## Abstract

Miller Children's Abuse and Violence Intervention Center (MCAVIC) at Miller Children's Hospital, Long Beach, California, and the University of Southern California (USC) are collaborating to form the MCAVIC-USC Child and Adolescent Trauma Program. As a Treatment and Service Adaptation (TSA) Center, this venture will provide leadership, program development, and training in the treatment of multiply-traumatized children and adolescents. Empirically-informed approaches developed by MCAVIC, combined with similar treatment protocols for traumatized adolescents from the USC Psychological Trauma Program, will be adapted and disseminated throughout the National Child Traumatic Stress Network (NCTSN). Nationally-recognized trauma specialists from MCAVIC-USC will contribute training, consultation, and collaborative research projects with other Centers of the NCTSN. This TSA Center also will collaborate closely with other community entities such as The Guidance Center of Long Beach, California State University-Long Beach, and the Long Beach Unified School District, as well as with law enforcement, child protection agencies, and NCTSN committees and working groups. MCAVIC will be the primary site of this TSA Center for clinic-based and school-based trauma-specific treatment. It will focus on trauma associated with child abuse, family and community violence, traumatic bereavement, and medical trauma. Informed by a panel of trauma-focused clinicians with backgrounds and expertise relevant to various ethnic and cultural communities, direct services supported by this TSA Center grant will be used to develop, pilot, and evaluate intervention in Long Beach that can then be adapted to other underserved populations. Long Beach, one of the most culturally diverse cities in the nation, is the fifth largest city in California with the second largest school district for the State. Thirty-three percent of Long Beach children live in poverty. In 2004, there were more than 12,000 reports of alleged physical, sexual or emotional abuse, neglect, and witnessed violence from the greater Long Beach area. MCAVIC was awarded a 3-year grant in 2001 by SAMHSA as a Community Treatment and Services Center (CTSC) of the National Child Traumatic Stress Initiative (NCTSI), followed by a 1-year renewal of this grant, ending in September 2005. MCAVIC has used these grant awards to expand and evaluate assessment-driven, multi-modal, culturally-adapted, and developmentally appropriate interventions with inner city, culturally diverse, disadvantaged children and adolescents chronically affected by multiple forms of trauma. MCAVIC's treatment model, the Integrative Treatment of Complex Trauma, was identified as one of the eight "promising practices" by the Complex Trauma Workgroup of the NCTSN in 2004. The MCAVIC-USC Child and Adolescent Trauma Program will provide the expertise and knowledge necessary to disseminate effective, culturally-relevant assessment and treatment interventions to the NCTSN, adapted to "take root" in highly stressed and often underserved communities across the United States.

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**5. PROJECT NARRATIVE AND SUPPORT DOCUMENTATION**
**Section A: Background, Experience, and Need**

Specific Types of Child/Adolescent Trauma and Populations for MCAVIC-USC Child and Adolescent Trauma Program to Provide Leadership within the NCTSI

The Miller Children Abuse and Violence Intervention Center - University of Southern California (MCAVIC-USC) Child and Adolescent Trauma Program proposes to assume a leadership role within the National Child Traumatic Stress Initiative (NCTSI) using the assessment-driven treatment model, Integrative Treatment of Complex Trauma (ITCT) for children, adolescents, and families with complex trauma. Complex trauma is typically defined as a combination of early and late-onset, multiple, and sometimes highly invasive traumatic events, usually of an ongoing, interpersonal nature. In most cases, such trauma includes exposure to repetitive childhood sexual, physical, and/or psychological abuse, often in the context of concomitant emotional neglect and harmful social environments. As noted by the National Child Traumatic Stress Network (NCTSN) Complex Trauma Working Group, "children exposed to complex trauma often experience lifelong problems that place them at risk for additional trauma exposure and cumulative impairment… in childhood, adolescence, and adulthood" (Cook, et al., 2005). Among the impact of complex trauma are anxiety and depression; dissociation; relational, identity, and affect regulation disturbance; cognitive distortions; "externalizing" behaviors such as self-mutilation and violence; sexual disturbance; and substance abuse (Briere & Spinazzola, in press; Cook, et al., 2005). Although complex trauma and its effects are quite prevalent in mental health populations (Briere, 2004), there are few empirically-informed treatments for children and adolescents in this area.

The primary focus of effort for this project will be to provide leadership in further identification, refinement, and adaptation of effective treatment and service approaches as they relate to complex trauma in children and adolescents in culturally diverse populations. Through research, consultation, and training with other centers of the NCTSN, treatment and service approaches will be adapted and improved to optimally meet the needs of communities throughout the nation. The specific populations of traumatized children/adolescents for which this proposed Treatment and Service Adaptation (TSA) Center would assume a leadership role are: child abuse, including physical and sexual abuse; traumatic bereavement from loss of family members, friends, and other significant attachment figures; interpersonal violence, including witnessing or experiencing domestic, community, or criminal physical/sexual violence; and medical trauma, including physical injuries or incapacitation, chronic, severe, or painful medical conditions, or invasive or painful medical procedures. The applicant organization is qualified to provide national consultation and leadership as part of the National Child Traumatic Stress Network for these specific areas, with considerable experience and success in evaluating and treating these types of trauma with culturally diverse populations.

Both partners of this project have expertise in the area of complex trauma with culturally diverse, disadvantaged populations. During a typical quarter in 2004, 48% of 206 MCAVIC clients were Hispanic/Latino, 37% were African-American, 7% were White, 5% were multiracial, 2% were of Native Hawaiian/Other Pacific Islander, and 1% were Asian. The Long Beach Unified School District has students that are 78% minority ethnicity with many living in communities plagued by gang strife, poverty, under-education, and increasing racial tensions. According to the Federal Poverty Level assessment in 2001, 33% of children in Long Beach live below the poverty level (Long Beach Press Telegram, 2001). Of the 12,609 reports of alleged

child abuse and neglect to the Los Angeles County Department of Children and Family Services for the Long Beach area in 2004, 46% were for Hispanic children, 32% of the reports concerned African-American children, 14% related to White children, and 8% related to Asian/Pacific Islander, American Indian/Alaskan Native, Filipino or other ethnicity.

MCAVIC has special expertise in the assessment and treatment of high risk youth affected by community violence and child abuse/domestic violence, with specialized school-based interventions supported by SAMHSA grants for the NCTS Initiative, and funding from private foundations. Evaluations of these school-based interventions indicate improvement in trauma-specific symptoms among youth with complex trauma.

Although the proposed intervention will be developed and evaluated at MCAVIC, some information on the Psychological Trauma Program (PTP) at USC is relevant to the expertise, philosophy, and training approach contributed by this university. The PTP draws on the psychiatric outpatient and emergency room populations in which Los Angeles County-USC Medical Center (LAC+USC) is embedded. The nation's largest medical center, LAC+USC treats approximately 800,000 people per year, admits approximately 250,000 people per year in its emergency service system, and sees approximately 5,000 outpatients per day. Almost half of all LAC-USC patients fall beneath the poverty line, and many are uninsured. PTP clients tend to be Hispanic or African-American in ethnicity, followed by Caucasian and Asian, typically presenting with exposure to child abuse, rape, physical assaults (especially domestic and gang-related), motor vehicle accidents, witnessed violence, and house fires. PTP clients often present with additional/comorbid disorders, above and beyond posttraumatic stress, including depression, substance abuse, and, in some cases, psychosis.

As suggested by the above, the MCAVIC-USC Child and Adolescent Trauma Program has considerable expertise in developing and monitoring trauma services appropriate to the race/ethnicity/culture/age of the community's services population -- especially those identified as disadvantaged or underserved, who, in addition, have been impacted by traumatic experiences. Both MCAVIC and USC have dedicated services to reaching culturally diverse clients without resources, who otherwise would not receive interventions for severe and chronic trauma.

The proposed TSA Center is unique in bringing together clinical expertise, research experience, and previous collaborations and training within the NCTSN -- as well as having considerable hospital-, outpatient-, and school-based trauma knowledge and experience. In addition, both MCAVIC and USC have considerable experience in assessing and treating inner-city, culturally diverse, disadvantaged children, adolescents, and families who have experienced multiple incidents and types of trauma. This applicant organization uniquely contributes the ITCT model (Lanktree, 2003, 2004, 2005), an intervention that includes assessment-driven, trauma-focused individual, group, and family therapy approaches for both clinic-based and school-based programs. ITCT especially stresses multidimensional/complex trauma reactions and comorbidities, cross-cultural issues, and additional stressors such as the limited socioeconomic resources of many inner city and rural children. It is intended to be applied across a wide range of settings, including outpatient and child trauma clinics, regular school environments, and inner-city alternative education schools. It also adapts various components of existing manualized trauma models, including trauma-focused cognitive behavior therapy (Cohen, Deblinger, Mannarino, and Steer, 2004) and the UCLA program for traumatized and bereaved adolescents (Saltzman, Layne, and Pynoos, 2003). The ITCT is currently being integrated with Dr. Briere's Self-Trauma Model (Briere, 2002) as it applies to traumatized

adolescents (Briere & Lanktree, 2005), and may come to include the use of psychiatric medication in trauma therapy.

Finally, both MCAVIC and the USC PTP have considerable experience in collaborating with and training relevant services systems, i.e., schools, hospital departments, law enforcement, and child protection. Both partners of the proposed MCAVIC-USC Center have particular expertise in engaging systems (e.g. schools) and trauma survivors who otherwise would not have sought treatment. MCAVIC led the formation of the collaborative Research Committee with the Chadwick Center of Children's Hospital, San Diego (a Category II center of the NCTSN) to design collaborative research projects, and helped secure a mini-grant from the National Center of the NCTSN to support collaborative development of an expanded client database.

Current Status of Clinical Treatment and Service Intervention Approaches

Promising Intervention Approaches. The ITCT has been identified by the Complex Trauma Working Group of the NCTSN as one of the eight "promising practices" at it's June, 2004 meeting. The core components -- which have been presented throughout the Network at various times (e.g., NCTSN All-Network Meetings, Children's Hospital of San Diego annual International Conference on Child Maltreatment, the National Symposium on Child Abuse, Huntsville, Alabama) -- include:

- Assessment-driven treatment, with standardized trauma-specific measures administered at 3 to 4 month intervals to identify symptoms requiring special clinical attention.
- Multiple treatment modalities, including cognitive therapy, exposure therapy, play therapy, and relational treatment in individual and group therapy. Primary caretakers also participate in collateral sessions to help resolve their own traumatic reactions and to improve their parenting skills. Family therapy sessions are also frequently included.
- Therapeutic exposure and exploration of trauma is facilitated in a developmentally-appropriate and safe context, balanced with attention to increasing affect regulation capacities, enhanced self-esteem, and a greater sense of self-efficacy.
- Aspects of manualized trauma-focused cognitive behavior therapy (Cohen et. al, 2004) and traumatic grief therapy (Saltzman et al., 2003) are included.
- The relationship with the therapist is deemed crucial to the success of therapy; safety and trust are crucial for treatment effectiveness.
- Immediate trauma-related issues such as acute stress disorder, anxiety, depression, and posttraumatic stress are addressed early in treatment, in order to increase the capacity of the client to explore more chronic and complex trauma issues. In some clients, this may include the use of psychiatric medication.
- Complex trauma issues are addressed as they arise, including attachment disturbance, behavioral and affect dysregulation, interpersonal difficulties, and identity-related issues.
- Treatment is culturally and developmentally tailored, with adaptations made for individual client needs (e.g., the pacing and intensity of interventions) and cultural sensitivity to the form and meaning of trauma symptoms within different belief systems.
- Advocacy and interventions are made at a system level (e.g., family, forensic/protection, and school) to establish healthier functioning and to address safety concerns.
- Especially for adolescents, treatment includes nonjudgmental but focused intervention in issues such as substance abuse, self-mutilation, and dysfunctional sexual behavior.

Trauma-Informed Services. Trauma-informed services include consultation and training with school and hospital personnel, collaboration with law enforcement and child protection agencies when forensic evaluations and investigations occur, and advocacy and referrals for

clients when additional services are required (e.g., application for victim witness support, placement at a domestic violence shelter, coordination with medical services). MCAVIC and USC have experience in training and providing consultation to enhance trauma-informed services with Suspected Child Abuse and Neglect (SCAN) team meetings, Children's Hospital outpatient department meetings, Emergency Department meetings, pediatric and psychiatric Ground Rounds, and consultations to pediatric intensive care units. Ongoing collaboration with law enforcement and child protection agencies includes both (a) attention to trauma-related issues for clients, and (b) attempts to optimize service provision -- for example MCAVIC's use of specialized forensic interviews and evidentiary medical examinations.

Status of Standardization, Evaluation, and Product Dissemination of Intervention Approaches

MCAVIC has conducted several evaluations of the ITCT model as it has been applied to multi-problem, often previously underserved, traumatized children and adolescents. In each case, ITCT appears to be successful in reducing relatively complex trauma symptoms.

In a "store-front" setting. The first analysis of the ITCT model involved a 11-week intensive trauma-focused intervention for 21 traumatized students, predominantly African-American and Latino, ages 13 to 17 years (Lanktree, Neal, and Briere, 2005). Clients in this sample were noteworthy for being hard-to-reach youth, in all cases having been referred to store-front centers as a result of their recent aggressive or violent behavior. Clients attended eleven group sessions of ITCT, as well as receiving almost daily contact and support from their therapist(s) at the referring school. Teachers received training and support from the primary Project therapist. Treatment outcome analyses indicated that pre- to post-treatment scores decreased on measures of depression, posttraumatic stress, internalizing symptoms, and externalizing symptoms. These outcomes were reported at the annual meeting of the American Professional Society on Abuse of Children (APSAC) (Neal and Aguila, 2004).

In a "mainstream" school environment. In this outcome study, 11 traumatized -- primarily African-American and Latino -- elementary or middle school students received ITCT over a 13 to 15 week period. More time was needed than initially planned due to racial tensions among group members that required additional efforts to increase trust and cohesion. Group sessions were sometimes complemented with individual therapy for clients requiring more intensive interventions. In addition, ongoing consultation with teachers ensured greater continuity between the classroom and behaviors/feelings targeted in group session. The findings of this study were reported at the All-Network Meeting for the NCTSN (Lanktree, 2005). Despite the reduced statistical power of this study associated with the limited sample size, pre- versus post-treatment comparisons revealed significant and meaningful reductions in TSCC-A *Anxiety*, *Depression*, *Posttraumatic Stress*, and *Dissociation* subscales.

In the MCAVIC clinic. A third treatment outcome evaluation of the ITCT model was recently conducted in a preliminary quality assurance study, also reported at the March 2005 All-Network Meeting of the NCTSN (Lanktree, 2005). This investigation involved 37 clients, aged 7 to 13 years, from MCAVIC's outpatient clinic. As per the previous studies, this sample was culturally diverse (in this instance, 30% African American, 41% Hispanic, 16% Caucasian, and 14% other). A total of 59% had been sexually abused, 41% had been physically abused, 38% had witnessed domestic violence, 22% had experienced traumatic loss, and 8% were exposed to community violence. ITCT was provided, including individual therapy, collateral therapy for caretakers, and in some cases, family therapy. Treatment ranged from three months to one year. Analyses revealed statistically significant improvement on all subscales of the full TSCC: *Anxiety*, *Depression*, *Anger*, *Posttraumatic stress*, *Dissociation*, and *Sexual Concerns*.

Comparison to a randomized control study. None of the studies described above included a randomized control group, since doing so would have involved providing treatment that was less trauma-focused, or in some other way believed by MCAVIC staff to be potentially less effective than ITCT. As a result, the findings presented above do not demonstrate, one way or the other, the effectiveness of ITCT relative to treatment lacking a trauma-specific focus.

Fortunately, the results of a well-validated, randomized control group treatment outcome study -- using one of the same measures as used by the MCAVIC clinic study -- have been published recently (Cohen, Mannarino, & Knudsen, 2005). This study of Cohen et al.'s trauma-focused cognitive behavioral approach provides pre- and immediately post-treatment information on participants' TSCC scores, which can be compared to the results of the MCAVIC clinic study.

As shown in the table below, the ITCT intervention resulted in approximately twice the impact on mean TSCC subscales compared to Cohen et al. In addition, this greater improvement appears to have occurred in a sample that was initially more symptomatic than the Cohen et al. sample, and that involved more complex trauma (the Cohen et al., sample was limited to sexual abuse victims who did not display ongoing sexually-externalized behavior).

| Study | Treatment group N | Mean pre-treatment TSCC score | Mean post-treatment TSCC scale score | Mean TSCC scale improvement as a function of treatment |
|---|---|---|---|---|
| Cohen, et al., 2005 | 41 | 8.2 | 6.5 | 1.7 |
| Lanktree, 2005 | 37 | 9.6 | 6.3 | 3.3 |

These data should not be interpreted as suggesting that Cohen et al.'s cognitive-behavioral intervention is less than a successful treatment approach. This comparison does suggest, however, that ITCT is at least as effective as a well-known manualized approach to trauma -- even in children with greater symptomatology and more complex trauma exposure.

Treatment and Service Interventions that Need to be Developed

Although promising practices have been identified, especially for school-age children, the MCAVIC-USC Child and Adolescent Trauma Program would need to further develop ITCT, for example as it is applied to different age groups (especially older adolescent, upon whom little data are available), more severe mental health outcomes, as it is informed by relevant family input, and in relation to different cultural groups. The USC PTP would provide expertise and knowledge to further expand the trauma-focused interventions with adolescent clients. In addition, a small but growing literature (e.g., Donnelly & Amaya-Jackson, 2002) suggests that at least some traumatized children and adolescents may benefit from pharmacotherapy in the context of psychosocial treatment. For this reason, and based on apparent success of combined treatments at LAC+USC (see the trauma psychopharmacology chapter in Briere and Scott [in press]), the role of psychiatric medication in further facilitating ITCT effects should be investigated. The proposed project includes study of the helpfulness of including a child psychiatry resident at MCAVIC, under the supervision of a USC (or Long Beach Child Guidance) psychiatrist. In addition, to increase appropriate parental/family input in ITCT, a Consumer/Family Advisory Council will be created. This Council would advise the Program regarding additional treatment and service interventions to be implemented, for example, ways to increase family-related support and education through the school-based programs, as further described in Section B of this proposal. In addition, MCAVIC-USC will use the input from a panel of experts on cross-cultural issues (see Section B) to help determine ways in which this

treatment model can be adapted to the specific cultural contexts of other treatment populations. Closely tied to empirical testing of further adaptations to ITCT will be further development of the client database. As this database grows to include core clinical characteristics, as defined by the Data Core of the NCTSN, along with other demographic, trauma-exposure, and complete assessment data, further revision of ITCT can be accomplished based on empirical evidence.

Significant Barriers to Intervention Development and Dissemination

During the last 4-5 years of development and testing, ITCT has been adapted to meet the needs of multiple cultural groups with complex issues in varied service settings. Potential barriers to further development of ITCT include the inherent complexity, in fact, of complex posttraumatic presentations, and the various different trauma exposure scenarios that are present in various groups of clients. These between-client differences continue to make it difficult to create a "one-size-fits all" treatment package. An important aspect of ITCT's continued evolution is the challenge of creating core treatment principles and methodologies, but continuing to allow for adaptations based on trauma exposure, demographic, cultural, and symptom variables specific to any given client or group. Whether this will suggest the need for various "subtypes" of ITCT, based on different client variables, or a standard intervention package with different potential modifications, is an empirical question -- one that hopefully will be addressed by the progressive evaluation and re-evaluation of the model over time.

Service Delivery System in Proposed Areas of Trauma Expertise

The MCAVIC-USC Child and Adolescent Program will continue to develop and pilot adaptations of ITCT primarily through MCAVIC's clinic-based and school-based programs. MCAVIC is one of the only centers in Los Angeles County where all services needed by child victims of sexual and physical abuse, neglect, domestic violence, and community violence -- medical, investigative, and therapeutic -- can be provided in one Children's Hospital outpatient center. This is done in a closely coordinated and collaborative manner, while also incorporating school-based services. Law enforcement agencies, child protection, Long Beach Unified School District schools, mental health agencies, and medical professionals are the primary sources of referrals to MCAVIC. Collaborative, multidisciplinary investigative interviews regarding sexual and physical abuse are conducted at the center, frequently followed the same day by expert medical examinations. Therapy services are provided to child and adolescent victims, and their non-offending family members, within a week of referral, if not immediately. Treatment plans are devised based on information from the standardized assessment protocol, as determined by the child's age, language spoken, availability of caretaker etc. (See Appendix 2). ITCT may include individual therapy for some child clients, collateral (parent) and family support, and follow-up groups for more severely traumatized children. Continuing advocacy and collaboration includes reports to members of the investigative team (law enforcement, child protection), court testimony, and consultation. School-based intervention, including evaluation of trauma-specific symptoms using standardized measures, crisis intervention, and consultation was first established in 1998, in collaboration with local schools based on their identification of student needs. School-based therapy groups were implemented in 1999.

MCAVIC's priority is to provide expanded outreach to vulnerable and under-served traumatized populations, such as those in Long Beach, with whom we have established considerable knowledge and experience during the past eight years. Through collaboration with other centers in the NCTSN, knowledge and expertise gained from both MCAVIC and USC can be further expanded upon and disseminated throughout the NCTSN.

How Access to These Service Systems Can Be Attained

MCAVIC and USC have long histories of accessing and engaging hospital departments, schools, law enforcement, child protection, and community agencies (e.g., domestic violence shelters, substance abuse programs) in the implementation and coordination of trauma-informed services. Consultation and advocacy have been provided during past years for both MCAVIC and the USC Psychological Trauma Clinic at their respective hospitals, Miller Children's Hospital and LAC-USC Medical Center. MCAVIC, as an established multidisciplinary investigative center adhering to the "children's advocacy center" model of delivering trauma-informed services, provides investigative forensic interviews, medical examinations, and close collaboration with the involved agencies (law enforcement, child protection, and district attorney's office) to provide optimal services in cases of sexual and physical abuse. It is an oupatient center of a Children's Hospital that is part of the National Association of Children's Hospitals and Related Institutions, associated with Long Beach Memorial Medical Center, the 2nd. largest not-for-profit, community-based medical center on the West Coast. MCAVIC and USC have developed a strong collaboration on behalf of innovative effectiveness studies of NCTSN-supported promising practices. Through a joint TSA Center, their organizational synergies can become a model for broader dissemination of treatment innovations and outcomes evaluation, nationwide.

Experience and Expertise of Key Staff

Cheryl Lanktree, Ph.D., is the Project Director and Primary Investigator for the proposed TSA Center, with over 18 years of specialized experience in the field of child abuse and family violence. She was Clinical Assistant Professor of Psychiatry at the LAC+USC Child and Adolescent Outpatient Clinic from 1987 to 1988, where she supervised and taught trainees in psychiatry, child psychiatry, and psychology. From 1988 to 1996, she was Clinical Director at Stuart House, Santa Monica-UCLA Medical Center, sexual abuse outpatient treatment program for children and adolescents. During this time, she presented workshops, locally and nationally, on the effective assessment and treatment of traumatized children, adolescents, and their families. She also conducted a study that evaluated the role of detailed trauma assessment in understanding clinically-presenting children and adolescents (Lanktree, Briere & Zaidi, 1991). In 1995, she and Dr. Briere published a 4-year treatment outcome study conducted with sexually abused children and adolescents (Lanktree & Briere, 1995).

Dr. Lanktree was Clinical Director at MCAVIC from 1997-1998, and has been the Director of MCAVIC from 1998 to the present. She is the Project Director of MCAVIC as a Community Treatment and Services Center of the National Child Traumatic Stress Network (NCTSN), funded by SAMHSA since 2001. She has developed and refined the ITCT model over the last 5 years. In the process of developing, testing, and disseminating the ITCT, she has received support to fund ITCT programs at MCAVIC from the State Office of Criminal Justice Planning Child Trauma Reduction Program, In-N-Out Burger Foundation, Mark McGwire Foundation for Children, UniHealth Foundation, Ralph Parsons Foundation, SAMHSA, and the Greater Long Beach Foundation.

Dr. Lanktree has provided invited presentations for a number of sites in the NCTSN during the past 3 years of SAMHSA funding, including National Children's Advocacy Center's National Symposium on Child Maltreatment, Huntsville, Alabama; St. Louis, Missouri; Children's Institute International, Los Angeles; and the Chadwick Center, Children's Hospital, San Diego. She also presented on an NCTSN-specialized assessment track and gave a workshop

on ITCT at the annual conference of the American Professional Society on the Abuse of Children, as well as with other NCTSN sites on panels focused on complex trauma assessment and treatment at the All-Network Meetings of the NCTSN, and at the annual conference for the International Society for Traumatic Studies. Dr. Lanktree also provided training for the National Center on the administration and clinical applicability of the TSCC and TSCC-A for dissemination in the NCTSN. She is currently part of the Measures Committee, the Complex Trauma Working Group, and the Medical Trauma Working Group of the NCTSN. Previously, she served as a member of the first Steering Committee for the NCTSN. She has lectured on empirically-informed treatment interventions for traumatized children, adolescents, and their families throughout the United States, as well as in Australia, New Zealand, Canada, Russia, and Scotland.

John Briere, PhD., the co-director of the proposed TSA Center, is Associate Professor of Psychiatry and Psychology at USC School of Medicine and Director of USC's Psychological Trauma Program. A past-president of the International Society for Traumatic Stress Studies and an Advisory Board member of the American Professional Society on the Abuse of Children, he is author or co-author of over 70 articles, 17 chapters, 10 books, and 8 psychological tests in the areas of child abuse and psychological trauma. He has also co-edited both editions of the APSAC Handbook on Child Maltreatment (Briere, et al, 1996; Myers, et al., 2002). Dr. Briere participated in the development of the Standards of Care Task Force Guidelines: Mental Health Care for Child Crime Victims, published by the State of California Victim Compensation and Government Claims Board. Within these standards, he outlined the "assessment-driven" approach to child trauma treatment (Briere, 2001). He is the author of three measures for traumatized children and adolescents: the TSCC, TSCYC, and the Trauma Symptom Review for Adolescents (TSRA; Briere, 2005); the first two of which have been translated into a number of different languages. A version of the TSCC (the TSCC-A) has been adopted by the Data Core group of the NCTSN as a requirement for all NCTSN Centers in their assessment of traumatized children.

Dr. Briere currently provides consultation to the pediatric intensive care units at Loma Linda University Medical Center in Loma Linda, California, the Indian Child and Family Services (ICFS) in Temecula, California, and the Program for Torture Victims (PTV) in Los Angeles. He has lectured on treatment-related cultural issues for both the ICSF and PTV. He has collaborated with personnel from other NCTSN sites on several projects involving dissemination of effective trauma assessment and intervention. Most recently, these include a paper with authors from Children's Hospital-Los Angeles, Medical University of South Carolina, Family Stress Center, and the Inova-Keller Institute in a multi-site study of the effectiveness of the TSCYC (Briere, et al., 2001), and a chapter on the assessment of traumatized children and adolescents in the criminal justice system (Wolpaw, Ford, Newman, Davis, & Briere, 2005). He also has co-authored a paper with Joseph Spinazzola, Ph.D., of The Trauma Center, Massachusetts Mental Health Institute, on the assessment of complex posttraumatic outcomes (Briere & Spinazzola, in press), and a paper with Dr. Lanktree (Briere & Lanktree, 2005) on treating traumatized adolescents. He has provided consultation and training to various Centers of the NCTSN, including to the National Center for the NCTSN on the development and psychometric aspects of the TSCC; consultation and training on adolescent trauma to the Mental Health Center of Dane County, Inc., Wisconsin; research consultation to Dr. Jeffrey Wherry and the Greater St. Louis Child Traumatic Stress Program; and consultation to the Research Committee formed by MCAVIC with the Chadwick Center, Children's Hospital of San Diego.

In addition, he has consulted in the development of a comprehensive database for demographic and assessment data on clients, to be shared with the Data Core of the NCCTS.

William Saltzman, Ph.D., provided extensive training on school-based interventions to clinicians in New York City following the terrorist attacks of September 11, 2001. He has continued to provide training and consultation extensively to numerous sites of the NCTSN, including Children's Institute International, and the Chadwick Center. Since he is also a staff member at the National Center for Child Traumatic Stress and a member of the UCLA Trauma Psychiatry Program, directed by Dr. Robert Pynoos, he has developed further school-based and family-focused evidence-based programs in the Network, apprises MCAVIC staff of Network initiatives, and identifies additional opportunities for collaboration. The manualized UCLA Program for Traumatized and Bereaved Adolescents, co-authored by Dr. Saltzman (Saltzman & et al., 2003), and other manualized materials for school-based trauma/grief interventions will contribute to the ITCT intervention model. Dr. Saltzman continues to be actively involved in co-chairing the Family-Based Interventions Working Group of the NCTSN.

Carl Maida, Ph.D., will continue to be program evaluator for this proposed TSA Center, as he has been for MCAVIC since 2001. A Professor of Public Health at UCLA, Dr. Maida is also the Monitoring and Evaluation Manager for the NCCTS Terrorism and Disaster Branch. He completed a two-year postdoctoral fellowship in Medical Anthropology at UCLA Neuropsychiatric Institute with a research focus on neurological and psychological aspects of end-stage renal disease. Since 1985, he has conducted research on children's mental health and posttraumatic stress, co-authoring, among other books, Children and Disasters (Gordon, Farberow & Maida, 1999). He has also conducted ethnographic fieldwork in diverse ethnic communities in the greater Los Angeles area, and has evaluated programs for children and youth in the areas of sexual abuse, access to health services, community-based learning, and environmental health.

Data collection and implementation of treatment outcome studies will be provided by MCAVIC staff, include two full-time Child Therapists, Kathleen Watkins, Ph.D., an African-American registered psychologist with a Ph.D. in Clinical Psychology, and Karianne Chen, M.S., who has a Master's degree in Marriage and Family Therapy. Both are experienced therapists, providing culturally-appropriate assessment and treatment to clients at MCAVIC and in its local school programs. Ms. Chen has contributed significantly to the development of the MCAVIC database, participates on the MCAVIC-Chadwick Research Committee, is collaborating on several research projects, and has helped prepare applications to the IRB Committee of the Office of Research Administration, Memorial Health Services for several projects, including data delivery to the NCTSN Data Core. A postdoctoral fellow in clinical psychology will contribute to studies testing ITCT protocols with traumatized clients. A USC child psychiatry resident will help evaluate the usefulness of medication as an adjunct to ITCT with traumatized adolescents. The Project will attempt to fill these positions with candidates who reflect the cultural diversity of MCAVIC clients. In the past, MCAVIC has been successful in recruiting trainee and staff therapists who were Filipino, Cambodian, Latino, and African-American. Laura Benson, Community Coordinator and Laurie Trimm, Resource Staff, provide crucial services (e.g., administrative support, data entry, preparation of reports) that support the training, research and dissemination activities of this proposed TSA Center.

Key staff, funded through other sources, would also help facilitate the new MCAVIC-USC Child and Adolescent Program. A bilingual/Spanish-speaking Forensic Interviewer at MCAVIC facilitates community agency collaboration and has participated on the System

Integration Working Group of the NCTSN. The Medical Director for MCAVIC is a forensic expert who is bicultural (Filipino-White). She has actively participated in the NCTSN Forensic Medical Working Group. Two additional part-time licensed child therapists (a psychologist and a marriage and family therapist) would also assist in the piloting of treatment interventions and data collection with clients. Three to five non-funded predoctoral and premaster's level psychology interns from The Guidance Center, Long Beach, and California State University, Long Beach are recruited each year, and will assist the project as needed.

**Section B: Proposed Approach**

Responsibility for Treatment and Service Adaptation in Areas of Trauma Expertise

The co-directors of the proposed MCAVIC-USC center have provided extensive trainings and consultations to a number of Network Centers since 2001. These include (1) assessment presentations on the TSCC for the National Center, (2) assessment and intervention trainings for Category II sites in New York, San Diego and Huntsville, Alabama, (3) presentations to Category III sites in St. Louis and Los Angeles, and (4) presentations on complex trauma at national conferences such as the annual meetings of the American Professional Society on Abuse of Children (APSAC) and the International Society for Traumatic Stress Studies (ISTSS). The MCAVIC-USC Child and Adolescent Trauma Program plans to continue to provide training and remain very involved in the NCTSN collaborative committee and working group organization as described below. As well, MCAVIC-USC intends to continue to work on cross-site evaluation projects with other Network Centers such as those with the Chadwick Center, San Diego, and to continue to work on developing the logistical system -- with approval of the IRB Committee of Long Beach Memorial Medical Center and in collaboration with the National Center -- to transfer demographic and assessment aggregate data to the Data Core group at Duke University/National Center.

The proposed TSA will continue to partner with the above and other Network Centers to further identify, adapt, and standardize the Integrative Treatment of Complex Trauma (ITCT) model. As noted in Section A, the ITCT includes adaptations of the manualized Trauma-Focused Cognitive Behavior Therapy (Cohen et al., 2004) and the UCLA Program for Traumatized and Bereaved Adolescents (Saltzman et al., 2003), both considered standardized practices by SAMHSA. However, this model also includes additional components relevant to more complex posttraumatic outcomes. By partnering with other Network Centers, and collaborating within committees of the NCTSN, the ITCT can be piloted in various locales and sociocultural contexts throughout the U.S. -- perhaps especially treatment systems serving cultural minorities and the economically disadvantaged. As a result of its initial development in clinic, school, and "store front" contexts, the ITCT may be relatively portable to a variety of treatment settings, including outpatient clinics, hospitals, schools, and multidisciplinary treatment/forensic centers. On the other hand, replication in multiple centers will no doubt reveal ways in which ITCT can be more effectively targeted to the requirements of specific groups, including addition to -- or subtraction from -- current ITCT core components. Because the ITCT intrinsically requires periodic, detailed assessment, data from providers and consumers can be fed-back to MCAVIC-USC so that the overall model can further adapted and refined.

MCAVIC staff will continue to collaborate with other Centers through participation on Committees and Workgroups, in order to collect and disseminate information and techniques

garnered from the various applications of the ITCT, and to provide consultation on trauma assessment and treatment in general. These groups include the following:

The Complex Trauma Workgroup (CTWG): Dr. Lanktree contributed to the CTWG paper on complex trauma (Cook, et al., 2005), and has presented on complex trauma interventions on numerous occasions with other members of this group, e.g., Dr. van der Kolk and Dr. Spinazzola at NCTSN All-Network meetings (2002, 2005), and at the annual meeting of the International Society on Traumatic Studies (2002, 2003). Plans are underway for this group, with the active participation of Dr. Lanktree, to create training curricula for the eight "promising practices" identified by the CTWG, including the ITCT. The component core domains of these practices, which well-reflect the goals and foci of ITCT are: safety, self-regulation, self-reflective information processing, trauma experience integration, relational engagement and attachment, and positive affect enhancement. In addition, the curricula calls for individualized adaptations to treatment, based on age/development, gender, and ethnocultural variables, and multiple treatment modalities, i.e., child therapy, therapy for parents, family treatment, and milieu treatment. It is anticipated that data on the further development and evaluation of ITCT will inform the work of the CTWG. Input from the CTWG will assist in further development of the ITCT training protocols and products for interventions that permit replication and evaluation.

The Family-Based Interventions Working Group: Dr. Saltzman, one of the MCAVIC-USC project staff therapists, helped found this group, which is devoted to improving the standard of care for children by facilitating access and active involvement of families/caregivers in treatment. He conducted an interview-based survey of all Network sites regarding current family-based services, and co-authored a white paper on the results, including a literature review of evidence-based practices family and conjoint trauma interventions. He co-hosted conference calls and meetings of the group, coordinated group efforts with the NCTSN policy and training core. He is currently taking a leadership role in the consolidation of Network efforts to develop guidelines and recommendations for the inclusion of families and consumers in policy, program development and service delivery issues. Because clinic-based ITCT often includes family therapy, input from this working group will potentially assist in the further development of the MCAVIC-USC model. As well, continued outcome data on the family treatment component of ITCT may provide helpful information to the working group.

The School Interventions Working Group: Dr. Saltzman also has been active with this group, both as a staff member of the NCCTS and as a member of the MCAVIC staff. He co-conducted a survey of all Network sites regarding extant or planned school-based trauma services. He has provided training and on-going consultation to many of the NCTSN sites (Louisiana Rural Trauma Service Center, St. Louis Child Traumatic Stress Program, Chadwick Center, Children's Institute International, Northshore Hospital, Jewish Board of Family Services, Safe Horizons, St. Vincent's, etc.) on trauma and grief-related school-based services. Dr. Saltzman also authored a significant portion of the school-based materials on the NCTSN website, and he jointly conducted all of the school working group conference calls and meetings. In light of the successful adaptation of ITCT to school-based programs, the MCAVIC-USC TSA Center plans to continue its involvement with this group, and plans to continue to move forward in providing leadership regarding culturally- and developmentally-appropriate adaptations of school-based interventions.

The Measures Committee: Dr. Lanktree has participated on this Committee since its initial formation in 2002. Drs. Lanktree and Saltzman also provided training on two NCTSN Data Core adopted measures -- the TSCC and the UCLA Trauma Reaction Index -- to Network

Centers at the NCTSN All-Network Meeting in 2003 and the annual meeting of APSAC in August, 2004. MCAVIC-USC TSA Center staff, including Drs. Lanktree and Briere, plan to provide input and participate in further activities of this Committee as requested and as appropriate for the Network. As noted elsewhere, Dr. Briere has particular expertise in the development and standardization of assessment measures which is expected to contribute significantly to not only this committee but Network Centers. Major goals of the NCTSN include facilitating standardized implementation of assessment protocols, and uniform data transfer on collected measures to the Data Core group of the NCTSN. Since Dr. Briere created one of these measures (the TSCC, with the TSCC-A version mandated for the core data set), he would be available to provide further training on methodological, statistical, and evaluation issues to the Network and the Measures Committee. In addition, he has recently developed a new measure of trauma impacts, the Trauma Symptom Review for Adolescents (TSRA), which he will make available to Network Centers during the next year. The further validation of this measure through the NCTSN will be a significant contribution to the successful trauma assessment of adolescents.

The Medical Trauma Working Group: The MCAVIC-USC Project plans to continue to participate in this working group, including adapting the MTWG's recently developed "medical trauma tool-kit" for use at Miller Children's Hospital. In addition, the MCAVIC-USC TSA Center will further participate with this group to identify, adapt, and standardize the ITCT model for interventions with clients traumatized by medical trauma. Cross-site collaboration with other Children's Hospitals in the Network (such as those located in San Diego and Philadelphia) is specifically planned for this implementation.

The Cultural Competence Sub-Committee of National Center: The MCAVIC-USC Project plans to continue to contribute knowledge and expertise based on its clinical practice with culturally diverse clients, and through the diverse cultural background of Project staff and interns. Cultural awareness and culturally competent intervention practices are a mainstay of both MCAVIC's and USC's daily clinical activities, and -- given its focus on low income, underserved populations, and its application in diverse sociocultural contexts -- are "built in" to the ITCT. As before, TSA Center staff will be available for translation of information, consultation, and training with reference to integrating cultural competence in intervention strategies.

The Systems Integration Group: Through its continuing participation in this group, the MCAVIC-USC TSA Center plans to contribute knowledge and expertise, based on many years of collaboration with schools, child protection, prosecution, and law enforcement agencies. The need to have a two-way flow of communication between external child-focused systems and the ongoing treatment process, within the constraints of child rights and ethical guidelines, will be emphasized.

The Steering Committee: Dr. Lanktree participated actively as a member of the first Steering Committee. The proposed MCAVIC-USC TSA Center plans to contribute input, as appropriate, to this committee.

Learning from Research to Clinical Practice: Dr. Saltzman is a core member of this committee and has collaborated over the past 2 years to identify, evaluate, and rank promising practices and evidence-based interventions resulting in two ranked rosters of these practices. He participates in all conference calls and meetings. He has also presented to the Network at All-Network Meetings regarding the development of evidence-based interventions.

The Residential Treatment Working Group: In 2003, Dr. Briere was the keynote speaker at an NCTSN-sponsored conference for NCTSN Centers providing treatment in residential

treatment centers. He and others of the MCAVIC-USC TSA Center plan to continue to provide training and consultation for this group as needed. Although not formally conceptualized at this time, the proposed MCAVIC-USC TSA Center has considered the possible application of ITCT to residential treatment, especially for multiply traumatized adolescents. Further interactions with the Residential Treatment Working Group may facilitate this eventuality.

Through partnerships with other Network Centers, and by using the collaborative committee organization, the proposed MCAVIC-USC TSA can contribute expertise regarding additional assessment and intervention protocols and can assist in the piloting and empirical testing of promising interventions (including further adaptations of the ITCT) across Community and Treatment Services Centers (CTS). Ultimately, this will ideally increase the standardization of trauma assessment and treatment for traumatized children and adolescents.

MCAVIC has demonstrated during the past three and half years of membership in the NCTSN the ability to collaborate with other CTS Centers in assessing effectiveness of assessment and intervention approaches. Through collaboration with the Chadwick Center, San Diego, for example, a two-site evaluation and comparison of assessments of traumatized children and adolescents with the TSCC and TSCYC has recently been completed. Once data analysis is complete, this study will help determine the relative and interacting effectiveness of co-administered child- and parent-report trauma measures as they inform treatment. It is anticipated that each assessment approach will yield unique information on the child's psychological functioning, that can then serve as specific targets for intervention.

Dr. Briere, Co-Director of the MCAVIC-USC Project created the TSCC, the alternate version (TSCC-A) of which is required by the Data Core group of the NCTSN. As part of MCAVIC-USC's dissemination efforts, he would be available for technical assistance to CTS Centers, perhaps especially those that may be new to the Network and may not be familiar with the TSCC or the TSCYC. With further training, consultation and cross-site evaluation by additional CTS Centers, the MCAVIC-USC TSA Center plans to evaluate the effectiveness of the ITCT with adolescents, using Briere's new Trauma Symptom Review for Adolescents (TSRA; Briere, 2005). This measure may provide additional sensitivity and specificity to the assessment of treatment outcome in adolescents, for whom the TSCC or other child measures may be too elementary, and adult trauma measure norms inapplicable. The special relevance of a trauma measure developed especially for adolescents includes the proposed MCAVIC-USC TSA's plans to further adapt and integrate the Self-Trauma model of treatment for complex trauma in adults (Briere, 2002) to traumatized adolescents via the ITCT model. This intent to expand the ITCT to older adolescents with complex trauma is an example of the adaptation of existing "best practice" models to new client populations and contexts.

Because the partners of this collaborative TSA project have experience in developing, evaluating, and adapting intervention protocols for diverse cultural groups and resource-impoverished populations (e.g., the “storefront” [alternative education sites for highest risk youth] adaptation of the ITCT), the MCAVIC-USC Center would be able to provide this knowledge to other TSA and CTS Centers seeking to adapt existing treatment models to a broader range of cultural and demographic populations. Further, the experience of the proposed TSA partners in administering multi-site programs is likely to enhance the capacity of different NCTSN Centers to adapt the interventions in varied ways according to the needs of the consumers and the communities they serve.

MCAVIC's significant experience in collecting clinical data and conducting quality assurance/treatment outcome studies also may be of assistance to other NCTSN sites as they

endeavor to measure the effects of implementing standardized interventions in diverse community settings. For example, using a pre-post design and a range of psychological measures, MCAVIC found that a standardized, manualized treatment approach for traumatized youth in school settings (Saltzman et al., 2003) could be adapted to some of the most traumatized, highest risk children and adolescents in the Long Beach Unified School District.

The MCAVIC-USC TSA Center plans to further share expertise on empirically-informed and assessment-driven treatment interventions as they relate to further adaptations of the ITCT model. These adaptations will include (a) structured group treatment models using components of manualized protocols and a newly integrated, empirically-informed, adolescent trauma protocol, (b) psychometrically valid treatment assessment protocols, and (c) strategies for multi-site coordination. In addition, this proposed TSA Center will participate in the cross-site evaluation of the Network. MCAVIC already has participated in interviews conducted by the cross-site evaluators, and has provided program evaluation materials. The MCAVIC Project Director and staff also contributed to the NCTSN progress report: Children and Trauma in America published and distributed in 2004.

In summary, the proposed MCAVIC-USC Child and Adolescent Trauma Program plans to provide leadership and consultation in the NCTSN, with continuing collaborative relationships with other TSA and CTS Centers in hospital-based, clinic-based, and school-based environments. In doing so, the MCAVIC-USC TSA Center can assist in determining the effectiveness of standardized interventions, and assist in the revision of these interventions based on data and feedback from the constituents of these community/service systems. It is also anticipated that, subject to continuing positive outcome data on additional adaptations of the ITCT, this treatment model may inform, to some extent, the content of other TSA and CTS Center approaches to complex posttraumatic outcomes.

Dissemination

Year 1

- Conduct a needs assessment with a representative sample of Network Centers, coordinated through the National Center. The assessment survey will inquire about Centers' needs for
    - training in recognizing and understanding complex trauma;
    - information on which current adaptation of the ITCT would be most relevant to a given Center's client population; and
    - assistance in implementing a data collection approach for assessment-driven treatment, as well as analytic methodologies relevant to the evaluation of treatment effectiveness.
- Consult with local and national community practitioners to identify challenges and barriers to implementing recommended best practices, including the ITCT model.
- Work with NCTSN Centers directly and through the collaborative committee organization of the NCTSN to further develop ITCT treatment protocols and training curricula. Specifically, develop initial written treatment protocols for ITCT, as adapted for three treatment environments: Clinic-based, school-based, and alternative school/"store-front" centers. This task will require a considerable portion of Year 1 efforts.
- Provide training and consultation to other Centers in the context of disseminating these ITCT protocols. This will occur through two mechanisms, as coordinated

through the National Center: in response to direct requests from specific Centers, and through conferences, trainings and committees/working groups of the NCTSN.

- Continue to participate in clinical data collection, both in the development of clinical data protocols for NCTSN, and assistance in Centers' collection of clinical data from service recipients.
- Submit further IRB protocols to test the expanded ITCT treatment protocol, incorporating additional trauma-specific interventions for adolescents (e.g., the Self-Trauma model).
- Establish, through USC, a website for dissemination of materials from the MCAVIC-USC Child and Adolescent Program to other Centers of the NCTSN, with linkages to the NCTSN website, USC's Trauma Clinic website, and the Miller Children's Hospital section of the Long Beach Memorial Medical Center website. Prepare initial information on ITCT and other best practices interventions for this website, with plans to update and expand this information over time.

Years 1 – 4 (throughout project)

- Continue to provide direct services at MCAVIC for the specific purpose of refining treatment and service approaches in the areas of trauma responsibility.
- Apply and validate new assessment procedures, such as the Trauma Symptom Review for Adolescents, (TSRA), using the insights obtained from this testing to evaluate newly-piloted modifications of ITCT for the treatment of traumatized adolescents.
- Begin and evaluate the use of psychotropic medications for those clients assessed by the child psychiatry resident (in supervision with a USC or Long Beach Child Guidance psychiatrist) as likely to benefit from psychiatric medication. This will not be a true experimental design, since there will not be a comparison group of equally-symptomatic but not medically treated trauma survivors. Develop an analytic plan that allows naturalistic comparison of medication effects on outcome, controlling for initial (intake/pre-treatment) assessment findings.
- Solicit feedback from NCTS Centers regarding the fidelity and quality of assessment and treatment interventions. Adapt and improve treatment and service approaches based on feedback from practitioners and evaluation results.
- Serve as a resource for training, consultation, and technical assistance to CTS Centers in complex trauma, ITCT, assessment protocols, and appropriate treatment outcome methodologies.
- Provide leadership in the NCTSN on the identification, refinement, and adaptation of effective treatment and service approaches to complex trauma. Continue to evaluate the quality of intervention implementation with evaluations, including cross-site adaptations of interventions.
- Participate in the NCTSN Cross-Site Evaluation, contributing input, collaborating on training and the implementation of effective interventions.
- Collaborate with CTS Centers to document the effectiveness of Network child trauma interventions, including submission for review by SAMHSA's National Registry of Effective Programs and Practices (NREPP).
- Regularly update the MCAVIC-USC website with current information on research findings and treatment adaptations to specific clinical contexts.

Year 2–3 (Particular goals for the proposed TSA Center to emphasize during this time period)

- Based on responses to the needs assessment of Year 1, and in close collaboration with the National Center, develop a general analysis for what topics and issues in the complex trauma area are most important to the individual Centers, and develop a set of training curricula that address these issues and needs, so that dissemination of information to the Centers will be relevant and efficiently targeted.
- Based on the curricula, and further input from the National Center, provide training on current empirically-based treatment interventions for complex posttraumatic outcomes, including ITCT.
- Obtain feedback from sites regarding the helpfulness of MCAVIC-USC training, and continue to seek consultation from the National Center, and the National Resource Center of the NCTSN regarding the most effective ways to disseminate treatment methodologies, for example, emulation of the "Breakthrough Series" approach. Based on this combined input, make adjustments in the curricula and training approach as needed.
- Continue to evaluate implementation and outcomes associated with the MCAVIC-USC TSA protocols. Revise and adapt the ITCT specific models based on feedback from structured evaluations, coordinated through the National Center. In conjunction with the expert panel on cultural issues, and the Consumer/Family Advisory Council, integrate feedback from Centers and service recipients in order to increase the cultural relevance of interventions and to take full advantage of familial and other local resources.
- Continue to provide training regarding the successive adaptations of effective treatment interventions (e.g., the ITCT) as informed and modified by feedback and empirical findings from NCTSN sites.
- Establish multi-site evaluations of the adapted protocols. Provide technical assistance regarding the establishment of assessment and treatment interventions. Collaborate with NCTSN cross-site evaluation of Centers.

Year 3-4 (Particular goals for the proposed TSA Center to emphasize during this time period)

- Based on feedback from treatment outcome research, both at MCAVIC and at other Centers, in combination with National Center suggestions, develop more specific manual(s)/products on ITCT.
- Use the manual(s) and other products (e.g., additional assessment instruments) in the dissemination of these validated treatment approaches to service providers, with a goal of broad implementation in community and service settings. With further training and dissemination of the expanded and adapted ITCT, the various forms of this treatment model will be sufficiently standardized, delineated, and validated such that other sources of funding and support can be obtained. As the ITCT and other best practice interventions become accepted approaches to the effects of complex trauma in children and adolescents in various settings, it is expected that they will "take root" in the community and become independently sustainable without further SAMHSA/MCAVIC-USC involvement.

Plan to partner with service provider organizations and other constituency groups. The proposed MCAVIC-USC Child and Adolescent Trauma Program will continue to partner with the following groups, in order to facilitate dissemination and adoption of effective interventions for complex trauma outcomes: Long Beach Unified School District (LBUSD); The Guidance Center in Long Beach; the College of Education at California State University-Long Beach; the

Program for Torture Victims, in Los Angeles; Indian Child and Family Services, in Temecula; law enforcement and child protection agencies; the various departments of Miller Children's Hospital; and consumer/families (former clients) on the newly formed MCAVIC-USC Consumer Advisory Council. MCAVIC-USC Project staff will meet with the Consumer/Family Advisory Council on a quarterly basis. This Advisory Council will be comprised of members from the Long Beach Area Child Abuse and Domestic Violence Prevention Council; faith-based organizations; members of local parent-teacher organizations; former clients (some of whom are also employees of the Long Beach Memorial Medical Center); and individuals such as Dixie Swift, former Cultural Program Supervisor of the Long Beach Homeland Neighborhood Cultural Center -- the location of MCAVIC's after-school program in 2004.

Consultation with MCAVIC-USC's newly constituted advisory panel on cultural issues (see further in this section for this group's composition) will occur on a bi-monthly basis. Consultation with agencies and groups where regular dissemination and adoption of interventions occur locally, such as LBUSD and The Guidance Center, will provide ongoing feedback regarding the usefulness of ITCT, thereby informing further adaptation of the model as necessary. MCAVIC-USC will regularly solicit feedback from service provider organizations and other constituency groups on a more national level regarding dissemination and adoption of effective interventions provided by Centers nationwide.

Resource Development

A primary product of the proposed TSA Center will be a detailed treatment manual for ITCT. The first version of this manual will outline ITCT as it was used in the three treatment outcome studies described earlier, revised somewhat to reflect initial feedback from the Expert Panel on cultural issues, and elaborations of the model based on further discussion between co-directors and staff of MCAVIC and USC. Later versions will incorporate MCAVIC-USC experience in applying the model in additional contexts, as well as feedback from the various Centers of the NCTSN, consultant panels and councils on cultural issues and family/community involvement, other clinicians who have received dissemination of the model during conferences and presentations, and consumers and consumer organizations.

Although ITCT will be described in an overall manual, its applications in different settings will require specific sections on fine-tuning and adapting this model to address the needs of specific treatment-seeking populations. Minimally, this will include sub-protocols for child/adolescent trauma clinics such as MCAVIC, "mainstream" school-based programs, and alternative "store-front" school-based settings. It is likely, however, that over the next four years the application of ITCT to a number of other specific settings will require programmatic information on different or adapted interventions in these particular cultural/psychological/social contexts. Thus, this manual will provide a standardized protocol for the specific ITCT intervention foci summarized earlier in this application, including integration of other standardized trauma treatments, but also will enumerate the various ways in which these procedures will have to be adapted for different client groups and contexts. It will also contain information relevant to differences in individual clients' needs, such as those with major attachment issues or developmental disabilities. Examples and usable exercises will be included wherever indicated. The manual is expected to contain, at minimum, the following sections:

- an overview of complex psychological trauma and its effects;
- the impacts of low socioeconomic status and diminished social resources on symptom expression and the accessibility of standard treatment interventions;

- major cultural influences on trauma perception, trauma symptom expression (i.e., "idioms of distress" most commonly employed by different cultures), and response to trauma treatment;
- an outline of the core interventions of ITCT; and
- specific sections on its adaptation in different settings (e.g., "store-front environments, as opposed to classic walk-in clinic settings).

In addition to treatment manuals, the proposed TSA Center plans to develop a website -- in consultation with the National Center -- that will provide easy public access to multiple resources on complex trauma, its impacts, and its intervention. Divided into "general" and "clinician" areas (with more technical material found in the latter), this site will include information on ITCT treatment guidelines and protocols, and directions for accessing project trauma measures. There will be links to other NCTSN-developed products, such as the fact sheet from the Complex Trauma Working Group (CTWG), the Medical Trauma tool-kit, and other materials relevant to the public, service providers, consumers, and policy makers. Finally, this site will link to other sites, such as Dr. Briere's website and the Miller Children's Hospital/Long Beach Memorial Medical Center website and other web resources on trauma and recovery.

MCAVIC has developed brochures and information materials for service systems and providers, describing interventions available and outlining referral mechanisms. These material will be adapted and expanded to meet the needs of the current Project, including information on additional traumas and the availability of additional services. MCAVIC also was involved in the development of the Progress Report of the National Child Traumatic Stress Network (2004), a document that has been well-received by service providers, consumers, and policy makers. This progress report continues to be available through the National Resource Center of the NCTSN, and will be orderable from the MCAVIC-USC website.

Dr. Lanktree, Director of MCAVIC and Co-Director of this proposed TSA, is an author of the Complex Trauma Workgroup's (CTWG) white paper and the upcoming article version (accepted for publication by Psychiatric Annals). She will continue to be involved in the development of the CTWG's training curriculum, as well as the CTWG's complex trauma media kit, which will include findings from the NCTSN survey of complex trauma in the Network, a casebook, informational fact sheet, and press release. There is a plan for collaboration with the National Center for Child Traumatic Stress on the development, production, and dissemination of this information.

Sustainability Plan

A key goal of this proposed TSA Center is to identify an empirically-based treatment and service approach (ITCT) that can "take root" in community settings across the country. This means that the proposed TSA Center will be instrumental in disseminating the empirically-based interventions for complex trauma developed by the MCAVIC-USC Child and Adolescent Trauma Program. These treatment and service approaches will be developed with awareness of common funding and implementation constraints in community systems across the nation.

The development of a relatively standardized and validated treatment package, with options for adaptation to specific cultural or client factors, will increase the likelihood that other sources of funding and support can be obtained. MCAVIC, for example, has been able to secure outside funding for its programs by showing positive treatment outcomes for the treatment it provides to schools and in its clinic. Primarily due to the success of their intervention programs, over the last year MCAVIC has been successful in obtaining a renewal of the SAMHSA grant

(until September 2005), a second renewal of the UniHealth Foundation, annual renewals from the In-N-Out Foundation, and a grant from the Greater Long Beach Community Foundation.

Most recently, MCAVIC submitted a proposal to the U.S. Department of Defense to apply for funding to support trauma-specific intervention services to children, adolescents, and their family members affected by military deployment -- specifically addressing trauma involving separation, potential loss of a parent or sibling, and adjustment difficulties when family members return. Since neither a military hospital or military-related (e.g. Veterans Administration) outpatient agency is in the area, it is thought that MCAVIC could offer such services. This potential funding could further MCAVIC-USC's attempts to adapt of trauma-specific interventions (i.e., ITCT) to yet another population.

MCAVIC-USC Child and Adolescent Trauma Center will dedicate approximately 70% of grant funds from SAMHSA to the following Network participatory and collaborative activities:

- linking, networking, collaborating, and coordinating with other NCTSN Centers;
- treatment and service product development (i.e., the ITCT) and dissemination;
- general training and consultation on complex trauma and assessment;
- evaluation/data collection assistance to improve quality of treatment and services for children and adolescents exposed to complex trauma.

MCAVIC will participate and collaborate with the National Center of the NCTSN on committees and working groups (e.g., Medical Trauma Working Group, Complex Trauma Working Group, Measures Committee, School-based Working Group, Systems Integration Working Group, Cultural Competency Committee), and with the Data Core group of the NCTSN collecting data for cross-site evaluations. By doing so, the proposed TSA will contribute to the efforts of the NCTSN to further support trauma interventions with empirical data, as well as the dissemination of training materials and products associated with these empirically-based interventions. By virtue of their quality and effectiveness, these are the products that are most likely to "take root" and endure in community systems. Such collaboration will also lead to the development and implementation of multifaceted community sustainability plans for further grant-funded programs and activities, in areas such as policy change, service improvement, improved service access, community support, and financing of additional trauma services.

The proposed TSA center will serve as a resource for the NCTSI and the National Resource Center for Child Traumatic (NRC-CTS) regarding various aspects of community treatment/service delivery, including training provided for the Network on adopted assessment measures (Trauma Symptom Checklist-Children and UCLA Trauma Reaction Index). MCAVIC-USC will work with the NCTSN and NRC-CTS to ensure that best practices in training, assessment, and intervention approaches that are developed, evaluated, and adapted by the MCAVIC-USC Child and Adolescent Trauma Program can be standardized, documented, and disseminated within the NCTSN and to other service programs nationwide.

The proposed TSA center will work with NCTSN Centers to create community sustainability plans and activities that demonstrate vision, creative financing, community support, and positive results. The MCAVIC-USC TSA Center is likely to be successful in this because of the extensive experience of both partners in obtaining some combination of victim-witness support, government funding, private donations, and private foundation grants. Such efforts can lead to the successful implementation of effective models and strategies of interventions to sustain grant-funded activities beyond the period of federal funding.

Consumer Collaboration

The proposed MCAVIC-TSA Center will create new liaisons with culturally diverse service providers, and with constituency groups such as faith-based organizations, parent-teacher associations, and local, culturally-based organizations focused on the needs of various cultural groups in the community, including African-American, Latino, Asian, and Pacific-Islander. Such activities can help the TSA Center's mission and programs address the needs of the consumers and family members of the community, but also can provide a body of information to assist the process and outcomes of treatment and services at other Centers within the Network.

In addition to these new liaisons, MCAVIC-USC will continue and further develop relationships with California State University-Long Beach, Long Beach Unified School District (LBUSD), The Guidance Center, law enforcement, child protection, the community-based Long Beach Area Child Abuse and Domestic Violence Prevention Council, City of Long Beach department of gang-prevention, SCAN Committee of Miller Children's Hospital, Indian Child and Family Services, in Temecula, the Program for Torture Victims, in Los Angeles, and Loma Linda University Medical Center, in Loma Linda. Many of these organizations include culturally diverse professionals who are also parents and reside in their local communities.

MCAVIC-USC Project staff will continue to include culturally diverse and bilingual (especially Spanish-speaking) professionals who -- in addition to better serving children and adolescents from equivalent cultures -- often are able to create liaisons with professionals and consumers in the communities in which these youth originate. Additional liaisons will be created during MCAVIC-USC's training and outreach to the schools, including at parent-teacher meetings, and at local agencies such as battered women's shelters. In each cases, every effort will be made to include consumers and consumer groups as planned participants in all phases of program design.

Procedures to include input from consumer constituency groups. The proposed TSA Center will create a Consumer/Family Advisory Council in the first year of the Project, consisting of parents, teachers, hospital staff, former clients, as well as professionals from the organizations described above. This Council (hospital guidelines preclude naming this group a "board") will provide feedback regarding the state of current services to traumatized children and adolescents, and will make suggestions for adaptations and expansions that would improve the TSA Center's usefulness to the community. For example, there might be suggestions of ways in which the TSA Center could partner with community organizations to provide a safe after-school program for clients living in violent communities with limited school resources. It will also provide input and feedback to the TSA regarding the relevance of materials developed by the Project for dissemination. See Appendix 1 for letters of support provided by professionals and former clients who have agreed to be involved in this advisory council. Meetings will occur on a bi-monthly basis, and will provide a structured context for collecting input on service delivery, outreach activities, evaluations of services, and program planning from both service recipients (past clients who are children/adolescents and their families) and community service providers.

Dr. Kathleen Watkins will direct this Council in collaboration with other Project staff. Dr. Watkins is an African-American child therapist who has worked at MCAVIC for almost six years. She has successfully collaborated with many community agencies, as witness her 2004 Child Protection award from the Long Beach Area Child Abuse and Domestic Violence Prevention Council (LBACADVPC). It is expected that members of the LBACADVPC will participate in this Consumer/Family Advisory Council, and will further the Council's mission to provide feedback from the wide range of cultural perspectives extant in the Long Beach area.

Incorporation of cultural and social diversity. An expert panel of professionals will be created to provide input to the proposed TSA Center regarding cultural issues in the development, implementation, evaluation, and dissemination of clinical services to traumatized children and adolescents. Individuals who have agreed to be part of this panel include: Megan Berthold, LCSW, Ph.D., of the Los Angeles Program for Torture Victims (PTV), who has provided trauma services to children in refugee camps in Cambodia and Thailand, and currently works with a wide range of immigrants and refugees at PTV (see her letter of support in Appendix 1); Renda Dionne, Ph.D., of Indian Child and Family Services, in Temecula, California, who is funded by the State and Federal government to provide culturally-relevant services to American Indian children and adolescents. Dr. Dionne is one of a small group of American Indian psychologists in the United States, and is highly competent to advise the project on culturally-informed clinical services (see her letter of support in Appendix 1); Veronica Abney, LCSW, Ph.D., in private practice, who is a past-president of APSAC and author of the chapter, "Cultural Competency in the Field of Child Maltreatment" for the APSAC Handbook on Child Maltreatment. Second Edition (Meyers et al., 2002); and Eliana Gil, Ph.D., of the Inova Keller Center in Washington DC, who is an renown child therapist with many years of teaching and consultation in the provision of services to traumatized Latino children; and James Rodriguez, MSW, Ph.D., a psychologist at the department of child and adolescent psychiatry, Columbia University, New York, NY. and director for Project Liberty/Enhanced/CATTS Program. Additional authorities on minority/cultural issues will also be included in this panel, subject to their expected agreement.

Through close collaborative relationships with the LBUSD, MCAVIC programs involving culturally diverse groups will continue to solicit input from parents, teachers, school counselors, and principals regarding the cultural appropriateness of successive adaptations of ITCT and other NCTSN best practice interventions. Specific procedures will continue to include: consultation and training meetings with school and agency personnel, support group and parent education groups for parents and families, as well as questionnaires and surveys to evaluate the effectiveness of interventions. Feedback from the surveys will be used to maximize the appropriateness of MCAVIC-USC services for diverse cultural/social groups.

**Section C. Evaluation**

A process evaluation has been designed to measure change relating to project goals and objectives over time, compared to baseline information, and will serve to provide feedback for improved program operations and, ultimately, the outcomes. New evaluation tasks will begin at project start-up to insure readiness for the core descriptive and outcome study. MCAVIC has developed strong working relationships with NCCTS in monitoring and evaluation, and collaborates with other sites in the expansion of the client database. The proposed TSA Center has the capacity to provide data on key areas related to treatment adaptation and collection of longitudinal child and family measures, in addition to the Government Performance and Results Act (GPRA) data. Its Evaluation Team systematically collects and implements all data and evaluation activities, routinely monitors each element of the data collection process, and meets monthly for timely feedback and identification of potential problems. The proposed TSA Center's Performance Evaluation Plan, or internal evaluation plan, assesses the degree of success in achieving the goals specified for the elements in the "Proposed Approach" above. It identifies indicators measuring goal achievement, *benchmarks* indicating degree of goal achievement, and

*data collection methods.* To confront potential problems in data collection, evaluate the likelihood of success in formulating the appropriate treatment adaptation strategies and to insure appropriate evaluation of the program, the Expert Panel (see Section B) and Consumer/Family Advisory Council will provide critical feedback. Follow-up will be conducted to ensure that the suggestions are incorporated and inform all TSA Center activities. The Expert Panel includes nationally recognized trauma experts familiar with cross-cultural intervention design and dissemination, consumer and constituency issues, and community consultation and training, who will provide additional feedback. Council members represent consumers and family members (former clients and others) who can provide a culturally appropriate, "real world" perspective to the TSA Center's functions. Panel and council members will be kept informed of progress regarding progress and any difficulties encountered in implementation and evaluation. Suggestions for overcoming obstacles to effective execution of the program will be elicited from the participants. Complex Trauma, as used in the plan below, includes as described previously: child abuse, traumatic bereavement, medical trauma, and interpersonal violence including domestic and community violence.

Process Indicators, Benchmarks, and Data Collection Methods

1. Treatment and Service Adaptation

- Identify, adapt, and standardize critical and/or promising interventions including refined protocols and the newly created Trauma Symptom Review for Adolescents.

*Benchmark:* By the end of year 1, promising interventions in complex trauma, including ITCT, will be adapted and refined.

*Data Collection Methods*: Summary report of collaborative intervention design activities

- Develop training protocols and products for interventions.

*Benchmark:* By the end of year 1, the training protocol for the ITCT and allied interventions in complex trauma will be developed.

*Data Collection Methods*: Set goals and objectives for training protocol; completed reviewer evaluation form with reviewers' comments; final versions of training protocols

2. Assessment of Effectiveness of Intervention Approaches

- Assess effectiveness of intervention approaches and products in complex trauma.

*Benchmark:* By the end of year 2, effective and adapted intervention protocols will be implemented and evaluated, with further feedback from other Centers, consumers, and Expert Panel informing further adaptations of assessment and treatment protocols, and additional analyses of outcomes for interventions provided by the Project to further identify empirically-based approaches.

*Data Collection Methods*: Multi-site evaluation protocol, pre-post tests, evaluations of trainings and implementation success, transcripts of onsite reflection and online follow-up sessions

- Assess outcomes of implementing standardized interventions at NCTSN and outside sites.

*Benchmark:* By the end of year 2, the assessment of intervention outcomes will be completed.

*Data Collection Methods*: Summary report on training, consultation, piloting activities and their outcomes.

- Assess achievements in using results of community/service system replications to revise interventions, training procedures, or materials.

*Benchmark:* By the end of year 2, the intervention revision process will be completed.
*Data Collection Methods*: Summary report on appropriateness, adaptation, standardization of interventions, treatment effectiveness tracking, and the revision process.

3. Dissemination

- Promote further dissemination and adoption of effective intervention approaches and products in complex trauma for community/child-serving systems.

*Benchmark:* By the end of year 2, consultation and training materials will be finalized.
*Data Collection Methods*: Consultation and technical assistance guidebook and training manual.

- Collaborate with the other Network Centers and the NCCTS in the dissemination of intervention products and training.

*Benchmark:* By the end of year 2, a Network-wide plan for dissemination will be finalized and implemented.
*Data Collection Methods*: Dissemination plan using a modified version of the IHI-based "Breakthrough Series Learning Collaborative" model.

- Partner with service provider organizations and other constituency groups to facilitate dissemination and adoption of effective interventions in complex trauma.

*Benchmark:* By the end of year 3, an expanded dissemination plan will be finalized and implemented.
*Data Collection Methods:* "Discussion forum" webpage for ongoing feedback on dissemination, adoption, piloting, and appropriateness of interventions.

4. Resource Development

- Identify resources on complex trauma for the public, service providers, consumers, and policy makers.

*Benchmark:* By the end of year 1, existing resources in complex trauma will be identified.
*Data Collection Methods*: Annotated list of existing print, video, and web-based resources in complex trauma

- Develop additional public and professional resources in *complex trauma* for use by the NCTSN and beyond the Network.

*Benchmark:* By the end of year 2, additional resources in complex trauma will be identified.
*Data Collection Methods*: Website for newly developed treatment guidelines, assessment measures, and other web-based resources (casebooks, informational fact sheets, tool-kits, published articles), with links to existing resource materials.

- Collaborate with the NCCTS in the development, production, and dissemination of resources.

*Benchmark:* By the end of year 3, a plan for broad-based production and dissemination of resources in complex trauma will be finalized, with products developed by year 4.
*Data Collection Methods*: White paper on best approaches for resource dissemination, including an assessment of various training technology and platforms

5. Sustainability

- Assist communities to sustain progress in best practice implementation beyond the NCTSN and Federal funding.

*Benchmark:* By the end of year 3, a community-based consultation to sustain best practices in *complex trauma* interventions will be implemented, including specific evaluation outcomes for effective interventions, adaptations, and dissemination practices. By year 4, a set of recommendations provided for community sustainability.
*Data Collection Methods*: Sustainability plan for grant funding and alternative financing of best practices. Analysis of data collected throughout the first 3 years.

6. Consumer Collaboration

- Create liaisons with key professional provider and constituency organizations in complex trauma.

*Benchmark:* By the end of year 1, a network of liaisons with culturally diverse professional providers and constituency organizations will be established and mobilized.
*Data Collection Methods*: List of provider and constituency organization contacts (name, current position), and notes on issues discussed; continued collaboration with NCTSN committees and working groups with resulting products such as press kits and intervention protocols distributed.

- Create Consumer/Family Advisory Council for input from consumer constituency groups on all aspects of Center activities to ensure cultural and social diversity in the development, implementation, evaluation and dissemination of assessments, clinical data collections, and interventions in complex trauma.

*Benchmark:* By the end of year 1, a Consumer/Family Advisory Council with a regular meeting schedule will be established. See Appendix 1 for potential participants (e.g., teachers and parents from schools, former clients).
*Data Collection Methods*: List of Consumer/Family Advisory Council members (name, current position), and process transcripts of meetings. Document needs assessment survey results and discussion of issues and concerns, input for project activities, and actions taken to incorporate consumer/family feedback.

- Create Cross-Cultural Expert Panel for input on developing interventions appropriate to diverse cultural/social populations.

*Benchmark:* By the end of year 1, panel of cross-cultural experts in complex trauma will be established and an expert panel review process will be initiated; many of these experts have provided letters of support (See Appendix 1).
*Data Collection Methods*: List of cross-cultural experts including curriculum vitae, and notes on issues discussed

**Section D: Staff, Management, and Relevant Experience**

Staffing Plan for How the Goal Specified in the Proposed Approach will be Accomplished

Treatment and Service Adaptation. The co-directors of the TSA Center, staff therapists, as well as postdoctoral and child psychiatry fellows selected for child and adolescent trauma-related experience and cultural competence, will have the background and experience to identify, adapt, and standardize critical and/or promising interventions with the clients served through this Project, as well as develop training protocols and products for interventions.

Assessment of Effectiveness of Intervention Approaches. All therapists and postdoctoral fellows have the expertise to collect data to meet this goal, with the child psychiatry resident being particularly involved in an evaluation of the efficacy of psychopharmacological interventions, in collaboration with USC and the Medical Director at The Guidance Center (see

Appendix 1). Multi-site evaluations, analyses, and reports will be accomplished by the co-directors.

Dissemination and Resource Development. All TSA Center staff will be involved in accomplishing goals related to dissemination, e.g., therapists, postdoctoral and child psychiatry fellows will help to finalize training materials. The program evaluator and co-directors will be especially involved in the evaluation and coordination of training. All will continue collaboration with committees, working groups, the NCCTS, and other Network Centers to further expand dissemination of effective interventions established through empirically-based evaluations. The community coordinator will continue to facilitate communication with the NCCTS and Network Centers, as well as helping to compile resources and coordinating with USC the website for newly developed treatment guidelines, assessment measures, and other web-based resources.

Sustainability and Consumer Collaboration. All TSA Center staff will contribute to the accomplishment of goals as described above, with the co-directors particularly leading the data evaluation and exploration of other funding sources to support sustainability of communities beyond NCTSN funding. In addition, project staff with particular understanding of cultural diversity issues will lead the coordination of the culturally diverse Consumer/Family Council, while the co-directors will primarily interact with the Expert Panel and bring the feedback to the TSA Center staff.

How the Proposed TSA Center will Support and Promote Cultural Competence in Center's Activities through Staffing and/or Training

- The proposed TSA Center currently includes African-American and Spanish-speaking staff members, and will continue to recruit staff-- including the postdoctoral fellow and child psychiatry fellow and trainees/interns-- with culturally diverse backgrounds.
- With training available through collaborative organizations such as the Los Angeles Program for Torture Victims (especially regarding Cambodian traumatized adolescents), and Indian Child and Family Services, Temecula, along with training provided by other NCTSN sites, cultural competence will be further promoted.
- The Consumer/Family Advocacy Council and Expert Panel will ensure that culturally-appropriate adaptations are made to TSA interventions, training strategies and materials. Feedback from culturally diverse families and consumers will have the potential to educate staff further in cultural issues relevant to services.

Staff and Resources Dedicated to Support Evaluation and Data Collection Activities

Client data, including data on assessment measures (See Appendix 2), will be collected by therapists, postdoctoral fellows, and child psychiatry fellows, then entered into the database by an experienced data entry staff person who has been involved with database development and expansion for the past year. The community coordinator collaborates with project staff to collect data required by SAMHSA and the NCTSN to support Network-wide data summaries and analyses, most of which are conducted by the MCAVIC Director. Staff members have been trained to transfer the required data to the Data Core of the NCCTS, and are prepared to do so once IRB approval has been received. The program evaluator and Dr. Briere have provided consultation regarding the implementation of evaluation projects. Analyses of evaluation data have been conducted by Dr. Briere as well as other members of the Evaluation Team. This team with the addition, in particular, of postdoctoral fellows, will further support evaluation and data collection activities.

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**Section G: Biographical Sketches and Job Descriptions**

*Biographical Sketches*

**Cheryl B. Lanktree, Ph.D.**

Cheryl Lanktree, Ph.D. is a licensed clinical psychologist and Director of Miller Children's Abuse and Violence Intervention Center (MCAVIC), Long Beach, California. She has a part-time private practice and has specialized in the treatment of trauma in children, adolescents, and adults since 1990. She received a B.A. in Honors Psychology (1975) from the University of Western Ontario, London, Canada, an M.A. in Developmental Psychology (1977) from the University of Guelph, Guelph, Canada, and a Ph.D. in Clinical Psychology (1984) from the University of Manitoba, Winnipeg, Canada. She completed a predoctoral internship in Clinical Psychology at Yale University (1982-83) and a postdoctoral fellowship in Behavioral Medicine at UCLA School of Medicine, Harbor-UCLA Medical Center (1985-86).

Dr. Lanktree was Assistant Professor, Department of Psychology, University of Manitoba and Clinical Consultant, Children's Home of Winnipeg and Manitoba Committee on Wife Abuse from 1984-1985. She was Assistant Clinical Professor, Department of Counseling, California State University, Fullerton (1986-87) and Assistant Clinical Professor, Department of Clinical Psychiatry and Behavioral Sciences, University of Southern California (1987-88). Dr. Lanktree was Clinical Director of Stuart House, Santa Monica-UCLA Medical Center (1988-1996) and Assistant Clinical Professor, Department of Psychiatry, UCLA (1988-1994). She was Clinical Director at MCAVIC from 1997-1998 and has been the Director of MCAVIC from 1998 to the present. She is the Project Director of MCAVIC as a Community Treatment and Services Center of the National Child Traumatic Stress Network (NCTSN), funded by the Substance Abuse and Mental Health Services Administration (SAMHSA) since 2001 and would be Co-Director of the proposed TSA Center, MCAVIC-USC Child and Adolescent Trauma Program. She has directed the development of the MCAVIC treatment model: Integrative Treatment of Complex Trauma (ITCT), considered a "promising practice" by the Complex Trauma Working Group of the NCTSN. Dr. Lanktree was awarded the Child Protection Award by the Long Beach Area Child Abuse and Domestic Violence Prevention Council in 2001.

She has published articles on the assessment and treatment of child sexual abuse including Lanktree, Briere, & Zaidi (1991) and Lanktree and Briere (1995) in Child Abuse and Neglect and a chapter on treating child victims of sexual abuse in the book, Assessing and Treating Victims of Violence (Lanktree, 1994). She has also served on the editorial boards of Journal of Child Sexual Abuse and Child Maltreatment. Dr. Lanktree is a nationally-recognized expert on the assessment and treatment of abuse and violence-related trauma in children and adolescents. She has presented extensively since 1989 throughout the United States and internationally, including Canada, New Zealand, Australia, Russia, and Scotland.

Dr. Lanktree has successfully attained several grants as Project Director and Primary Investigator to fund programs at MCAVIC from: State Office of Criminal Justice Planning, State of California (1998-2001), Greater Long Beach Foundation (1998-1999, 2003-2004), In-N-Out

Burger Foundation (2000-present), Mark McGwire Foundation for Children (2001-2003), UniHealth Foundation (2001-2002, 2003-2004, 2004-2005), Ralph Parsons Foundation (2001-2002), and SAMHSA (2001-2004, 2004-2005).

**John Briere, Ph.D.**

John Briere, Ph.D. is associate professor in the departments of psychiatry and psychology at the Keck School of Medicine, University of Southern California, and, since 1991, director of the Psychological Trauma Program at the Los Angeles County-USC Medical Center. Dr. Briere would be Co-Director of the proposed TSA Center, MCAVIC-USC Child and Adolescent Trauma Program. He received an A.B. in psychology from U.C.L.A. (1974), an M.A. in psychology from California State University, Los Angeles (1976), and a Ph.D. in Clinical Psychology at the University of Manitoba, in Manitoba, Canada (1985). He completed his predoctoral internship in clinical/community psychology at the University of California, Davis, Medical School (1979-1980), and a postdoctoral fellowship in crisis resolution in the department of psychiatry, U.C.L.A. School of Medicine, Harbor-UCLA Medical Center (1985-1986).

He is past-president (2001-2002) of the International Society of Traumatic Stress Studies (ISTSS), and on the advisory board of the American Professional Society on the Abuse of Children (APSAC). He is a consultant to Miller Children's Abuse and Violence Intervention Center, Indian and Child Family Services (Temecula, CA), the Program for Torture Victims (Los Angeles, CA), Loma Linda Medical Center (Loma Linda, CA), and the Center for Research on Violence Against Women, University of Kentucky (Lexington, KY). Honors include the Robert S. Laufer Memorial Award for Scientific Achievement (ISTSS), Outstanding Professional Award (APSAC), election to Fellow status (American Psychological Association [APA]), Cadre of Experts on Violence (APA), Distinguished Alumnus (University of California, Davis Medical School), and Highly Cited Researcher: Behavioral Science – General (Institute for Scientific Information). He was a member of the Standards of Care Task Force, Child Trauma Victims, for the California Victims Compensation and Government Claims Board (1998-2000), and served as faculty at a week-long NATO Advanced Study Institute, in Talmont St. Hilaire, France.

John Briere has been on the editorial boards of, among other journals, the Journal of Consulting and Clinical Psychology, Journal of Interpersonal Violence, and Child Abuse and Neglect. He is author of 7 psychological tests, including the Trauma Symptom Checklist for Children; Trauma Symptom Checklist for Young Children; Trauma Symptom Inventory; and the Detailed Assessment of Posttraumatic Stress, and has just finished developing the Trauma Symptom Review for Adolescents. He has written 8 books, including the 1st and 2nd editions of Psychological assessment of adult posttraumatic states: Phenomenology, diagnosis, and measurement (APA), 1st and 2nd editions of Therapy for adults molested as children (Springer), and Child abuse trauma (Sage), and was co-editor of the 1st and 2nd editions of the APSAC handbook on child maltreatment (Sage). He has 61 publications or in-press papers (primarily on posttraumatic symptomatology, interpersonal violence, treatment, gender issues, statistics/methodology, and assessment) in peer reviewed journals such as the American Journal of Psychiatry, American Journal of Orthopsychiatry, Annals of the New York Academy of Sciences, Behavioral Sciences and the Law, Child Abuse and Neglect, Child Maltreatment, Journal of Abnormal Psychology, Journal of Consulting and Clinical Psychology, Journal of Interpersonal Violence, Journal of Personality Assessment, Journal of Nervous and Mental Disorders, Journal of Traumatic Stress, Psychotherapy: Theory, Research & Practice, and Violence

and Victims He has written 17 book chapters, 2 encyclopedia entries, and 10 invited reviews or commentaries. He regularly presents papers and workshops on trauma research, assessment, and treatment in North America, Europe, and Australasia.

**Laura Benson**

Laura Benson is the Community Coordinator for Miller Children's Abuse and Violence Intervention Center (MCAVIC) at Miller Children's Hospital (MCH) affiliated with Long Beach Memorial Medical Center (LBMMC), Long Beach, California providing investigative and treatment services for children, adolescents, and their families traumatized by child abuse, violence, medical trauma, and loss of a family member. She has been Office Manager for MCAVIC for the past 5 years. Her current duties include assisting the Director in the administration of MCAVIC, including coordinating referrals and facilitating efficient delivery of all services to clients, managing office operations, facilitating outreach activities within the community, and performing liaison interactions with MCH and community agencies. During the past 3 ½ years that MCAVIC has been a member of the NCTSN, Ms. Benson has facilitated the coordination of crucial activities and communication with other Network sites and SAMHSA, including facilitating site visits and assisting in the preparation of grant reports and applications. She works closely with law enforcement agencies, the DCFS, and other community agencies to coordinate evidentiary medical examinations and forensic interviews with suspected child victims of physical and sexual abuse. She also assists the Director and Medical Director of MCAVIC in collaborations with MCH and LBMMC Administration. Other duties include collaboration with the Director on the annual budget, maintaining accurate units of service and admissions for the Center via MCH/LBMMC, maintaining employee data and patient medical files, and overseeing the daily office operations.

Ms. Benson has 20 years of experience at LBMMC and MCH. This experience includes work in the Payroll department for approximately 3 years as a payroll coordinator, processing payroll for more than 3000 employees as well as maintaining employee benefits for LBMMC. She spent 10 years in the Human Resources department where she analyzed, maintained, and distributed employee data information for over 3000 employees. Ms. Benson collaborated with Management regarding employment functions such as reviewing, interviewing, and processing new hires, assisted with employee separations from LBMMC, and participated in job fairs in the community. Prior to joining the staff of MCAVIC, she was Office Manager for two years for the department of Memorial Transitional Rehabilitation Services.

**Karianne Chen, M.S.**

Karianne Chen received her M.S. in Counseling: Marriage and Family Therapy in 2001, from California State University, Long Beach. During her graduate training, she completed her practicum at Miller Children's Abuse and Violence Intervention Center (MCAVIC) from 2000 to 2002. Ms. Chen was awarded a B.A. in Political Science from the University of California, Los Angeles (UCLA) in 1999. While an undergraduate student at UCLA, she volunteered for the Child Advocates Office of Los Angeles at the Los Angeles Superior Court, as a Court Appointed Special Advocate (CASA)/Guardian Ad Litem. In this role, Ms. Chen advocated for the best interest of children in dependency proceedings from 1998 until 2002.

While completing her graduate practicum at MCAVIC, Ms. Chen provided counseling to children and families. She also co-facilitated school-based counseling groups. From 2001 until 2002, Ms. Chen worked for the Los Angeles County Office of Education (LACOE), Employee Assistance Service for Education. As an employee assistance program (EAP) counselor, she worked with school district employees from over 30 school districts in L. A. County, providing crisis intervention, phone assessments, as well as individual, couples, and family counseling. Other duties involved providing stress management education and referrals for clients regarding legal, financial, and mental health services. She also developed a county-wide resource guide that was used for the participating school districts. In 2002, she joined the Drake Institute of Behavioral Medicine and Medical Associates as a case manager. There, she evaluated and treated children with Attention Deficit/Hyperactivity Disorder and learning disabilities. She also supervised a program treating auditory processing disorders and developmental language delays.

Since July 2003, Ms. Chen has held the position of full-time Child Therapist at MCAVIC. Currently, she provides individual and family therapy at MCAVIC as well as group treatment and crisis interventions in local schools. Ms. Chen helps coordinate the school-based counseling program at MCAVIC, providing consultations and training for school counselors, social workers, and teachers. At MCAVIC, she maintains a client tracking system of all agency and school-based clients. She has been instrumental in developing a database for client assessment data. She is also participating on the Research Committee at MCAVIC involving collaborative projects with the Chadwick Center of Children's Hospital, San Diego, a Category II site of the NCTSN. Ms. Chen is also a native of Norway and brings a special understanding of varied cultural backgrounds to her work at MCAVIC.

**Sara Dickes, Psy.D.**

Sara Dickes, Psy.D. has been a licensed psychologist since 2002. She received an M.A.in Clinical Psychology (1997) and a Psy.D. in Clinical Psychology (with an emphasis in Child and Family Psychology) in 2001 from the California School of Professional Psychology, Fresno, California. She earned a B.S. in Psychology and Sociology from Wayne State College, Wayne, Nebraska. Dr. Dickes also received a Pupil Personal Services (P.P.S.) Credential in School Psychology from National University, Costa Mesa, California in 2003.

From 2001 to 2003, Dr. Dickes held the position of full-time child therapist at Miller Children's Abuse and Violence Intervention Center (MCAVIC). Since 2003, Dr. Dickes has continued as part-time child therapist and supervisor of predoctoral psychology interns from The Guidance Center, for their MCAVIC rotation. At MCAVIC, she has provided numerous trainings to staff, trainees, and interns on play therapy for traumatized children, domestic violence, child abuse, and laws and ethics. Dr. Dickes has provided outreach and trainings to professionals of local schools and the Department of Children and Family Services (DCFS). She has also provided trainings on play therapy interventions for traumatized children and adolescents to students in the Marriage and Family Therapy program at California State University, Long Beach.

Dr. Dickes was a per diem counselor from 1996 to 1998 at Cedar Vista Psychiatric Hospital, Fresno, California. She provided milieu management, crisis management, and facilitation of peer and personal growth groups for child, adolescent, and adult inpatients. From 1997-1998, Dr. Dickes volunteered as a rape counselor at Rape Counseling Service, Fresno, California. She provided immediate support, informal counseling, and advocacy to women and children who had been sexually assaulted. In 1998, Dr. Dickes worked part-time as a school-based therapist at Tulare Youth Services Bureau, Tulare, California, providing individual and family therapy to children, adolescents, and familes.

Dr. Dickes completed her predoctoral child/adolescent internship in 1999 at the Greater Long Beach Child Guidance Center (now re-named The Guidance Center) in Long Beach, California. During the internship, Dr. Dickes provided psychotherapy and psychological testing for culturally diverse, disadvantaged children, adolescents, and their families. She completed clinical rotations at Jonathan Jaques Cancer Clinic at Miller Children's Hospital and MCAVIC. Following her internship (1999-2001), she worked part-time as a child therapist at MCAVIC providing individual and family therapy, as well as group treatment and crisis interventions in Long Beach Unified School District (LBUSD) schools. She was also a school-based therapist during that time at the Greater Long Beach Child Guidance Center.

Dr. Dickes has worked full-time as a school psychologist in a high school in the Jurupa Unified School District, Mira Loma, California since 2003. This high school is in a rural area and services mainly minority students (the majority are Latino) from disadvantaged backgrounds. Dr. Dickes provides outreach, crisis intervention, and psychological testing for special education programs.

**Carl Maida, Ph.D.**

Carl Maida, Ph.D. is Professor of Public Health at UCLA, where he teaches courses in culture and health, ethics, behavioral science, and health policy in the Schools of Dentistry, Medicine, and Public Health, and conducts studies of access to health care by children and families in immigrant communities and among persons living with HIV. Dr. Maida serves as Program Evaluator for MCAVIC and will continue as Program Evaluator for the proposed TSA Center. At UCLA Geffen School of Medicine, he conducts studies of the impact of terrorism and disaster on children's mental health and posttraumatic stress as a member of the National Center for Child Traumatic Stress (NCSTN). He received a B.A. in English from Syracuse University in 1969, an MA in Anthropology from the Graduate Faculty-New School for Social Research (1972), and a Ph.D. in Anthropology from UCLA in 1981. His post-doctoral research in the Department of Psychiatry and Biobehavioral Sciences at UCLA School of Medicine (1982-84), funded by the Helena Rubinstein Foundation, used psychometric and sociometric techniques to understand the adaptation of renal patients to Continuous Ambulatory Peritoneal Dialysis (CAPD), a new form of medical technology at that time.

A medical anthropologist, his research has included familial and peer influences in substance abuse, funded by the John D. and Catherine T. MacArthur Foundation; analyses of the coping styles of patients with lupus funded by the Joan B. Kroc Foundation and the Spencer Foundation of Chicago; access to oral health care in immigrant communities funded by the California Policy Research Center; and the resettlement of Mexican immigrants and of Salvadoran refugees in California, funded by the California State Department of Health Services.

Over the past decade, at UCLA Schools of Medicine and Dentistry, and the RAND Health Program, Dr. Maida served first as study director and subsequently as a co-investigator of a national health services research study of the HIV costs and care--HIV Cost Services Utilization Study (HCSUS) funded by the Agency for Health Care Research and Quality, the National Institutes of Health (NIH), and the Robert Wood Johnson Foundation. He was co-principal investigator of a study of ethnic cultural disparities in HIV oral health care in the HCSUS study population, funded by NIH. One co-authored paper on HIV that discussed perspectives and lessons from the HCSUS, notably its unique sampling design, was awarded "Article of the Year" by the Academy for Health Services Research in 2000.

Dr. Maida has conducted research on children's mental health and posttraumatic stress, co-authoring Children and Disasters (1999), and conducting ethnographic fieldwork in diverse ethnic communities in the greater Los Angeles area. His current community-based research focuses on the impact of community-scale crises on urban populations. These studies of how populations-in-transition adapt to such critical events will be presented in an edited volume, Sustainability and Communities of Place, to be published by Berghahn Books, Oxford in 2006, and in Common Worlds: Urban Risk and Civic Culture currently under editorial review. He has evaluated programs for children and youth in the areas of sexual abuse, access to health services, community-based learning, and environmental health. He is a Fellow of the American Anthropological Association and of the Society for Applied Anthropology, and serves as Chair of the Health Sciences Section of the American Association for the Advancement of Science/Pacific Division.

**William Saltzman, Ph.D.**

Dr. Saltzman is a nationally-recognized expert on the treatment of childhood and family trauma and bereavement, and on the development of school and family-based trauma interventions. Currently Professor of Counseling at California State University, Long Beach, Dr. Saltzman has been a staff member at MCAVIC since 2001 for the SAMHSA-funded Community Treatment and Services Center of the National Child Traumatic Stress Network (NCTSN). He provides supervision and training to staff, trainees, and interns as well as school-based interventions and direct clinical services at MCAVIC. He is also on staff at the National Center for Child Traumatic Stress at UCLA, co-directs the Family & Consumer Working Group, serves on the School Crisis and Recovery Unit, and is a core member of the Learning from Research to Clinical Practice Committee. Since 1995, Dr. Saltzman has developed, implemented, and evaluated a number of school-based trauma/grief programs in the United States and in countries impacted by war and disaster. These programs have identified traumatized youth and provided interventions for students and their families based on a manualized treatment protocol co-developed by Dr. Saltzman. He has also worked with school districts where severe violence has occurred on school campuses, including Columbine High School in Littleton Colorado, Thurston High School in Springfield, Oregon, and Santana High School in San Diego California.

Dr. Saltzman received his Ph.D. in Clinical Psychology from the University of Maryland (1995) following a predoctoral internship at the University of California, San Diego, Children's Hospital. His postdoctoral fellowship at the UCLA Neuropsychiatric Institute included work with children and adolescents in medical, outpatient, and inpatient settings. While at the National Institute of Mental Health, Child and Adolescent Division (1988), he co-authored the first widely used measure of community violence exposure and conducted some of the first large-scale screenings of violence exposure and post-traumatic distress in public schools.

Following the terrorist attacks of September 11, 2001, Dr. Saltzman worked closely with state and federal agencies in New York to help plan and implement wide-scale assessment and recovery programs after the attack on the World Trade Centers. His manualized program, the UCLA Trauma/Grief Intervention for Adolescents, was adapted for use by a consortium of mental health care providers in the greater New York area including Network Partners: North Shore University Hospital, St. Vincent's Hospital, Jewish Board of Family Services, and Safe Horizons. Dr. Saltzman continues to provide on-going training and case consultation to these NCTSN sites. Training and consultation regarding school-based interventions have been provided to other Network Partners including Children's Institute International and the Chadwick Center.

During the past two years, Dr. Saltzman has been developing family-based interventions for trauma and bereavement and the adaptation of these programs for military families. As co-Director of the Family and Consumer Working Group at the NCTSN, Dr. Saltzman is bridging the efforts of multiple family and consumer-focused working groups within the Network. He has recently co-developed an eight session family-based trauma treatment protocol which has been piloted at UCLA Medical Center and is being adapted for use at Camp Pendleton Marine Base for military families in which a parent has either been wounded or suffers from combat-related stress. NIH and private foundation grants are also supporting these efforts.

**Kathleen Watkins, Ph.D.**

Kathleen Watkins, Ph.D. is a registered psychologist who has held the position of full-time Child Therapist at Miller Children's Abuse and Violence Intervention Center (MCAVIC), Long Beach, California since 1999. She provides crisis interventions, advocacy services, individual, group, and family therapy to traumatized children, adolescents and their families at MCAVIC. She has provided school-based treatment services and training for teachers at 8 schools in the LBUSD. She is particularly knowledgeable in the area of culturally-appropriate interventions with clients who have experienced a wide range of traumatic experiences within a disadvantaged, minority context.

Dr. Watkins received her Ph.D. in Clinical Psychology (with emphasis in Ethnocultural Psychology) in 1997 and an M.A. in Clinical psychology in 1992, from the California School of Professional Psychology, Fresno, California. She was awarded a B.S. in Psychology from the University of Redlands, Redlands, California. She completed a predoctoral child/adolescent internship at the Morrison Center Child and Family Mental Health Program, Portland, Oregon, where she worked with all ages and ethnicities of children and adolescents. Dr. Watkins also received specialized training in child abuse and juvenile probation assessments. During her doctoral training, Dr. Watkins participated in several research projects such as a study of Attention Deficit-Hyperactivity Disorder among children and adolescents. She also participated in a research project investigating African-American attitudes and views toward mental health.

Dr. Watkins was the Director of the Bridge Ministry Counseling and Mentoring Program providing outreach counseling and mentoring to gang-challenged youth in communities afflicted with violence, in North East Portland from 1994 to 1997. She was also Adjunct Professor, Department of Sociology, Western Evangelical Seminary, Portland, Oregon from 1995 to 1996. From 1997 to 1999, prior to relocating to California, Dr. Watkins was Clinical Coordinator at Unity, Inc. Child and Adolescent Mental Health in North Portland, Oregon.

Dr. Watkins has received training in abuse-focused and trauma-focused cognitive behavior therapy from Drs. Judith Cohen and Anthony Mannarino, Center for Traumatic Stress in Children, Allegheny General Hospital, Pittsburgh, a Category II Center of the NCTSN. She has provided training on this manualized approach for staff, interns, and trainees at MCAVIC and continues to incorporate these interventions into the school-based groups with approaches also adapted from the manualized school-based trauma/grief program described previously co-authored by Dr. Saltzman and Dr. Christopher Layne.

Dr. Watkins has also served on the Board of Directors with the Long Beach Area Child Abuse & Domestic Violence Prevention Council from 1999 to the present. She collaborates extensively with multi-disciplinary and culturally diverse professionals in the Long Beach community to provide the most culturally appropriate assessment and treatment interventions with traumatized children and adolescents. She was the 2004 recipient of the Child Abuse Prevention award from the Long Beach Area Child Abuse and Domestic Violence Prevention Council.

*Job Descriptions*

**Miller Children's Hospital**
**Abuse and Violence Intervention Center (MCAVIC)**
**Director**

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The MCAVIC Director who will also be Co-Director of the MCAVIC-USC Child and Adolescent Trauma Program will be responsible for program development and administration, clinical supervision, research, training and community collaboration. Including administering and overseeing all operations of MCAVIC: clinical activities, general administration of program and interfacing with other members of the NCTSI, networking functions at all levels and training and community education, research activities, and required reports, etc.

**Quality**

A. Collaborate with MCAVIC Medical Director to ensure 24/7 availability of medical exams, forensic interviews, expert testimony, and child therapy.
B. Provide overall organization directorship of MCAVIC clinical, educational, research and administrative activities.
C. Develop outreach activities, collaboration strategies, and marketing plan to increase awareness of MCAVIC and its services.
D. Training and research development.
E. Participate in overall personnel management of MCAVIC staff.

**Hospital-Physician Relationships**

A. Collaborate with community agencies to investigate the opportunities to participate in violence prevention/treatment programs. Develop other means of collaboration to enhance the available services throughout the community.
B. Lead the development and activation of the SCAN committee at Miller Children's Hospital (MCH)/Long Beach Memorial Medical Center (LBMMC).
C. Collaborate with Medical Director to provide medical staff, house staff and other health professionals and medical students with instruction in clinical and research approaches to child maltreatment issues.

**Cost Effectiveness**

A. Preparation of the annual operating and capital budgets for MCAVIC.
B. Achieve annual budget targets.
C. Explore and develop other sources of funding.

**Harmony in Governance**

A. Provide supervision of all staff including therapists, office management, interns, and volunteers.
B. Collaborate with MCH administration.

**Requirements**

Licensed Clinical Psychologist with minimum of five years in administration for major medical center.

*Job Descriptions*

**Miller Children's Hospital**
**Abuse and Violence Intervention Center (MCAVIC)**
**Child Therapist**

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**Purpose Statement/Position Summary**
To provide clinical evaluations and treatment services to suspected victims of child abuse, family and community violence, medical trauma; and appropriate family members. Participates and collaborates with community child protection activities.

**Essential Job Outcome & Functions**
Effective performance in providing treatment services. Children and families experience positive outcomes with regard to recovery from symptoms and are able to establish healthy functioning patterns. Patients and families acquire skills to prevent further victimization.

**Job Specific Competencies**
Effectively evaluates and intervenes in crisis situations.
Consistently meets MCAVIC and legal standards in reports of and Intervening with situations involving suspected child abuse and other safety issues.
Completes thorough assessment of all needs for clients referred.
Effectively collaborates with other professionals and agencies in coordinating services for clients.
Ensures child clients receive all necessary interventions in appropriate manner
Effectively interfaces with community agencies and schools; participates in continuous quality improvements studies.
Completes appropriate referral forms and maintains chart documentation for all client services.
Consistently demonstrates ethical and professional behavior in all interactions with clients and other professionals; enhances relationships with community agencies; facilitates positive interactions among multidisciplinary team members.
Consistently demonstrates ability to incorporate supervisory feedback.

**Minimum Requirements/Work Experience**
Three to five years' experience providing evaluation and treatment services to children and families traumatized by abuse and violence is required.
Experience in treating children and adolescents impacted by sudden parental loss, medical procedure and/or other traumatic events would also be considered relevant to this program.
Spanish speaking preferred but not required.

**Education/LICENSURE/Certification**
Licensed or license-eligible with a MSW, MA or Ph.D. from an accredited program in Clinical Social Work, Marriage/Family Therapy or Clinical Psychology.

*Job Descriptions*

**Miller Children's Hospital**
**Abuse and Violence Intervention Center (MCAVIC)**
**Community Coordinator**

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**Purpose Statement / Position Summary**
Provides direct oversight of all office systems to ensure efficient operation of the Miller Children's Abuse and Violence Intervention Center (MCAVIC). Supports and facilitates fund raising and grant management. Coordinates outreach and collaboration within Miller Children's Hospital and community agencies. Maintains environment and information systems according to hospital and grant requirements to ensure compliance with regulations. Oversees general operations on site, including staff scheduling all department communications, to facilitate prompt, appropriate patient care and systems flow.

**Coordinated efficient delivery of services and administrative functions at MCAVIC.**

1. Collaborates as primary administrative liaison between MCAVIC and Miller Children's Hospital Administration.
2. Collaborates with the Director of MCAVIC and LBMF staff in writing and submitting grant applications for funding.
3. Ensures consistent, effective communication with foundations and government entities that provide funding for MCAVIC.
4. Ensures collaboration with the Director of MCAVIC that all reports associated with grants, budgets, and protocols are submitted in a timely and accurate manner.
5. Collaborates actively with MCAVIC staff with Center-based projects such as: Community Outreach.
6. Coordinates within MCAVIC forensic interviewer increased inter-agency collaboration.
7. Actively facilitates expansion of services through outreach and collaborations with outside agencies and MCH inpatient/outpatient departments.
8. Facilitates a positive work environment with staff, patients, and collaborating professionals. Facilitates efficient and courteous delivery of services to all patients.
9. Coordinates with the MCAVIC Director all Human Resources Functions.
10. Facilitates efficient and courteous delivery of services to all patients.

**Uses age specific interventions for the infant, child, adolescent and adult when dealing with both patients and staff.**

**Additional responsibilities:**

1. Attends department specific staff meetings, in-services, education and training.
2. Participates in department specific Performance Improvement Projects.
3. Participates in leadership or committee activities as assigned.
4. Participates in orientation and development of students and/or new staff as assigned.

**Minimum Requirements / Work Experience**

A. At least five years experience in administration coordination, collaboration with community agencies, and office management in a best practices outpatient children's clinic setting.
B. Extensive experience with computer operations.
C. Excellent interpersonal and communications skills required.

The Organization-wide Mandatory Requirements and Organizational Exceptions are required for all employees and are on a separate list available from Human Resources and all departments.

**Section H: Confidentiality and SAMHSA Participant Protection/Human Subjects**

**Confidentiality and Participation Protection:**

**1. Protect Clients and Staff from Potential Risks:**
Psychological risks involve discussing traumatic experiences and the resulting thoughts and feelings which may accompany these events. These may include feelings of anxiety, depression, anger, guilt, shame or general dysphoria. The thoughts may include; thoughts, memories, and images about a traumatic event(s). These thoughts may then result in the above stated feelings. Risks from experiencing these thoughts or feelings may also result in behavioral disturbances such as aggression, defiance or oppositionality. Physical and medical risks that may result from these experiences could consist of headaches, stomachaches, nausea, or other somatic reactions. Foreseeable legal risks may involve mandated reporting obligations which would involve the Department of Children and Family Services (DCFS) and/or law enforcement agencies. This may result in bringing abuse and violence issues to the forefront of family issues and result in a stressor placed upon the family. Disclosure of abuse may also result in a social risk to the family and child as a result of increase involvement in child safety or law enforcement systems. Such a risk may consist of shame and guilt surrounding exposure of family problems to these other systems. The benefit however of protecting children in potentially abusive situations outweighs these stated risks. The treatment team will work towards supporting families in these situations to minimize these risks. The risk associated with the data collection activity of the NCTSN Data Core and any data collection activity is loss of confidentiality. However, the data will be provided to the NCTSN Data Core as a limited data set with no direct identifiers. A log linking indirect identifiers with direct identifiers for all data collection activities will be established but only the MCAVIC study team will have access to this log which is kept in a locked facility.

Risks to staff include vicarious traumatization from working with individuals who have experienced traumatic events. This may result in experiencing symptomatology consistent with the experiencing of a traumatic event. Supervision, debriefing, stress management, collegial support, and training will be utilized to minimize this potential risk factor.

The evaluation activities involve paper and pencil measures identifying trauma related symptoms; risks may involve experiencing trauma-related symptomatology as described above.

Confidentiality will be maintained for all participants in the study, which includes for all assessment information, therapy information and related information obtained from other collateral sources. Any information obtained pertaining to the client and significant other will be held in confidence. Consistent with the law, there are limits to this confidentiality and include reports of any kind of physical, sexual, or emotional abuse or neglect, statements that a client is a danger to themselves, or a danger to others. The appropriate reporting agency or person will be contacted in these situations. This will also include participant agreement to the following statement on the informed consent, “I understand that any information about me or my child obtained from this research will be kept strictly confidential, and my child’s name and personal information will never be identified in any report or publication unless I sign a release. Information regarding my child’s therapy records, just like hospital records, may be subpoenaed by court order. I consent to the publication of study results as long as the information is

anonymous and/or disguised so that identification cannot be made. I also understand that authorized representatives of MCAVIC may examine my records, and there will be no breach of confidentiality."

Participants experiencing any adverse effects will be initially assessed by the therapist to evaluate for further services that may be needed. Therapists will work closely with clients to provide skills to manage thoughts and feelings, such as those stated above that may arise as a result of talking about their experiences. The appropriate interventions will be used to provide support to clients who experience these effects. This may involve individual therapy, more frequent sessions, phone contact, or family interventions. In case of physical or medical side effects an appropriate referral will be made to a medical physician to rule out organic causes of symptoms and evaluate continued appropriateness for involvement in the program. In the case of reporting issues, support will be provided to the family to minimize the stressors that may arise due to involvement or investigation from other systems such as law enforcement or the DCFS. These services may involve phone consultation/ support, family therapy, individual therapy, advocacy, referral services, letters or other support services. This will also involve agreement with the following statement on the informed consent form in the event of research studies:

"I recognize that the primary risk is the possibility of experiencing some side effects. Those that have been observed in the past include experiencing negative emotions such as anger, sadness, or fear in association with traumatic memories or thoughts. If I have any side effects, I will report them immediately to my therapist or his/her associates. If side effects are severe, I may be removed from the study. I will be closely monitored by my therapist and his/her associates for any unforeseen side effects."

Alternative treatments may involve pharmacological treatment, in which case the client would be referred for a psychiatric consultation at MCAVIC from the child psychiatry fellow newly hired for this proposed TSA Center. Other treatments may involve higher levels of care such as inpatient hospitalization, system of care programs, day treatment programs or more intensive interventions. The appropriate referral will be made in cases in which the program cannot adequately address the treatment needs or the needs can more appropriately be addressed at another facility. In these cases the participant will be made aware of alternative interventions via referral to other appropriate agencies.

They will also agree with the following statements on the informed consent form detailing lack of benefits.

"I understand that if no benefit is occurring from this treatment, I will be informed of this, the treatment will be stopped and further treatments will be discussed at that time. If any new information about any of these treatments develops or any other new treatment for my condition is discovered, my therapist will inform me."

"My therapist has fully and clearly explained to me the risks associated with this study, and my alternatives. Although it is impossible for the therapist to inform me of every possible complication that may occur, he/she has satisfactorily answered all of my questions."

**2. Fair Selection of Participants:**
The target population includes children from preschool age (3 years old) to adults aged 21years as primary clients with the majority being elementary school-aged to high school-aged clients. The participants will include both genders and all racial/ethnic backgrounds. The predominant racial/ethnic background of the participants will be Latino, African/American, Asian, Caucasian, and Pacific Islander. The target population will include children and adolescents who have been traumatized by: child abuse, including physical and sexual abuse; traumatic bereavement from loss of family members, friends and other significant attachment figures; medical trauma, including physical injuries or incapacitation, chronic, severe, or painful medical conditions, or invasive or painful medical procedures; and interpersonal violence, including witnessing or experiencing domestic, community, or criminal physical/sexual violence. Appropriate family members such as parents will also participate, except those who may be alleged offenders of child sexual abuse. The population served will include foster children, children of substance abusers, pregnant women and individuals with HIV/AIDS. Pregnant women will be included as participants since they may be caretakers, and the majority of caretakers of referred traumatized children and adolescents will participate in treatment. Pregnant teens will receive services since the targeted population is at risk for teen pregnancy; pregnancy may also have resulted from a sexual assault. The use of children and adolescents as participants coincides with the mission of the National Child Traumatic Stress Initiative to provide optimal therapeutic services to help alleviate the effects of trauma and abuse in children, adolescents, and families. Also, the proposed TSA Center has the expertise to provide services for these participants in the Project, will include outpatient center of a Children's Hospital, and has strong collaborative relationships with community agencies and schools that provide referrals of this target population (See Appendix 1).

Participants will be recruited through the identification, evaluation, and assessment process. Clients who do not meet criteria will be excluded from the treatment and depending on individual issues referred to other applicable resources. The treatment interventions are designed to help those children and adolescents with trauma-related issues. Those excluded would not necessarily benefit from the trauma-focused interventions. Hence, the participants will meet criteria regarding the experiencing of traumatic events, have significant trauma-related symptomatology, or be at risk for experiencing trauma. The selection of participants will occur through a collaborative process with therapist and supervisor using all available assessment and background information. A determination for program involvement will be made with this information.

**3. Absence of Coercion:**
The participants in the program are voluntary and also mandated by court orders (e.g., parenting classes, individual and family therapy). The participants do not receive any monetary compensation for their participation in the program. Individuals who participate in the school group programs can earn small token rewards for participation in the group programs. Absence of coercion involves agreeing to the following statements on the informed consent form,

"I understand that my child's participation in this study is voluntary. I may decide not to have my child participate, or I may withdraw my child from the study at any time, without penalty or loss of benefits in his/her psychotherapeutic care to which they might otherwise be entitled. If I

do decide to have him/her leave the study, I agree to contact the therapist and inform him/her of my decision. If at any time my therapist feels that further participation in this study is not in my child's best interest, he/she may withdraw from the study."

"I understand that I will receive no monetary compensation for participating in this study"

Volunteer participants may continue to receive services or appropriate referrals even if they do not complete a particular data collection component of the Project. Participants and clients will be informed of this during the informed consent process as stated above.

**4. Data Collection:**
Data will be collected from the participants themselves as well as other significant persons in the participants' environment. The data will consist of paper and pencil measures completed by the participant, the participants teacher and parent and/or guardian. Data will also consist of interviews with the participant and participant's parent(s) and teachers. The data will also involve observations of the participant in the classroom. The psychological assessments will consist of the Trauma Symptom Checklist for Children (TSCC), Trauma Symptom Checklist for Children-Alternate (TSCC-A), the Children's Depression Inventory (CDI), The Achenbach Child Behavior Checklist (CBCL) parent, teacher, and youth report forms, the Trauma Symptom Checklist for Young Children (TSCYC), the UCLA Reaction Index-Revised, the Trauma Symptom Review for Adolescents (TSRA), and when appropriate, the Child Sexual Behavior Inventory (CSBI). See Appendix 2 for data collection instruments. The data will be collected by the therapists at the school or clinic as appropriate and be used for clinical assessment of clients. The data will be used to tailor the treatment program for individual participants as well as assess the overall efficacy of the program. The data will be secured in a locked facility in a locked room at MCAVIC. In the event of research studies or publications, the participant will also be provided with the following information as part of informed consent,

"This proposal has been reviewed and approved by the Memorial Health Services Institutional Review Board (MHS Research Council) composed of physicians and laypersons. If I have any questions about my rights as a research subject, a treatment-related injury, or desire further information concerning the availability of compensation or medical treatment, I may contact, Harris Stutman, M.D., Executive Director of Research Administration, Office of Research Administration, Memorial Health Services, at (562) 490-3737."

"I understand that if I have any further questions during the course of this study, I should contact Dr. Cheryl Lanktree, Ph.D. and/or her associates at (562) 933-0590."

**5. Privacy and Confidentiality:**
Privacy and confidentiality will be maintained in the following ways. Data will be collected by the child therapists during the assessment and evaluation phase of the treatment program. The data will be collected from the participants as well as from teachers and parents at these times. The data will be collected at 4 month intervals at MCAVIC and at 3 month intervals at schools for clients participating in treatment. The data will be collected via the self-report and questionnaire measures described above. The data collection instruments will be administered either individually or occasionally, in groups in the school setting group, but always while

maintaining confidentiality of responses. The data will be used to assess client appropriateness for intervention and involvement in the program, to tailor individual interventions specifically to the concerns of the client, and to assess the overall effectiveness of the treatment program. The data will be stored in a locked room at MCAVIC. The identity of the participants will be kept private by using a coding system for all of the data. When the data is being used as part of the individual treatment plan, the therapist will be able to identify the participant in order to tailor treatments effectively. All data gathered at the agency is entered into a database subsequent to collection. Only a few MCAVIC staff members are involved in this process and the database is password protected and in a locked facility. When data is entered into the database, the participant is given a unique identification number or indirect identifier. This indirect identifier is used for all studies and/or research purposes to protect confidentiality and participants' privacy. For the purpose of the data collection activity, the data provided to the NCTSN Data Core from this database is provided as a limited data set with no direct identifiers. A log linking indirect identifiers with direct identifiers for all data collection activities will be established but only the MCAVIC evaluation team will have access to this log which is kept in a locked facility.

**6. Adequate Consent Procedures:**

The participants and participants' parent/guardian who participate in the project will be provided with information regarding the purpose and rationale of the program, the expected risks and benefits, and information regarding the use of the assessment measures for intervention and research purposes. The privacy of the data will be explained to participants as being held confidential. The consent forms will indicate that participation is voluntary and that participants are free to leave the project at any time. Further, the consent forms will describe the potential risks and benefits from the project and plan to address these risks should they arise. These consent forms will be available in the parent's/child's' native language and will be explained or read if needed. These consent forms will be in written form and must be signed prior to any assessment or intervention. The therapist obtaining consent will also address any questions that the participant has and will ask follow-up questions to make sure the participant is adequately informed. The participants can be provided with copies of the informed consent forms. A copy of the consent for treatment will be kept in the client's chart.

The participant will be provided with consent forms that will describe the intervention, the data collection activity component as well as research aspects of the program, if applicable. Separate consents will be used for participation in treatment interventions, participation in research projects, and for the data collection activity of the NCTSN Data Core. If the participant withdraws from the program and at a later date decides to become involved again, a new consent form will be obtained. Those individuals not wanting to have any information identified will be able to participate in the program, but data will not be reported from them. A participant that does not want to complete any of the assessment materials, however, will be referred to another appropriate service as the assessment process is considered a part of the treatment. Without assessment information inclusion/ exclusion criteria for the client cannot be attained. When participants are providing consent for research studies beyond clinical interventions, they will also be provided with the following information on the informed consent,

"I certify that I have read the preceding, or it has been read to me, that I understand its contents, and that any questions I have pertaining to the preceding have been, or will be answered by my

therapist and/or his/her associates, and that my permission is freely given. I have been given a copy of this consent form along with a copy of the "Rights of Human Subjects in Medical Research," and I consent to have my child participate in this study."

Prior to information being exchanged with another collaborating agency, treatment provider, or school personnel, the participant and the participant's parent, legal guardian, or authorized representative of the participant will be asked to sign a consent for this release of information. Signed consents will be required before any information regarding the client(s) is released. The consent includes the specific information that will be disclosed or is being requested of another agency and with whom the information is being shared. See sample consent forms in Appendix 3. Under certain circumstances as determined by legal statutes for the State of California, an older minor (e.g., who is a victim of alleged sexual abuse or assault) may be able to sign this type of consent and consent for intervention, without the consent of a parent or legal guardian. Consent for treatment of the minor, from the appropriate parent or caretaker would still be pursued, as is clinically appropriate. There is also an option provided on the consent to complete an expiration date. Clients are informed that they may revoke the consent at any time by written notification to the project.

**7. Risk/Benefit Discussion:**

The risks associated with the project involve possibly experiencing negative emotions or thoughts in relation to discussing past traumatic experiences. However, this risk is also important in the treatment process. Individuals who experience negative feelings in response to past traumatic material will have the opportunity for support in a safe environment when this occurs as well as learn new skills to be able to cope with these experiences. It is also a part of the recovery process. The benefits of participating in this project will provide the investigators with knowledge on how best to treat and work with individuals who have been exposed to numerous types of trauma. The benefits of participating in this project and the data collection activity of the NCTSN also include contributing to learning how the NCTSN can better help children, adolescents, and families that have experienced trauma. Moreover, the benefits include a contribution to the field of trauma and psychology with the potential for publication of research articles on outcome data collected through this proposed TSA Center.

**Protection of Human Subjects Regulations**

Regarding the process for obtaining Institutional Review Board (IRB) approval, materials have been procured from the MCH/LBMMC IRB for the purpose of this treatment effectiveness evaluation. Regarding the data collection activity of the NCTSN Data Core, MCAVIC has received consultation from the IRB and is in the process of submitting a proposal to the IRB Committee. IRB approval will then lead to the submission of the signed Data Use Agreement to the NCTSN Data Core and data can then be transferred to the Data Core and be used for cross-site evaluations. If funded as a TSA Center, the other collaborative partner, USC would also submit applications for IRB approval.

**Appendix 3: Sample Consent Forms**

**Miller Children's Intervention Center / Miller Children's Hospital**
**Sample Informed Consent to Participate in an Intervention and Research Study**

Your child has been selected to participate in a special program for children. This program will be facilitated by a child therapist from Miller Children's Intervention Center, Miller Children's Hospital in affiliation with your child's school. The program may involve either a group counseling component, individual psychotherapy services or both.

The groups will focus on helping children to be more successful in the classroom and at home, and will include topics such as anger management, problem solving, self-esteem, personal safety, family issues, social skills, and other related issues. In order to measure the helpfulness of these groups and determine whether this program will best serve your child's needs, the children will complete questionnaires at the beginning and end of the group.

Sometimes when children talk about these topics, feelings may arise that can be distressing. If this happens, you will be contacted, and extra support will be provided for your child. Also, if a child shares information indicating a safety concern including the child's physical safety, the therapist will take appropriate steps to protect the child.

The counseling groups will be held at the designated school site, typically once per week for 50 minutes. The individual therapy services will be held at our clinic or at the school one time per week.

As part of the evaluation process and to identify treatment progress the participants are assessed at least at the beginning and end of the treatment and periodically throughout the treatment. The data that will be collected is part of a larger research project designed to identify the best ways to help children who may be experiencing difficult thoughts and feelings. A research component is a part of this program and will be further described below. In order to participate, agreement with the following is required.

I understand that my child's participation in this study is voluntary. I may decide not to have my child participate, or I may withdraw my child from the study at any time, without penalty or loss of benefits in his/her psychotherapeutic care to which they might otherwise be entitled. If I do decide to have him/her leave the study, I agree to contact the therapist and inform him/her of my decision. If at any time my therapist feels that further participation in this study is not in my child's best interest, he/she may withdraw from the study.

I understand that if no benefit is occurring from this treatment, I will be informed of this, the treatment will be stopped and further treatments will be discussed at that time. If any new information about any of these treatments develops or any other new treatment for my condition is discovered, my therapist will inform me.

My therapist has fully and clearly explained to me the risks associated with this study, and my alternatives. Although it is impossible for the therapist to inform me of every possible

complication that may occur, he/she has satisfactorily answered all of my questions. Any medical treatment that is required as a result of a physical injury related to this study, is not the financial responsibility of Miller Children's Intervention Center / Miller Children's Hospital.

I understand that any information about me or my child obtained from this research will be kept strictly confidential, and my child's name will never be identified in any report or publication. Information regarding my child's therapy records, just like hospital records, may be subpoenaed by court order or may be released with my signed consent. I consent to the publication of study results as long as the information is anonymous and/or disguised so that identification cannot be made. I also understand that authorized representatives of SAMHSA / MCAVIC may examine my records, and there will be no breach of confidentiality.

I understand that I will receive no monetary compensation for participating in this study.

This proposal has been reviewed and approved by the Memorial Health Services Institutional Review Board (MHS Research Council), which serves as the IRB for MCH, which is composed of physicians and laypersons. If I have any questions about my rights as a research subject, a treatment-related injury, or desire further information concerning the availability of compensation or medical treatment, I may contact Harris Stutman, M.D., Executive Director of Research Administration, Office of Research Administration, Memorial Health Services, at (562) 490-3737.

I understand that if I have any further questions during the course of this study, I should contact Dr. Cheryl Lanktree, Ph.D. and/or her associates at (562) 933-0590.

I certify that I have read the preceding, or it has been read to me, that I understand its contents, and that any questions I have pertaining to the preceding have been, or will be answered by my therapist and/or his/her associates, and that my permission is freely given. I have been given a copy of this consent form along with a copy of the "Rights of Human Subjects in Medical Research," and I consent to have my child participate in this study.

Participant's Signature _____ Date _____ Time _____

Witness to Participant's Signature _____ Date _____ Time _____

If the subject is a minor, or otherwise unable to sign, complete the following:

a) Reason subject is unable to sign:_____

_____

b) _____Date _____ Time _____
Signature of Authorized Person

_____

Relationship and Basis of Authorization to Give Consent

For the Investigator or Designee:

I certify that I and/or my associates have reviewed the contents of this form with the persons signing above, who, in my opinion, understood the explanation. I have explained the known side effects and benefits of the research.

I also certify that I am the Prinicipal Investigator or Co-Investigator, and am responsible for this study, for ensuring that the subject is fully informed in accordance with applicable regulations, and for advising the Human Subjects Committee of any adverse reactions that may develop from this study.

_____ _____ _____

Principal Investigator or Co-Investigator | Date | Time

**Assent Form**
(Children 7-18 years)

Name: _____ Date: _____

You understand and have had the following things explained to you:

_____ 1. How trauma can effect children in different ways

_____ 2. That your therapist wants to learn more about how children play, learn, talk and listen after they have experienced traumas

_____ 3. That your therapist and his/her helpers will want to know about you.

_____ a. They may need to look at your records (chart)
_____ b. They may ask you to do different things such as fill out questionnaires, play with toys and talk about your family, friends, and school
_____ c. Some of these activities will be like the ones teachers do in school.
_____ d. These activities may take ½ to 2 hours.

_____ 4. That you may ask questions about what your therapist and his helpers are doing.

_____ 5. That if you feel tired or do not want to do the activities, you may stop. The therapists, helpers, and your parents may stop the activities if they want.

_____ 6. You may keep a copy of this paper.

_____ 7. Your therapist is Dr. (add P.I.'s name). You can call him/her at (add telephone number)

_____ _____ _____ _____
Signature of Patient Time Signature of Investigator Time

**Appendix 4: Letter to the SSA**

**Appendix4: Letter to the SSA**