broadly concerned with data collection, analysis, and dissemination and includes key members from the National Center, including UCLA, Duke, and the Duke Clinical Research Institute (DCRI). DCRI will serve as a repository for Network data. In addition to the key members from the National Center, the Data Core has three working committees: **Measures, Data Operations, and Design and Analysis**. These working committees are comprised of members from the Data Core National Center leadership and Category II and III sites.

Mission

To collect and report data that document the progress of the NCTSN in meeting its goals of expanding availability and access to care and enhancing the quality of care to traumatized children and their families across the United States.

Learning from Research and Clinical Practice Core

Overview

The Learning from Research and Clinical Practice Core is broadly concerned with gleaning vital information about clinical practice in the area of child traumatic stress, from both the clinical field and the research literature, that can be used to improve practice and to inform research. This will involve careful review and synthesis of the literature and devising a method for documenting clinical practice in the field. The process for achieving these efforts will be both iterative and interactive.

Mission

To learn about effective interventions for childhood trauma from research and clinical practice, and to disseminate such learning to policymakers, practitioners, and children and families.

Training Core

Overview

The Training Core is dedicated to developing, supporting, and providing state-of-the-art, multi-platform, effective training to enhance the quality of clinical assessment, treatment, and services for traumatized children, adolescents, their families, and communities. Training programs will incorporate advances in development knowledge, cultural competencies, and ecological frameworks. The Core will identify critical training needs and resources within the Network, promote training-related linkages between Network partners, and provide centralized training opportunities for Network members in essential knowledge and skill areas. In addition, the Core will work closely with the other Cores to prioritize, coordinate, and integrate training functions within the Network and to provide specific training programs to meet Network needs. Through the National Resource Center, training materials and programs will be disseminated for professional and public use.

Mission

To enhance the care of traumatized children, adolescents, families, and communities through development and provision of the highest quality of education and training.

Policy Core

Mission

To develop and advance a strategic policy agenda for the NCTSN aimed at improving the visibility and understanding of the problem of child traumatic stress and strengthening the infrastructure, funding, and public will to address it.

Vision

- Addressing child traumatic stress is a high priority for funders, policy makers, opinion leaders, and a number of key constituency groups
- Services are organized, delivered, and funded such that they adequately respond to the scope and seriousness of child traumatic stress
- Policies at the local, State, and Federal level support the delivery of services to all traumatized children and families who need them

Service Systems Core

Overview

The Service System Core encompasses Network activities aimed at improving access to services for traumatized children, raising the standard of care that children receive within various service systems, and improving the integration of services for traumatized children. Activities focus on identifying unserved or underserved populations, determining barriers to service access, measuring unmet need, and promoting strategies to improve the access, the nature, and the coordination of services delivered to traumatized children by various systems. The goal is to ensure that there is a comprehensive continuum of care available and accessible to all traumatized

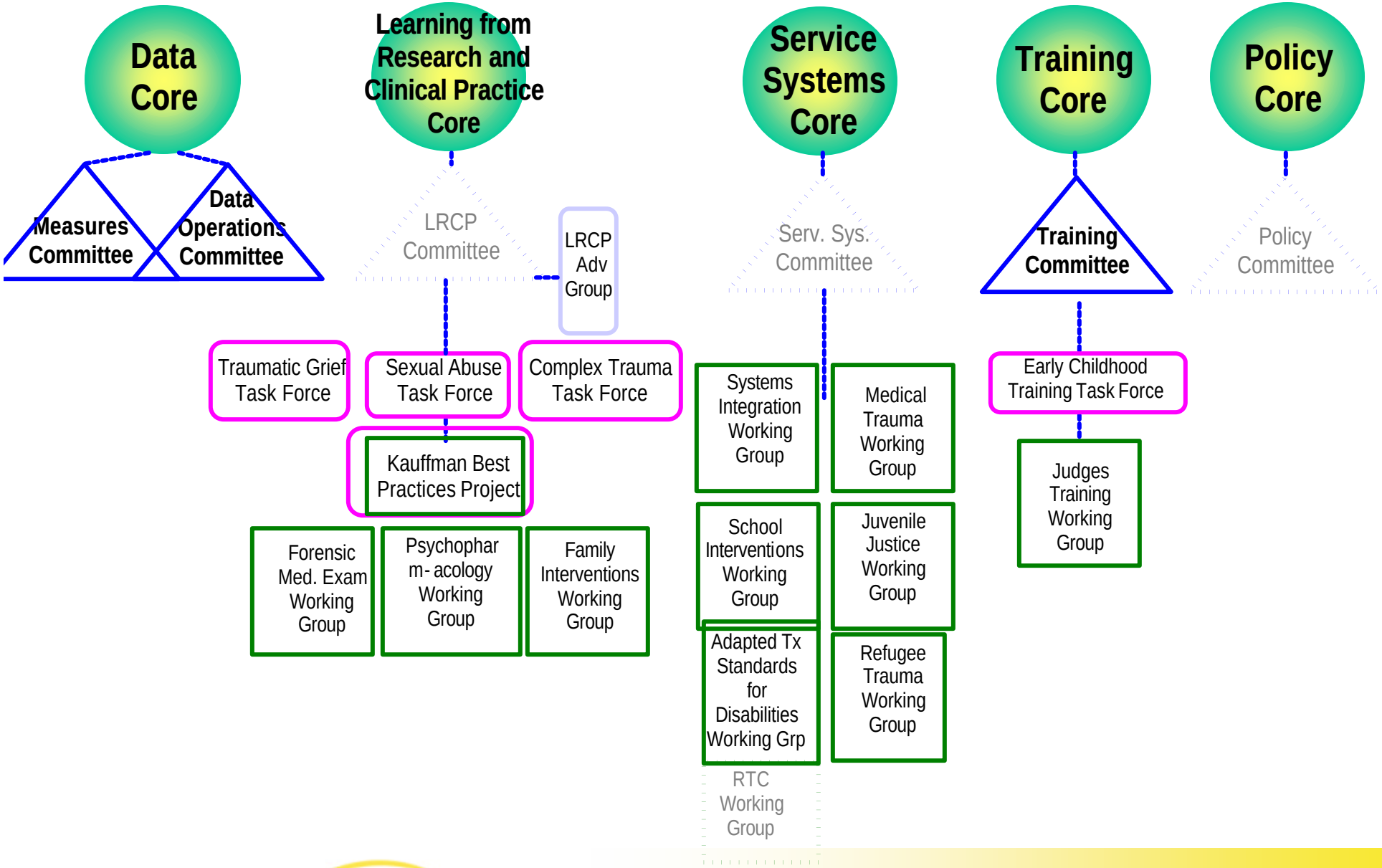
children and their families. Network activities within the Service System Core are directed toward the health system, mental health and substance abuse systems, law enforcement, court system, childcare system, education system, victim assistance, and child welfare and juvenile justice systems.

Mission

To promote the access of traumatized children and their families to an effective and integrated array of developmentally and culturally appropriate evidence-based interventions.

APPENDIX H

Functional Cores and *Planned* Collaborative Groups



APPENDIX I

NATIONAL CHILD TRAUMATIC STRESS NETWORK COLLABORATIVE ACTIVITIES
TYPES AND DESCRIPTIONS

What range of collaborative activities can be undertaken by Network members?
Network members are encouraged to engage in a broad range of collaborative activities aimed at furthering the goals of the NCTSN. In fact, collaborative opportunities are limited only by the time and resources of participating Network members and the National Center. Collaborative activities can involve only a few centers or can involve multiple centers working together through a task force or committee.

What types of collaborative groups exist in the Network?
Although collaborative activity may be initiated informally between two or three centers, much of the collaborative work of the Network takes place through formal or informal groups or committees composed of multiple centers. The Network has five basic types of collaborative groups available to Network centers.

Working Committees

Working Committees are planned and launched by the National Center and are permanent groups overseeing issues that span trauma types and settings and are central to achieving the NCTSN mission. The membership, terms of service, and operating procedures for working committees are usually fairly formal, and they are usually chaired, at least on an interim basis, by a professional from the National Center.

Task Forces

Task forces are driven by Network interests or developed in response to emerging needs. They are more flexible in their size, structure, and organization than are working committees and are usually chaired or co-chaired by Network members. They may be time-limited and focused around a particular project, trauma type, or product.

Working Groups

Most interest groups within the Network start out as small working groups. These groups may later develop broader participation of Network members and do more formal planning. They eventually may develop into a task force.

Advisory Groups

Advisory groups advise the National Center regarding its core functions, such as developing the National Resource Center or Monitoring and Evaluation.

Collaborative Activities – Brief Descriptions

As of March, 2003

DATA CORE

MEASURES COMMITTEE

The mission of the Measures Committee is to assist the Network in planning and implementing clinical and service measurements needed to accomplish the goals of the National Child Traumatic Stress Initiative. The Measures Committee is currently working on a Needs Assessment Tool for the Network, which they began piloting at the beginning of March 2003. This committee has also developed a Measure Review Sheet to evaluate measures used in practice by Network members in order to create an information database for the Network. The next project planned for this group is a Measures/Data Consultation Service, which will impart advice and expertise on the use, reliability, and effectiveness of reviewed data collection tools.

DATA OPERATIONS COMMITTEE

The Data Operations Committee mission is to assist and advise the Data Core and Network in the collection, management, and dissemination of Network data. The focus of the Data Operations Committee is working with the NCCTS Data Core, the Duke Clinical Research Institute (DCRI), the UCLA Center for Health Services (CHS), and the Center for Community Health (CCH) to develop the Network Data Repository, which will house quantitative survey data, administrative site details, individualized data on every client seen by Network members, and aggregate data summaries. The target date for beginning pilot data input from the Network is in the second quarter of 2003.

LEARNING FROM RESEARCH AND CLINICAL PRACTICE CORE

CHILD TRAUMATIC GRIEF TASK FORCE

One focus of the Child Traumatic Grief Task Force is to collect epidemiological data from sites that will inform the Network and our field on factors related to child traumatic grief. This group has done work to define "traumatic grief" as it relates to the PTSD field. Treatment manuals, trainings on interventions, and treatment guidelines for young children are some of the past accomplishments of this task force. The task force currently has two subgroups working on educational fact sheets for various audiences on child traumatic grief and a Network survey of epidemiological work in the field.

SEXUAL ABUSE TASK FORCE

The Sexual Abuse Task Force is committed to enhancing the quality and access to treatment services for those affected by child sexual abuse. Currently planned work includes surveys, checklists, and focus groups of Network clinicians in the area of child sexual abuse. The information gathered will include clinician level of awareness and knowledge of trauma-focused treatment, knowledge of cognitive-behavioral treatments for trauma, and attitudes about manualized treatment.

COMPLEX TRAUMA TASK FORCE

The initial focus of the Complex Trauma Task Force is to better describe the nature of complex trauma and the range of developmental adaptations associated with it. The Task Force has developed a clinician survey to gauge the perceived scope of the problem of complex trauma and is developing a white paper that will define the phenomenon of complex trauma, describe emerging interventions, and outline recommendations for the field.

FORENSIC MEDICAL EXAMINATION WORKING GROUP

The Forensic Medical Examinations Working Group is dedicated to development and implementation of therapeutic strategies during forensic medical examinations for suspected child maltreatment that will help children and parents cope with traumatic experiences and successfully resolve them. The group has begun an important exploratory project to interview Network sites on their current practices during forensic medical exams. A near-term product will be an information pamphlet that reconceptualizes these exams as an early point of therapeutic contact with restorative and preventive functions.

FAMILY INTERVENTIONS WORKING GROUP

The Family Interventions Working Group has identified a need for evidence-based models for family-based interventions and a lack of good resources for those who may need to conduct family-based interventions. This group's first activity is to survey the Network regarding current interventions used for traumatized children and their families. This group will also conduct a literature review that will identify effective family interventions that may be currently used or intended for other types of problems, but may be appropriate for translation to trauma-focused work. This work will result in a report that will be disseminated throughout the Network.

PSYCHOPHARMACOLOGY WORKING GROUP

The Psychopharmacology Working Group has just recently become established with the aim to develop a research effort to inform the use of psychopharmacological agents in the field of child trauma treatment. Very little empirical research exists in the field and plans are underway to conduct a multisite Network study on the use of medications in child trauma treatment. The group plans to evaluate whether psychopharmacological interventions are effective in treating the neurobiological alterations that occur with childhood PTSD.

LEARNING FROM RESEARCH AND PRACTICE ADVISORY GROUP

The Learning from Research and Practice Advisory Group was developed to inform the work of the National Center's Learning from Research and Clinical Practice Core. This Core will disseminate learning about evidence-based interventions by reviewing current literature and practice and making recommendations to clinical practice settings. The Advisory Group hopes to begin building an evidence base for promising practices and model programs and is beginning with a review of the literature.

SERVICE SYSTEMS CORE

SCHOOL INTERVENTIONS WORKING GROUP
The School Interventions Working Group operates alongside the School Crisis and Intervention Unit and the Terrorism and Disaster Branch, but it is focused more specifically on intervention protocols for school-aged children. The group is working on developing a crisis response package of educational materials in collaboration with the U.S. Department of Education. A project is also underway to develop a grid of core/critical components necessary for a school-based intervention program.

JUVENILE JUSTICE WORKING GROUP
The Juvenile Justice Working Group mission is to improve the identification, assessment, and treatment of traumatized children and youth within the juvenile justice system. The group has begun to look at existing evidence-based practices for youth in the juvenile justice system. A primary focus has been a review of existing data on the prevalence of trauma among youth in the juvenile justice system, as well as identification / adaptation of instruments for assessing trauma exposure in this population.

ADAPTED TREATMENT STANDARDS FOR DISABILITIES WORKING GROUP
The mission of this Working Group is to develop adapted trauma treatment standards for children with various types of disabilities. The group intends to offer not only "aspirational" standards, but also to define ethical and legal standards where possible. The group will address a wide range of disabilities over time, but their immediate plans include fact sheets on deafness and developmental disabilities.

REFUGEE TRAUMA WORKING GROUP
The mission of the Refugee Trauma Working Group is to promote the identification, development, and adaptation of psychometrically, developmentally, ecologically sound, and culturally appropriate assessment measures and intervention services for traumatized child and adolescent refugee and immigrant populations and their families. This group is currently planning a Network site survey of activities, measures, information sources, and interventions used when working with child and adolescent refugees and their families. A short report will follow that will include a listing of measures used, commonalities in interventions, and recommendations on practices for working with these populations. The group has also developed a white paper on refugee trauma to give an initial focus to its collaborative work.

SYSTEMS INTEGRATION WORKING GROUP
The mission of the Systems Integration Working Group is to explore the role and coordination of concurrent services and systems that impact directly on how children process and recover form crime-related traumatic events. This group was recently established, and has been developing a logic flowchart model to identify and prioritize a few elements of the child trauma treatment system to focus on from an integration standpoint.

MEDICAL TRAUMA WORKING GROUP

The Medical Trauma Working Group addresses health outcomes related to traumatic stress, acute trauma interventions, and medical trauma. The group recognizes that these issues contain separate elements and areas of overlap. The group will produce multiple products, each geared towards a different area. For example, their planned projects include a white paper on Medical Traumatic Stress and another on Crisis Intervention and Treatment.

TRAINING CORE

TRAINING COMMITTEE

The mission of the Training Committee is to assist the Network in planning and implementing clinical and service training needed to accomplish the goals of the National Child Traumatic Stress Initiative. This committee is determining the current state of training in the Network by analyzing data from two assessment tools they have developed: a Training and Materials Survey and a Training Needs Assessment Tool.

EARLY CHILDHOOD TRAINING TASK FORCE

The Early Childhood Training Task Force has been established to focus on the training needs of caregivers in early childhood settings who work with children affected by trauma. One subgroup is planning to conduct eight focus groups to assess caregiver needs in this area. Other subgroups are working on a review of existing training materials and identification of possible funding opportunities for creating educational materials for teachers and childcare providers.

JUDGES TRAINING WORKING GROUP

The Judges Training Working Group is still in early stages of development and will be developing a mission and set of objectives. The group is interested in educating and training judges regarding issues related to child traumatic stress, and they plan to seek a partnership with the National Council of Juvenile and Family Court Judges (NCJFCJ). The group hopes to compile and review State-specific requirements for judges' training.

APPENDIX J

NCTSN DATA COLLECTION DOMAINS

Center Service Utilization and Activities (assessed quarterly and annually)

- Direct clinical services for children
- Other client-related services for children
- Activities that promote cultural competence
- Training provided
- Products developed such as training materials or clinical service manuals
- Knowledge dissemination and transfer
- Trauma types addressed
- Development and use of evidence-based interventions and treatment models

Center Network and Collaborative Activities (assessed quarterly and annually)

- Committee and working group participation
- Technical assistance, training, and/or evaluation provided or received

Core Clinical Characteristics/ Client and Treatment Outcome Data

- Baseline assessment of types, history, and extent of trauma exposure, such as assessed through the NCTSN data core assessment.
- Trauma symptoms (such as assessed in the Briere Trauma Symptom Checklist)
- Traumatic stress symptoms (such as assessed in the UCLA PTSD Reaction Index –Pynoos et al.)
- Child behaviors (such as assessed in the Achenbach Child Behavioral Checklist)
- Type and severity of child's problems (qualitative)
- Child's symptoms and problems that are focus of attention