Safe Horizon Center for Child Trauma Treatment and Innovation

Safe Horizon’s Center for Child Trauma Intervention (CCTI) provides innovative, evidence-based treatment and services to traumatized children and adolescents, up to 21 years of age, in New York City. Our goal is to create agency- and city-wide opportunities to enhance the capacity for identification and response to child trauma at every level of contact – crisis, education and support, mental health treatment – no matter how emergent or brief.

With over 27 years of experience, Safe Horizon is the nation’s leading victim assistance agency, assisting more than 350,000 women, men, children and families each year. Our programs and services are available across New York City, through 100 programs in 80 sites located in neighborhood-based community offices, shelters, child advocacy centers, courts, police precincts, and schools. The target population of Safe Horizon's CCTI includes youth who have developed significant emotional or behavioral difficulties following exposure to a traumatic life event, such as physical and sexual abuse, domestic and community violence, stalking, homicide, and terrorist attacks.

With SAMHSA funding, Safe Horizon will enhance and expand CCTI by: adapting and implementing a range of evidence-based engagement and treatment models to best respond to diverse groups of traumatized children and youth (treatment models include trauma-focused CBT and SPARCS model); developing evaluation measures to monitor and assess the effectiveness of these models; creating implementation manuals for our Streetwork and Safe Harbor service models; and building internal and external networks of service providers, consumers and other stakeholders to build consensus, inform the adaptation and implementation of models, promote access to child trauma services, and create a culture of evidence-based child trauma practice throughout New York City. SAMHSA funding will also allow Safe Horizon to implement a multifaceted sustainability plan to incorporate the CCTI's products and services as permanent features of our range of services for children and families.

The CCTI’s activities will further extend the reach and mission of the National Child Traumatic Stress Network. The CCTI will significantly increase the availability of culturally competent, evidence-based child trauma services in the New York City area. Through this project, the skills, ability and expertise of the CCTI and its staff will be greatly increased, the knowledge we gain first-hand through service provision will provide crucial feedback to our NCTSN partners, and the community planning and consensus-building activities will expand the knowledge base and understanding of child trauma issues among a wide range of child and youth serving programs and systems.

Safe Horizon is an excellent example of what it means to be a Community Treatment and Services Center. Our extensive collaborations with a wide array of service providers in New York City allow us to effectively expand the reach of trauma-informed services to a large number of children. Safe Horizon understands that the need to provide a wide range of intervention services – from primary prevention to tertiary care – is the true mark of an effective trauma services organization. Our collaborations with community providers, child protective services, law enforcement, schools, and other youth-serving organizations and systems make Safe Horizon uniquely positioned to provide both preventive and treatment models to children.

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Section A: Statement of Need and Readiness. New Haven is consistently ranked among the poorest cities in the U.S. By 1999, the median household income for New Haven County was $48,834 compared to $53,935 for Connecticut. In 2002, 11 percent (11%) of greater New Haven residents lived in poverty compared to 7.9% for the State (U.S. Census Bureau, 2001.). Eighteen percent (18%) of the households in New Haven County received means-tested public assistance or non cash benefits (American Community Survey Profile, 2002.) New Haven County also ranks 4th by percent of multi or bi-racial population in the whole state (U.S. Census Bureau, 2001.) In 2002, New Haven County had a household population of 808,000 inhabitants. 26% percent of the population were under 18 years and 13% were 65 years and older. The majority of the geographical area that Clifford Beers Clinic (CBC) serves is New Haven, North Haven, West Haven, East Haven, Hamden, Branford, Guilford, Madison, North Branford, Bethany, Woodbridge, Clinton and Orange. The City of New Haven has a population of 123,626. Of this, 47.9% (59,185) is male and 52.1% (64,441) is female. 43.4% (53,723) are white, 37.4% (46,181) are African-American, and 26,443 (21.4%) identify themselves as Hispanic. 25.4% of the population (31,446) is under the age of 18. According to the U.S. Census Bureau’s most recent figures, the Latino population has grown significantly: between April 2000 and July 2002, there was a 9.8% increase in the Latino population nationwide. Immigrants accounted for approximately 53% of the increase. In New Haven, Connecticut, the Latino population increased by 9,200, or 54%, making it the third largest in the state. Based on population data for the City of New Haven for the year 2000 there was a total of 31,446 children/youth under the age of 18 years. Of that number, 9,731 (31%) were Latino.

Numbers Served: The proposed program projects that 185 children and families will be served during Year 1, and over 200 will be served in Year 2. In terms of demographics, it is expected that they will closely mirror the demographics of the trauma-service victims that the Clinic currently serves 44% female, 56% male; 37% African American, 19% Hispanic (approximately 5% will be monolingual) (CBC clinic as a whole serves 1500 children and their families per year).

The major portion of the Latino population targeted by this grant proposal reside in the Fair Haven neighborhood of New Haven, Connecticut. According to the 2000 Census, the Fair Haven section has 3,348 family households. 30.8 percent of Fair Haven family members are under the age of 18.

The common types of urban distress found in many of the neighborhoods of New Haven include unemployment, business flight, dilapidated and abandoned houses. Risk factors are exacerbated by societal factors that contribute to criminal and violent attitudes and behavior, including poverty, easy availability of guns, racial and other prejudice, and exposure to violence in the mass media. Individuals with histories of violence, abuse, and neglect from childhood onward make up the majority of clients served by public mental health and substance abuse service systems. For example, 90% of people attending public mental health clinics have been exposed to (and most have actually experienced) multiple experiences of trauma (Goodman, Rosenberg et. Al., 1997; Muesser et. Al., 1998). 65% of all children at intake at CBC are identified as having been exposed to trauma; the numbers increase as treatment proceeds. 75% of women and men in substance abuse treatment report abuse and trauma histories (SAMHSA/CSAT, 2000). 97% of homeless women with mental illness experienced severe physical and/or sexual abuse, 87% experienced this abuse both as children and as adults (Goodman, Dutton, et. al., 1997). 55% of consumers and former consumers with a dual diagnosis of both mental illness and substance abuse report histories of physical and/or substance abuse (Maine Department of Behavioral and Developmental Services, 1998). Teenagers with alcohol and drug problems are 6 to 12 times more likely to have a history of being physically abused and 18-21 times more likely to have been sexually abused than those without alcohol and drug problems (Clark et. Al., 1997). 82% of all adolescents and children in continuing care inpatient and intensive residential treatment programs in the state of Massachusetts were found to have histories of trauma as reflected by a point-in-time review of medical records (LeBel J, Stromberg, N, 2004).
Nearly 8 out of 10 female offenders with a mental illness report having been physically or sexually abused (Smith, 1998).

Some risk factors for being exposed to violence are as follows: **Poverty:** Living in poverty is a risk factor. 20.5% of the families in New Haven live below the poverty level. (Census 2000). 27,613 individuals, or 24.4% of the population of New Haven, live below the poverty level (Census 2000). In addition, 66.5% of all students enrolled in the New Haven School District lived in households at or below 185% of the federal poverty rate, as indicated by eligibility for the federal free/reduced price meal (F/RPM) program. (CT Department of Education, New Haven Strategic School Profile, 2003-04). **Education:** According to most experts, it is virtually impossible to obtain a job that has a career track without a high school diploma. New Haven’s cumulative four year dropout rate for the Class of 2003 was 17.7%, compared to a statewide average of 9.5%. (CT Department of Education, New Haven Strategic School Profile, 2003-04). **Employment:** The City of New Haven has an unemployment rate of 5.2% as of March 2005. While this is not excessively high, it has increased from a rate of 4.1% as of October 2004. (Bureau of Labor Statistics) **Housing:** Lack of affordable housing options often results in families’ doubling up with relatives or friends, a situation that leads to overcrowding, a factor associated with domestic violence, substance abuse and other problems. Children who are homeless or living in emergency shelters have also been found to be at increased risk. New Haven has a low home ownership rate. 29.6% of housing units in the City of New Haven are owner-occupied. 70.4% of the housing units are renter-occupied. (Census 2000).

Although the State of Connecticut ranks 6th in the nation on child well being, 3rd lowest child poverty rate and 4th lowest teen violent death rate, (2003 KidsCount Report) there are important disparities between Connecticut’s affluent communities as compared to its less affluent towns and cities. The youth poverty rate varies in the state, (0% in 14 towns, over 20% in others). In New Haven the youth poverty rate is 32% (CT Voices for Children, 2003). 79% of the 1500 children served at Clifford Beers are eligible for the State’s Husky A (Medicaid program) which makes these families 185% below the national poverty level. The rates of abuse and neglect vary from city to city in the State of Connecticut. In the towns with higher annual incomes, the rates are lower compared to the national averages, and for those urban setting cities (as New Haven) the rates of abuse and neglect are higher. The Connecticut Department of Public Safety reported nearly 21,000 incidents of family violence in Connecticut in 2001. Children and youth were directly involved in 19% of these incidents and were witnesses in 24%. In New Haven alone, 1,645 arrests were made for family violence in 2001, with children present and/or involved in over 42.5% of these incidents; 249 children were reported as victims of family violence. (Annual Family Violence Report, 2001, Connecticut Department of Public Safety, Division of State Police). In the Report on the Social and Health Assessment (SAHA) of New Haven Public Schools (2000-1), 57% of 6th graders and 62% of 8th graders reported witnessing incidents of violence. There is a clear relationship between family income and maltreatment. 40-50% of all maltreatment cases occur in the 15% of families earning less than the poverty level. Another 40-50% occurs in the 35% of families that earn above the poverty level but below the median income. (Bloom, Sandr L., “Trauma and Recovery: A Bio-Psycho-Social Model for Understanding Family Violence”: Accessed from the website http://cpap.phillypeds.com/docs/CHOPPediatrics.pdf on 5/14/05)

Child abuse and neglect has long-term physical, emotional and social effects on a child. The Commonwealth Fund Survey of the Health of Adolescent Girls found that about half (46%) of abused girls had depressive symptoms, more than twice the rate of girls who had not been abused. Rates of smoking, drinking and using drugs were twice as high for abused girls; a third of the girls reported binging and purging. Abused girls’ apparent efforts to self-medicate are likely to have negative effects on their health. Compared with other students, those students who reported a history of child abuse were twice as likely to get into fights; twice as likely to get into trouble with police; twice as likely to damage other’s property; twice as likely to be a below-average student; 3 times more likely to have been a member of a gang; 3 times more likely to use hard drugs; 5 times more likely to carry weapons; and 6 times more likely to have attempted suicide. (The State of Connecticut’s Youth 2003, Connecticut Voices for Children).
For the Federal Year 2003, an estimate of 2.9 million referrals alleging child abuse and neglect were accepted into state and local child protective services (Child Maltreatment, 2003). In 2003, approximately 906,000 children were determined to be victims. 20% physically abused, 10% sexually abused (90,600) and 5% were emotionally maltreated. The national rate of victimization is 12.4 children are victimized out of 1000. At 14.7 victims per 1000 children, Connecticut ranks above the national average of 12.3 victims per 1000 children (Child Maltreatment, 2001, U.S. Dept. of Health and Human Services).

In the State of Connecticut, in 2004 there were 8753 substantiated reports of abuse or neglect (State of Ct, Department of Children and Families, 2005), including physical abuse, emotional neglect, physical neglect and at risk behaviors. 27% (745) of these were substantiated cases were for sexual abuse. These statistics do not, of course, cover all of the numbers of children who have been abused within the state. Sexual abuse numbers are particularly underreported, since sexual abuse victims may not evidence physical symptoms of harm. The national victimization rate for White and Hispanic victims of child sexual abuse or neglect is 11 per 1,000; Afro-American children is 20.4 per 1,000 children. In Connecticut 30% of African American and 26% of the Hispanic child population has been reported abused or maltreated. Clifford Beers Clinic serves approximately 1500 families per year, 37% of our total population identify as Black and 19% identify as Hispanic.

In the 17 towns in the Greater New Haven area that Clifford Beers Clinic served in FY 2004, there were a total of 4502 substantiations of abuse and neglect (source: DCF website, 2005). This is 51% of the state wide substantiations of child abuse and neglect. Out of that number there were 133 substantiated victims of sexual abuse (18% of the state-wide numbers). Clifford Beers Clinic serves approximately 196 children per year who have experienced sexual abuse. Over 850 (65%) of the 1500 families served annually report at intake that they have been exposed to abuse, neglect, traumatic loss, domestic violence and the like. Clifford Beers Clinic treats approximately 20% of all children and families in the Greater New Haven Region who have had some involvement in the Connecticut Department of Children and Families.

Clifford Beers Clinic's Sexual Abuse Treatment Team has been in existence since 1985. The SATT, including our CATCH Program, funded by the Victims of Crime Act (VOCA) which offers case management and advocacy, for child survivors of sexual abuse, is a multidisciplinary team that offers psychiatric diagnostic and treatment services to children and adolescents who have been sexually abused. Clifford Beers Clinic works collaboratively with the Yale-New Haven Hospital's Child Sexual Abuse Clinic (YCSAC) (see letter of support, Appendix 1). Yearly, approximately 200 children statewide are evaluated by the YCSAC for suspected sexual abuse. Often these families travel to New Haven to receive services at Clifford Beers Clinic as we are one of the few agencies in the State that has a sexual abuse and program for children. The Clinic's Domestic Violence Treatment Team was inaugurated in November 1997, as a result of many referrals from domestic violence shelters and other community agencies. Currently, the Clinic evaluates approximately 75 children annually for this problem and provides mental health treatment, case management and advocacy for these victims and their family members. Since the program's inception, it has helped over 500 child victims and family members successfully cope with the effects of violence. 57% of the children referred to the clinic have been involved with DCF for potential abuse or neglect, 100% of these children have been exposed to some form of trauma, abuse or neglect.

Monolingual Spanish-speaking families affected by sexual abuse and/or domestic violence have few options to turn to in the New Haven area. There are a limited number of Spanish-speaking practitioners and even fewer with training in treating victims of abuse; thus, waits of 2-3 months for adult treatment are common. For monolingual children, there is only one other outpatient clinic setting in New Haven area. Even if a child victim is bilingual, treatment requires parental involvement to be effective; when the parent does not speak English, the ability to successfully serve the victim is limited. 5% of our families are monolingual. In addition, families with children who do not have health insurance, because of their immigration status, are unable to get services from providers who require some form of payment. Our
VOCA funded bilingual Family Advocate and clinician are able to provide a range of culturally-sensitive treatment and support services to victims, and, through grant support, can provide treatment free of charge to those who have no insurance.

We have found that sexually abused children and their families are often reluctant to follow through with referrals for help. Due to complicated life situations and depletion of family resources, families are overwhelmed and need assistance to make the transition to engage with treatment and/or support services. Families that have previously had their children removed because of sexual abuse or physical abuse, neglect and/or other at-risk situations are suspicious of service providers. The difficulties these families face include substance abuse, domestic violence, psychiatric illness, poor parenting skills, unemployment, and poverty. Families are frequently in emotional conflict and are fearful, apprehensive, and confused on a broad range of issues and concerns currently affecting the family. Children who witness violence are at risk of developing behavior problems that perpetuate the cycle of violence into their adult lives and experience increased anxieties, poor school performance, conduct disorders, increased aggression, lower self-esteem and impaired social problem-solving skills. In the City of New Haven, approximately 25% of school-aged children in New Haven have psychiatric disorders (New Haven Board of Education, 1999).

Members of ethnic, racial, linguistic, and culturally diverse groups are often underserved or inappropriately served by the public mental health system. Culturally competent and appropriate services can: reduce inappropriate diagnoses; increase the utilization of mental health services by population groups that traditionally underutilize services; and change perceived negative encounters that are often experienced by population groups that seek treatment from systems that often do not provide culturally sensitive and competent services. It is, therefore, in the best interest of both mental health consumers and the public mental health system which serves them, that culturally competent services be consistently available, accessible and effective. In recognition of this fact, the Clifford Beers Clinic undertakes ongoing efforts to become more culturally competent in the provision of mental health services to ethnic, racial, linguistic, and culturally diverse populations. Services to these individuals should be based on concepts, policies, and procedures that provide a voice and choice; they should be flexible, individualized, and promote respect, dignity, and recovery. The Clinic, in its hiring and training practices, recruits and retains mental health professionals and paraprofessionals who can both represent these groups and understand their mental health needs and deliver the most effective methods of successfully responding to them.

 Describe current availability and status of trauma-informed treatment: Established in 1913, the Clifford Beers Clinic is the oldest community mental health outpatient clinic in Connecticut. It seeks to promote the emotional, psychological and physical well-being of children and families who are impacted by the effects of sexual abuse, domestic violence and other behavioral health issues. At present, the Clinic and Yale Child Study Center (NCTSN Category II site) are the only agencies in the New Haven area that specifically focuses on the outpatient mental health needs of child and adolescent victims of family violence and sexual abuse. Clifford Beers Clinic has been a participating member of community coalitions dedicated to treating victims of violence, many since their inception (see Chart 1, Appendix 1). Clifford Beers Clinic has a long-standing reputation for its collaborative efforts with community agencies in the Greater New Haven area, ensuring the provision of accessible and most appropriate services to children and families; thus, enhancing the probability of successful outcomes. Clifford Beer’s bio-psychosocial treatment philosophy is grounded in collaboration. Service provision includes close collaboration with parents, teachers, the State of Connecticut Department of Children and Families (DCF), the criminal justice system and other professionals and community agencies, in an effort to access appropriate services and not duplicate service provision. This proposal, which is being submitted by Clifford Beers Clinic, is to provide and improve trauma services for children and families for the New Haven Service area. Despite the multiple agencies working in the community, there is no evidenced based treatment program existing and there still room for improvement and growth in trauma informed treatment services available for children and their families, in particular for children and families living below poverty level. The Greater New Haven area offers an array of domestic violence services, including shelters,
support groups, advocacy, counseling and referral, special police intervention, 24-hour hot lines and psychiatric care in traumatic situations. Most interventions are woman-centered: women are given the protection, resources, and support they need to make their own decisions. The extent to which youth are disproportionately victims of violence has not been fully appreciated.

In meeting and discussing our proposal to develop a Category III site for the National Traumatic Stress Initiative with Dr. Steven Marans (see letter of support Appendix 1) Director of the NCCEV, it seems that our development of an outpatient treatment center will clearly augment the already excellent work that the NCCEV already does for the New Haven community. The National Center for Children Exposed to Violence presently conducts research in the following areas: (1) Child Development Community Policing Program Evaluation, (2) Domestic Violence Home Visit Intervention Program Evaluation, (3) the assessment of predictors of the functional impairment among children exposed to interpersonal violence, and (4) the efficacy of the Child and Family Traumatic Stress Intervention, a 4-session secondary prevention approach to children and families exposed to violence and other traumatic events. The NCCEV conducted intensive CD-CP Program evaluation in New Haven, Connecticut and in Charlotte, North Carolina, and it is designed to evaluate outcomes in terms of changes in law enforcement practice and child and family functioning. The NCCEV domestic violence research focuses on how the outreach worker and police officer follow up to improve physical and psychological security in the aftermath of children's exposure to violence. A range of outcomes is assessed including domestic violence recidivism, law enforcement service utilization and child functioning. The study of predictors provides standardized assessments over a 12-month period of child, caregiver and family functioning in the wake of interpersonal violence in an effort to identify risk and resilience factors for subsequent psychiatric and psychosocial functioning. The study of the NCCEV brief secondary prevention model for intervening with children and families exposed to violence and trauma is being piloted with referrals from the 24/7 on-call consultation service and from the Yale-New Haven Hospital Children's Emergency Department. CBC as an addition referral and intervention site will greatly increase the number of families served in New Haven. Collaboration with Clifford Beers and the NCCEV will enhance community access to trauma treatment which is needed in the Greater New Haven area as it is specifically riddled with incidents of family and community violence.

Clifford Beers has been a long standing member of, and the current manager of the Greater New Haven Multidisciplinary Investigative Team (MIT). The MIT is a bi-weekly forum focused on child sexual abuse cases, bringing together police, DCF, the courts, and social service agencies. Through mutual referrals, and through exchange of training for staff of the agencies, particularly on issues of sexual abuse and domestic violence, the community works together to provide protection for affected families and children. As a result of Clinic participation in the MIT, we collaborate with police from New Haven and other towns, DCF workers, Victim Advocates, as well as lawyers/prosecutors, which ease referrals, case consultation and advocacy for victims and other Clinic clients. CBC is responsible for organizing the meetings as well as offering training to members of the team and their employees. Clifford Beers has also been active in the planning of the newly proposed Child Advocacy Center of Yale-New Haven Hospital's Child Sexual Abuse Clinic. The Clinic has a long history of collaboration with child and adult serving agencies. The Clinic has been a leader in the implementation of the State of Connecticut's System of Care initiative in the Greater New Haven area by organizing, attending and chairing the monthly meetings. Since 1998 the Clinic has acted as the fiduciary organization for the area's collaboratives. The New Haven Collaborative in particular has a membership of nearly 20 providers, advocates, City staff, school representatives and parents. Families play a critical role in ensuring that every aspect of the plan is accountable and responsive to the needs of children. Family members, through a newly formed alliance of existing advocacy organizations comprised of NAMI-CT (National Alliance for the Mentally Ill), Families United (a Chapter of the Federation of Families for Children's Mental Health), Padres Abriendo Puertas, and AFCAMP (African Caribbean American Parents of Children with Disabilities) receive additional advocacy support and training. The clinic staff also ensure that families have access to these groups.
CBC manages the DCF KidCare Community Collaborative teams in New Haven, the Shoreline and Hamden/North Haven areas and participates in the West Haven Interagency Network for Children (WHINC). These are local consortiums of public and private health care providers, parents of children with behavioral health needs and service and education agencies organized to develop coordinated comprehensive community services, in collaboration with identified children and their parents, to prevent out of home placements or to ensure successful community re-entry for residential placements.

The Clinic also provides community consultation to local agencies and schools as requested. Through a collaboration with Life Haven, a shelter for women and children, Clinic staff offer consultation to staff and parents in child management techniques. In West Haven, CBC staff consults with day care providers through the School Readiness Program; our Executive Director participates in the School Readiness Council. The Clinic staff offer assistance to day care providers in the management of children’s problem behaviors. The Clinic has strong working relationships with the two local hospitals, Yale New Haven Hospital and the Hospital of Saint Raphael. In particular, the Clinic’s crisis service has developed a Memorandum of Agreement with Yale New Haven Hospital Emergency and Social Work Departments (see letter of support, Appendix 1)

In August 2004, the Clinic acting as a “lead agency” and the State of Connecticut-DCF, began to implement a Managed Service System to ensure that children returning to the community from residential care have comprehensive community discharge plans. Many of these children were victims of violence. This initiative has required strong collaboration with all DCF contracted child-serving agencies in the area. CBC has been a lead agency in the New Haven area to prevent violence within the community; we have a long history of developing and operating prevention programs for youth and families.

From 1989 to 1999, the Clinic conducted a state-funded substance abuse prevention program, Future Focus. In 2000, the Clinic operated a combined substance abuse and violence prevention program for children in the Newhallville/Highwood neighborhoods of Hamden and New Haven. The program has grown with varying grant supports. First funded by the CT State Department of Mental Health and Substance Abuse (DHMAS) as an anti-bullying program, we have now modified the project. It is located in the Fair Haven area of New Haven, and has expanded into a Youth Violence Prevention program, funded by a federal grant from the Substance Abuse and Mental Health Administration (SAMHSA) from 2003-2005. The DHMAS grant ended in September, 2004, was a multifaceted program grant that included prevention programming for parents and an anti-bullying program for teachers and students of grades K-5.

Due to the Clinic’s extensive involvement with victims of trauma, it has successfully sought federal funding (SAMHSA) to conduct a two-year youth violence prevention project, (YVVP) beginning in 2003 in the Fair Haven section of New Haven. In addition, the YVPP staff are building a broad collaborative with public and charter schools in Fair Haven, the New Haven Housing Authority, Farnam Neighborhood House, other community organizations and residents of all ages to develop multi-ethnic culturally competent community interventions to address and reduce violence. Clinic staff engaged in the Violence Prevention Project participates on the Fair Haven Community Management Team, a coalition of stakeholders of the Fair Haven community, agencies, police, businesses and residents.

Since 1998, Clinic staff members have co-chaired the Children Affected by Domestic Violence Work Group of the Greater New Haven Domestic Violence Task Force. This is a coalition of agencies who work with children and families, survivors of family violence, the police force, school personnel, as well as religious and community leaders. This active work group has produced conferences and think tanks dedicated to coalition building, identifying gaps in service to victims of domestic violence and to increasing the awareness of the effects of family violence upon children. The Clinic has been invited to participate on an advisory council called by the Area Director of DCF, to assist in educating DCF workers working with children and families impacted by domestic violence and sexual abuse.

Show that identified needs are consistent with the priorities of the State: In December of 2003, the United States District Court in Connecticut formally entered into an exit plan with the Department of Children and Families. The plan mandates DCF to ensure that “all children who are now, or will be, in the
care, custody, or supervisions of the Commissioner of the Department of Children and Families as a result of being abused, neglected or abandoned or being found at risk of such maltreatment” by adhering to 22 outcomes measures. These outcome measures dictate practice in several areas including the investigation of abuse/ neglect, the reunification process for families, the foster care training plans, the re-entry into DCF custody, the reduction of children placed in residential care and ultimately, how children and families are discharged from the Department. In July 2004, the Clifford Beers Clinic was awarded a contract from DCF as part of the Exit Plan efforts, to ensure that children returning to the community from residential care have comprehensive community discharge plans. In the Greater New Haven area, there are nearly 120 children scheduled to return to this community. Since this project was initiated, 39 children have been served by the Clifford Beers Clinic.

The Governor of Connecticut, Jody Rell, upon taking office in 2003, asked the Lieutenant Governor, Kevin B. Sullivan to prepare a report on the conditions of mental health services for the residents of Connecticut (see Appendix 5). In that report (2004) Lt. Governor Sullivan calls for Connecticut to build upon existing efforts and develop a statewide “Connecting to Care” initiative to decrease the negative effects of mental health issues for our children and families. This proposed initiative would provide timely and accessible information about resources and referrals as well as outreach that informs and trains those who are first responders. Sullivan also declared that trainings on evidenced based practices are also critical in the state’s mental health initiative. The agenda also articulates a call for an improvement in the systems of care for our children, including an increase in family advocates, care coordinators, and treatment sensitive to trauma, depression and loss. Clifford Beer's proposal for Child and Family Trauma Center is a direct response to the state’s evaluation of children’s mental health needs. Lt. Governor Sullivan has written a letter of support for our grant (See LOS Appendix 1).

The Department of Children and Families (DCF) has also begun a care coordination effort that includes trauma training. As stated in a letter of support found in Appendix 1, Robert Plant, PhD, Director of the Community and Mental Heath Centers, DCF recognizes that trauma and the heightened risk for traumatic stress is common in the lives of many children and families it serves. The Department has embarked on a statewide initiative to integrate trauma informed approaches to child protective and foster care practices, behavioral health and juvenile justice service design and delivery and departmental policy. In addition the state follows the President’s New Freedom Commission and other national policy beliefs that support the increased use of evidenced based practices in the delivery of behavioral health and child welfare services. This trauma initiative is a priority component in the state’s efforts to improve care to children and families. Clifford Beers Clinic participates on a sub-committee of Child Guidance Clinics and the Department of Children and Families that intends to increase the use of evidenced based practices within the State, and to increase training of providers of children and families affected by trauma. DCF also has access to multiple child servicing agencies within the community to help them improve and train them in their trauma informed practices. In the letter of support from Michael Steers, Area Director of the Department of Children and Families (Appendix 1), he articulates the need in the New Haven area for trauma-informed treatment, states that he and his staff would work very closely with Clifford Beers Clinic to improve trauma services for children and families.

Describe existing collaborations with local and State service system(s): Children who experience violence often have multiple, complex needs with many different agencies involved (e.g. childcare, DCF, Birth to Three, school system, Child Guidance). A coordinated family plan that not only serves the child but sees the child as part of a family and community is essential. Services that support all members of a family must be integrated. These are the roles of care coordination. Several efforts in New Haven work directly with families and service providers to coordinate services to families and children. The family service and support programs described above all have this as their mission, to some degree, but no to the degree that is needed. Currently, in most delivery systems, there is a lack of clear, consistent, comprehensive and coherent model for delivering care that takes into account the impact of exposure to violence, abuse, and other forms of traumatic experience on individuals, families, staff and organizations. Families victimized by
violence present sequentially and simultaneously to many different social service and healthcare settings and the responses to their problems is fragmented, disjointed, overlapping, sometimes leaving gaps, and frequently offering contradictory advice and options. To address this gap, Clifford Beers Clinic (CBC) has established an extensive collaborative network with other community resources serving victims of violence, in particular, victims of domestic violence and sexual abuse, and involvement with the juvenile justice system. The primary state agencies with which CBC interacts are Department of Children and Families, YCSAC, the Coordinating Council for Children in Crisis, including its Domestic Violence Outreach Program, local police departments, Office of Victim Services, the State's Attorneys Office, local school systems, and the MIT. CBC staff also has a leadership role in the Greater New Haven Domestic Violence Taskforce, and directs the MIT.

CBC is involved on the state level in working with agencies that work with victims of violence. For example CBC staff participate in the Connecticut Coalition for the Advancement of Prevention (CCAP). CCAP is an advisory committee, with representatives from key state agencies, coalitions, community-based providers, youth, families, minorities, and teachers, that provides strategic and operational advice throughout the state. The CCAP is a component of Connecticut's Partnership Resource Infrastructure Monies (PRISM) initiative funded through the Department of Mental Health and Addiction Services by the SAMHSA's Center for Mental Health Services. The Clinic is proud of its long-standing reputation for ongoing collaboration with those agencies that serve children and families within New Haven and the surrounding communities. In particular, the staff of the project for sexually aggressive/reactive youth, JOTLAB, works with parole and probation officers, staff of Connecticut Juvenile Training School (CJTS), High Meadows state residential facility, Juvenile Court, DCF, school personnel, other social service agencies, Youth Continuum, St. Francis Home for Children, Boys and Girls Village, the Children's Center of Hamden and local area police departments.

Provide evidence that community stakeholders are committed: As described in Section A., Clifford Beers Clinic is uniquely poised within the New Haven community to increase the NCTSN's goal of improving the quality of treatment services available to those families within the Greater New Haven Region through the piloting, testing and implementation of evidenced based treatment practices for trauma affected children and their families. In addition, Clifford Beers Clinic serves a large number of children and families affected by trauma in the New Haven community. Our long term collaboration with the NCTSN Category II program, the Child Development- Community Policing Program (CDCP) at the Yale Child Study Center, and the New Haven Police Service also places us in a positive position to join forces with their initiative, and our long term work together on The Greater New Haven Task Force to greatly improve trauma informed practice in the New Haven area. Clifford Beers Clinic offers clinical consultation to many organizations in the community, and we are an agency that provides children's mental health and family strengthening. Many agencies request that we consult with them about specific cases and to train their staff in regard to trauma treatment. We have letters of support and agreement to collaborate around the use of evidenced based treatment practices with the following human service agencies in New Haven (see Appendix 1 for all letters) if chosen for the Category III site: St. Francis Home for Children, a residential and community-based treatment provider serving emotionally and behaviorally challenged children and their families since 1852; Christian Community Action, Inc., a nonprofit organization that works with children and their parents who are homeless and poor, and they run a homeless shelter and transitional housing program. Chief Francisco Ortiz, Jr., of the New Haven Police Department promises to work collaboratively with CBC to improve trauma services for children and families. Dr. David Abrams, Director of Child and Adolescent Outpatient Psychiatric Services at the Hospital of Saint Raphael, and recent past President of the Connecticut Psychological Association, says in his letter of support that the Hospital staff has a long history of working with CBC, and that they are excited by the possibility of participating in a "network of people working with children and families affected by trauma.” Finally, CBC has received the support of the New Haven Collaborative for Youth, which is a team of agencies, parents, interested community members that coordinate services and supports for children with behavioral and/or psychiatric
needs, and they promise to work collaboratively with CBC to improve trauma services for children and families in New Haven. Hart Caparulo, the President of the United Way of Greater New Haven, speaks in her letter of support of the desperate need for the trauma based services in the New Haven corridor, which she says, “is the 7th most disparate region in the nation.” She says that the United Way has been a proud funder of Clifford Beers since 1922, and that their investment committee volunteers consistently give the Clinic high ratings for CBC's work with children and families. She also states that United Way continues their funding for CBC because CBC has evidenced measurable sustainable change, and has made a direct impact on the community. We have letters of support from Joseph Lieberman, U.S. Senator and Rosa DeLauro, member of Congress. Rep. DeLauro writes that she is in strong support of the application of CBC for the grant, and that she is confident that a grant would improve trauma services for children and families in the New Haven area.

In summary, the target Hispanic and Black populations are families living in areas besieged by crime and violence. In the community there is a normative use of ATOD by peers, family and community residents. The fact that there are few community resources (including shortage of treatment and recreational facilities for youth) and the many stressors for these families promotes risk factors which contribute to lack of access to mental health care. However, as noted earlier, potential negative outcomes can be mediated by resiliency and protective factors. New programs that increase access to mental health facilities and community based agencies that provide families opportunities for success are critically important.

Section B: Proposed Evidence-Based Practices Program: Child and Family Trauma Center (CFTC)

Mission: Clifford Beers Clinic will create a community based, clinical center for excellence for the treatment of children and families who have been exposed to trauma, for example, sexual abuse, domestic violence, community violence and traumatic bereavement, in particular to families living below federal poverty level. The purpose of such a center is to improve the quality of life for trauma exposed children and their caretakers, strengthen and create advocates within the community for and with survivors, as well as improve the quality of the treatment services available to those families within the greater New Haven Region through the implementation of evidenced based practices. Impact: By creating such a center in the Greater New Haven region, the quality of life will improve for those children and families who have experienced trauma. By their lives being less stressful, children exposed to trauma will have improved school performance, parents will have a greater sense of empowerment and the overall quality of life in New Haven will improve for a large amount of families who typically live under enormous stress. It is then predicted that academic performance on the Connecticut Mastery tests will improve for schools with large numbers of children exposed to trauma. In addition, due to the increase in advocacy and community education, there will be a decrease in the number of traumas perpetrated upon our children in the community. Targets: New Haven Community Child serving agencies, such as the New Haven and Greater New Haven Regions of the Department of Children and Families, school-based clinics, community agencies as well as an estimate of 150 children and their families (by year 4) who will participate in the Trauma Focused Cognitive Behavioral Treatment program Clifford Beers Clinic. In the fiscal year 2003-2004 Clifford Beers Outpatient Services admitted 395 new cases. These cases are in addition to those cases that were carried over from the previous year and were actively involved in treatment. Thus, in the fiscal year 2003-2004 we served 2552 children and families, and provided 21,280 units of service (including, but not limited to: Individual Therapy, Family Therapy, Group Therapy, Psychiatric Evaluations, Medication Management, Parent Education and Consultation). The Clinic serves children and their families between the ages of 3 and 17. Of the clients seeking services at Clifford Beers Clinic 37% are Black, 19% are Hispanic, 43% are White and 1% are Asian American and 1% are of other ethnic backgrounds. 44 per cent of the children are female, 56% are male. 73% of the children receive healthcare through the state and federally funded HUSKY program. These families fall within the 185% of the Federal Poverty Level Guidelines for the State of Connecticut. 57% of all children served have had some involvement with the Department of Children and Families. These children live in a number of settings, some with both
parents, some with one parent, grandparent or other relative, in DCF residential care, foster care, or group home. The children served present with multiple environmental stressors along with multiple emotional and behavioral difficulties. In the last year children presented with multiple problems such as: 44% of the families reported at intake that their child has experienced or witnessed domestic violence or sexual assault. 65% of the children at the Clinic have experienced or witnessed severe abuse, trauma or loss. 44% of the children report depression and 36% report anxiety as presenting problems. 55% of the presenting problems are related to family issues, including severe parent/child conflict, sibling conflict, and parenting issues. 22% of the children present with school behavioral difficulties, including expulsion, academic problems or phobias.

Identify the evidence-based practices that you propose to implement:  Clifford Beers Clinic proposes to implement the following treatment programs:


**Treatment Intervention: 2. Trauma-Focused Cognitive Behavioral Therapy** (TF-CBT) Judith A. Cohen, M.D. Anthony P. Mannarino, Ph.D., Allegheny General Hospital Center for Traumatic Stress in Children and Adolescents; Esther Deblinger, Ph.D., University of Medicine-Dentistry of New Jersey Center for Children’s Support. NCTSN Empirically Supported Treatments and Promising Practice: Well Supported and Efficacious

Justify the use of the practices for the target population: The Trauma-Focused Cognitive Behavioral Therapy (TF-CBT) and the Child and Family Traumatic Stress Initiative are two very complimentary programs that will help our families to bring about an improvement in the child’s quality of life as evidenced by a decrease in PTSD symptoms, depression and anxiety, decrease in sexually acting our behaviors, feelings of shame, and mistrust in others. In addition, the proposed interventions blend very well with Clifford Beer’s Clinic’s Trauma Treatment philosophy already in existence. Sixty-five percent of Clifford Beers Clinic total clientele report at intake that they have been exposed to trauma; that is approximately 900 identified children for an approximate 2000 adults and children from the Greater New Haven area. Our numbers alone call for the need for becoming part of the NCTSN; our social capitol and leadership in child social service agencies in the Greater New Haven region as well as our leadership roles within the state are also critical factors to the appropriateness of CBC joining the NCTSN. In addition, through the opportunity to join efforts with the Category II site already in New Haven at the Yale Child Study Center at the National Center for Children Exposed to Violence (NCCEV), we will be able to build upon our treatment of acute trauma and strengthen the work we already do for our trauma affected children and families. Many of our children have been exposed to multiple forms of trauma, including sexual abuse, domestic violence, traumatic loss and community violence. Although the TF-CBT has not been systematically evaluated for efficacy on children with complex trauma, we believe that the combination of the Child and Family Traumatic Stress Initiative, which is designed to decrease the negative impact on children’s potentially traumatic events (PTE) as well as the piloting and implementing the TF-CBT will greatly enhance the trauma-informed resources to the community in the Greater New Haven Region. Clifford Beers clinic staff are experienced, trained clinicians in child development and who are experienced in assessing and treating a wide range of child psychiatric disorders. All of our Full-time staff have worked with survivors of trauma for many years. Clifford Beers Clinic has 18 full time Clinical Masters and PhD level Employees, 4 part-time psychiatrists, 1 APRN and 1 Pediatrician., 5 or more part time clinical staff a part-time case manager and an APPIC approved internship training program which provides 6-8 full time clinical training hours to MA and PhD students.  Our treatment focus is on working with children and families. Both interventions are focused upon working with children and families. The TF-CBT will add an evidenced based treatment to the already existing wrap-around services we provide to our children and their families.
Our regular out-patient treatment program can be a support for families whose needs might extend beyond the TF-CBT or CFTSI to provide additional services if needed past the initial intervention.

Cohen, Mannarino and Deblinger (2003), in their treatment manual for TF-CBT state very clearly that it is difficult to articulate the critical elements needed in providing treatment to children and families affected by trauma. They mention that the therapeutic relationship that is, it is the therapist’s warmth, empathy and genuine care and concern is central to the treatment and critical to its success. Here at Clifford Beers we have found that the reestablishment of trust must be the first line of intervention in order to help families affected by trauma. Parental support, addressing the basic needs of the children and their families as well as advocating for the families within the multiple service agencies that may be in their life, is central to treatment. Clifford Beers Clinic’s current treatment model falls mostly in the psychiatric rehabilitation arena, with a particular focus on dynamic systems theory (Kielhofner, 1995). We conceptualize the presenting problems as not only existing within the child, but rather reflecting a combination of internal, familial and environmental factors that result in tensions that can cause undue stress on the child and the family. Current therapeutic interventions can include individual, play, family and group therapies as well as medication management, parent education, collaboration with other providers and advocacy, and a clear focus on the resiliency of the child and the family. For this reason, care management is critical in providing support to the families. Treatment focuses on ways to address the symptoms of the individual child, but also promotes modifications to the child and family’s environment in order to foster stability and safety. Many of our children live in stressful life conditions, and their behavior is often a reflection of those conditions. These cases require collaboration with school, caregivers, DCF and other human services agencies. Often it is both the child and family that need stabilization, from basic life needs to psychiatric evaluation to parent education. We know that promoting a broader range of emotional tolerance is critical for child trauma survivors (Dielh & Prout, 2002). In addition, we know that alleviating parental stress is also critical to recovery for the child and their family (Kazdin & Whitley, 2003; Banyard, Rozelle & Englund, 2001). The Clifford Beers Model of Trauma Treatment incorporates this “wrap around” approach and has been developed over the last 15 years by therapists working with child and family survivors of complex trauma. Implementing the proposed programs will increase our capacity of assessment, and data collection. By doing this, we will add to the network’s clinical database for children with complex trauma. Working closely with the National Center for Children Exposed to Violence at Yale Child Study Center, we believe that early interventions, that is the NCCEV occurs during the immediate aftermath of the domestic violence exposure; our collaboration with Yale Sexual Abuse Clinic will allow us access to children and families in the immediate aftermath of the disclosure of sexual abuse. We believe by becoming a category III site, CBC can place even more resources into the community to assist our families to become trained advocates for themselves and their children.

Describe the types of modifications/adaptations that may be necessary: In a review of the curriculum, it does not seem necessary to make many adjustments to our current program in order to meet the needs of the target populations, and it seems to be a “goodness of fit” for both our treatment philosophy and as well as our client population. Some potential barriers to treatment may be A. engaging foster families or biological family members who may not be inclined to be invested fully in the trauma interventions, B. to work carefully to avoid getting caught up on multiple crisis or events, or “secondary adversities” that may become barriers to treatment and that may interfere with providing the actual intervention, and C. being continually sensitive to the cultural factors of how the trauma has been experienced within our Latino and Black communities. We will address all three modifications as follows: A. Engagement of reluctant family members: CBC staff have increasingly seen that trauma-informed treatment must include all members of the child’s immediate family. Thus we have expanded our parent educational programs and case management services in order to actively recruit involvement of the parent in all aspects of understanding their child’s trauma exposure. We have recently changed our policy here at the clinic
requires children who are in the custody of the Department of Children and Families to have an adult
caregiver present for treatment. We have designed and are piloting a “parent orientation” program for
families requesting services that will address treatment requirements for both biological and foster families
bringing children to the clinic for treatment. At that orientation, families will be informed of the various
interventions open to them and their children. Many of the parents we see have also been exposed to
trauma. Forty-five percent of the 1500 families at intake report that they have experienced severe stress.
Thirty-one percent of parents report that they have been involved in domestic violence incidents, 27%
report they are depressed, 30% report the use of drugs and alcohol in the household and 30% report they
are divorced. Severe parental stress may interfere with family members getting involved with treatment.
CBC is part of a APPIC training consortium that works with an adult post traumatic stress center, run by
David Read Johnson, PhD and Hadar Lubin, MD. All of our psychology interns participate in this adult
program, and receive weekly trauma-informed training for adults. In addition, Drs Johnson and Lubin come
to the clinic and provide in-services for our child development staff on working with adults with PTSD. The
Post Traumatic Stress center and Clifford Beers Clinic has a 7 year history of taking referrals for our
parents and working with our staff to coordinate treatment needs of both adults and their children. (see
biographical sketch for David Read Johnson, and MOU Appendix 1).

B. Addressing Secondary adversities: CBC is acutely aware of the extensive needs of our children and families who have
experienced trauma. Many of the children (18%) seen have been in multiple foster placements or have had
several hospitalizations. If possible, we will see them through those placements as well as their
reunification with their biological family or adoption. We find, when working with these children and families,
it is necessary to be both an advocate for, and a provider of, treatment services for both the child and the
adults involved with the child. These coordinating efforts often require costly clinical time resulting in an
inability to serve more clients. To address this problem, the Clinic would, if we receive this grant, expand
the already successful care coordinator model of intensive clinical care management that has been used
with three of our categorical funded programs. We want to make care management available to the families
seen in the Trauma Clinic. By having care managers for all levels of severity of child behaviors, we can
help the child and family develop and utilize a network of services. C. Sensitivity to cultural factors:
Families need services that support their efforts to help their children learn, develop and grow within their
own homes and communities respectively, and services that understand the barriers to accessing
treatment for our families. Often the children’s negative behaviors are less related to the trauma as they
are escalated by issues homelessness, financial strain, domestic violence, language barriers; physical and
mental abuse, and lack of appropriate diagnosis and treatment. In order to raise strong, independent
children we need strong and healthy families. The fear of homelessness, the pain of hunger and the feeling
of no belonging, create scars that can be damaging or even fatal to a child already with a mental or
physical issues. Thirty-seven percent of our families at CBC are identified as Black. Research (Allen,
1996; Norris, 1992) has shown that African Americans report a higher and more severe level of traumatic
incidents than those experienced by European Americans. There are greater economic resources for
European Americans in the New Haven community, and positive economic resources often act as a buffer
to negative life events. African Americans experiencing trauma may confront hostility, prejudice, and
neglect, all of which serve to heighten the effects of a crisis. Nineteen percent of all families seen at the
clinic are Hispanic. Five percent of these families are monolingual, Spanish. Clifford Beers Clinic prides
itself upon service our Spanish speaking families, and we offer multiple services for monolingual families in
Spanish. We have found Latino families come from all walks of life, but all find themselves caught within
the same web: a web of language barriers, little or no education, financial strain, being undocumented and
uninsured. These barriers are found among single parent and two-parent families and in birth, adoptive
and foster families. They seek appropriate treatment, education and resources to help their children
become responsible, self supportive adults, but are often not successful at finding the help that they need.
They find themselves lacking in access to appropriate mental health services.
One of the challenges in doing community based work with people who are disenfranchised or with people who are of color is that community members are often initially distrusting of the clinical professionals. When the community is in close proximity to a major academic center community members can be even more wary. They are accustomed to researchers coming into their communities to collect data, but never returning to share their findings or to use their resources to improve the community. Being aware of this dynamic, we are particularly invested in building and maintaining trust. In this project we believe that several factors in place at CBC will help to decrease defensiveness and encourage the development of community partnerships. First, our bi-lingual, bi-cultural community outreach coordinator proposed for this project has a long history of personal and professional relationships in the community. As such, her connections have opened doors that may not have opened as quickly, or at all. Second, we will be able and willing to adapt our approach to meet the needs or desires of the various stakeholders.

We have found that there are two principal challenges to providing services for monolingual Latino families. First, Spanish speaking providers become responsible for bridging the gap between the client and the English-dominant network of services. Second, given the stigma associated with mental illness within the target population, providers must establish a level of trust and comfort with their clients to assist in linking them with needed services. This requires complex, time-consuming advocacy and case management. In Latino communities, the custom is to turn to the immediate or extended family for relief and support, or to seek advice and counsel from a clergy person or an “espiritist.” In this culture, seeking outside assistance, and divulging personal and family information to strangers is viewed negatively. It is only through the concerted efforts of connecting with families both through language and an understanding of the culture that service providers can be effective in linking with Latino families. It is also through the familiarity with the language, the culture, and family structure that a mental health service provider can develop a bond of trust and confidentiality, resulting in effective service provision.

This project will help Black and Hispanic families to overcome these obstacles to service. Project staff will reach out to families to develop a trusting relationship while providing needed concrete and supportive services. When trust is established, a therapeutic alliance can also be established, and perceptions regarding the value of mental health services can be altered, helping the child with behavior problems and the family to effectively utilize the evaluation and therapeutic services available. The case managers are available to be liaisons between the Clinic’s services and the community. As a result, the clinicians will be better able to address the behavioral and emotional problems of the children. The program targets the issues of cultural competency and sensitivity, and eliminates barriers to mental health services to an under-served, hard to engage target population.

Identify any additional adaptations or modifications that may be necessary in the target community:
Beside the above mentioned adaptations and modifications, we believe that there is a critical impediment to utilizing the propose practice in the target community: The sparse clinical resources for our Hispanic and African American communities that are on Medicaid. All assessment tools must be translated into Spanish if they are not already, and the instruments must be adapted for families that are not able to read or write.

We believe the following modification are necessary for both treatment programs: 1. Address the need to recognize the importance of clergy and family; 2. recognize spiritual views regarding mental health and domestic violence; 3.recognizing the Latino’s and African American’s hesitancy for little contact with police; 4. honor the importance of availability of voluntary treatment; 5. know that Hispanic and Black people are less likely to access services, as research has indicated a higher tolerance in the family structure for domestic violence; 6.recognize differences among countries and cultures, including differences in dialects, the importance of balancing allowing clients to teach providers about their culture, but not placing this burden on them; 7. the need to know when they came to the U.S., why, socioeconomic class, education level, legal status as it impacts assimilation/acculturation; 8. address the need for family-focused services, 9. Latino men may not feel comfortable speaking with female counselors, especially if they are Caucasian; 10. Understand what helps to deter domestic violence in Latino and Black communities; 11. Remember the importance of men in the family system and that they must be included in the treatment of
their families. The Child and Family Trauma Center at Clifford Beers would address many of the needs of our target population of primarily African Americans, Hispanics and European Americans.

The adaptability and educational nature of the interventions clearly will promote compliance and adherence. We believe that the program will be flexible enough to fit for our identified children and families. For example, the Stress Inoculation Techniques taught in the TF-CBT are already taught here at the clinic. We run a group program for girls and boys who have been abused to learn Yoga and relaxation. In addition, we hold a weekly Yoga and relaxation group for parents who have experienced trauma. Although we have not produced a formal evaluation of these interventions, qualitative data from parents and children who participate reports that they have begun to utilize these stress management skills at home. In addition, another factor of the TF-CBT is “Feeling Identification.” CBC staff have begun a pilot program of a clinical program called “Increasing Your Emotional Intelligence.” (EI) Staff attend weekly meeting at Yale University’s department of Psychology, at which there is an EI Research Lab, reviewing EI interventions in the community. Dr. Peter Salovey, attends and chairs these meetings. The Emotional Intelligence Groups at CBC are aimed at improving skills with regard to EI as defined by the Ability Based model of Emotional Intelligence (Mayer & Salovey, 1997) through the use of cognitive, metacognitive and emotion-focused experiential treatment modalities (Huebner, 2004). The EI group at Clifford Beers Clinic complements the Trauma Focused Cognitive Behavioral Therapy in a number of ways. There are the common goals of optimizing the child’s adaptive functioning through a corrective relational experience. Both programs emphasize the relationship between cognition, emotion and behavior. Both programs are flexible enough to address individual needs while at the same time both programs maintain a central focus. The EI group supports many of the concepts used in traumatic grief therapy, while providing a specific focus on improving EI-Q. Participation in our EI program before or after the TF-CBT intervention will greatly enhance the child’s ability to express and identify emotions, a critical component to TF-CBT.
CHILDREN AND FAMILY TRAUMA CENTER LOGIC MODEL
FULL PROGRAM (see separate logic models for each initiative)

Needs Statement: Economically disadvantaged children and families are at higher risk for exposure to potentially traumatic incidents both at home and in their community. Developing evidenced based practices that serve our children and families within a child guidance treatment community center that is a lead agency serving traumatized New Haven parents and children will benefit our families as well as provide opportunities for training and consultation with the other agencies to increase their trauma-informed practices. In addition, the proximity of a Category II site at Yale Child Study Center will deepen the opportunity for shared resources, increased research and for the NCTSN Network to grow and model community collaboration and the utility of evidenced based practice.

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<tr>
<th>Community</th>
<th>Treatment</th>
<th>Network</th>
<th>Evaluation</th>
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<tbody>
<tr>
<td><strong>Long-term Outcomes</strong></td>
<td></td>
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<tr>
<td>Clifford Beers Clinic will become a center for training and service provision, advocacy and family strengthening for children and families affected by trauma in the New Haven and Greater New Haven community.</td>
<td></td>
<td>Clifford Beers will be a lead contributing member of the National Child Traumatic Stress Initiative, organizing network meetings and participate in activities, locally, state-wide and nationally.</td>
<td>Clifford Beers Clinic will contribute to the knowledge base of trauma-informed interventions in the community and in clinical practice.</td>
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<td>Peri-trauma intervention and treatment programs running at clinic; Training center for trauma-informed practice has one annual conference.</td>
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<td>State and Local network of child trauma-informed practitioners organized and meeting.</td>
<td>Participation in cross-site evaluation for NCTS Initiative.</td>
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<td>Core Team of CBC staff will be trained and pilot program of TF-CBT and TB-CBT implemented</td>
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<td>CBC staff familiarized with National Traumatic Stress Initiative will participate in 90% of activities available within first year of grant</td>
<td>Evaluation plan designed for pilot clinical program and for the community education plan to increase trauma informed practices</td>
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**COMMUNITY INITIATIVE**

Needs Statement: As of a recent survey by The Connecticut Community Providers Association (2005), there were little to no outpatient trauma informed evidenced-based services for children in the Greater New Haven region, nor through the State of Connecticut. CBC will work with their community collaborations to promote and increase the use of evidenced based practices.

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<tr>
<th>Long-term Outcomes</th>
<th>Intermediate Outcomes</th>
<th>Initial Outcomes</th>
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<tbody>
<tr>
<td>New Haven will have a trauma-informed coalition of all existing task forces, the public and community agencies dedicated to the effort to provide trauma informed treatment.</td>
<td>Ongoing Public Awareness program will be held about the effects of trauma on children and families.</td>
<td>New Haven will have a parent and child based coalition of families who have been affected by trauma with their mission to educate the community about appropriate treatment and resources in the community.</td>
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<td>Staff from CFTC will attend all meetings of trauma treating groups and coalitions of local and statewide initiatives. Monthly parent/family meetings will occur.</td>
<td>Public Relations campaign will be implemented that will be accessed through State and local legislative, news and arts media sources.</td>
<td>CBC will host a community resource fair for children and families that will offer outreach and education about the effects of trauma on children. CBC will bring key stakeholders in the planning of the CFTC.</td>
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<tr>
<td>Identification of existing groups and the formation of a coalition in New Haven area to promote child trauma informed practices. Needs Assessed.</td>
<td>Compile a resource guide all coalitions and agencies in Greater New Haven area Form Advisory Board of community experts in trauma treatment</td>
<td>Develop a State and Local (Greater New Haven) communication strategy about trauma resources in the community.</td>
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<td></td>
<td>A local New Haven Parent advocacy group will be formed by parents from the Clifford Beers Clinic that will advocate and support families affected by trauma.</td>
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</table>
**TREATMENT INITIATIVE**

**Needs Statement:** Trauma informed treatment and service is available on a limited basis for children and families in the Greater New Haven Area. There are a limited number of clinics offering trauma informed therapy that accepted Medicaid.

**Short-Term Outputs:** A Greater New Haven Resource Guide for children and families Affected by Trauma will be compiled; Communication strategy plan designed; local parent advocacy group for families affected by trauma will be formed at the Clinic and families will participate in activities 1 & 2.

**Mid-Term Outputs:** An annual conference for treatment providers, families and the children and other organizations hosted in New Haven that will define resources in the community, initiative a community of like minded children, parents and providers all focused on alleviating the stress related to traumatic events.

**Long-Term Outputs:** Fully active parent advocacy group for families affected by trauma; Annual trauma based conference education community about evidenced based practice and resources in the community; Public Awareness campaign addressing trauma prevention and education. Two sessions of the Multi-Ethnic Strengthening Programs will be run for up to 15 families (20 Adults and 25 children) each year. See treatment Inputs below

**Short-Term & Long Term Outputs:** Year 1: Pilot Trauma Focused Cognitive Behavioral Treatment and CBT for Traumatic Grief Program for a total of 25 children ages 7-18 and their families; Pilot Child and Family Traumatic Stress Initiative with National Center for Children Exposed to Stress, Yale Child Study Center, Category II NTSC Center. Year 2: Serve 40 Children and their families, Years 3&4: Serve up to 60 families. Statistically significant decrease in Post traumatic Stress Symptoms (depression, anxiety, behavioral problems, etc.) as evidenced by reduced scores in the Trauma Symptom Check List for Children (TSCC) and (TSCYC) Young Children, Child Behavioral Checklist, OHIO Scale and Child’ Depression Inventory.

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**Outputs**

- **Short-Term Outputs:**
  - A Greater New Haven Resource Guide for children and families Affected by Trauma will be compiled;
  - Communication strategy plan designed;
  - Local parent advocacy group for families affected by trauma will be formed at the Clinic and families will participate in activities 1 & 2.

- **Mid-Term Outputs:**
  - An annual conference for treatment providers, families and the children and other organizations hosted in New Haven that will define resources in the community, initiative a community of like minded children, parents and providers all focused on alleviating the stress related to traumatic events.

- **Long-Term Outputs:**
  - Fully active parent advocacy group for families affected by trauma;
  - Annual trauma based conference education community about evidenced based practice and resources in the community;
  - Public Awareness campaign addressing trauma prevention and education. Two sessions of the Multi-Ethnic Strengthening Programs will be run for up to 15 families (20 Adults and 25 children) each year.

See treatment Inputs below
Two Full time M.A. level or higher clinicians will be trained in the TF-CBT program and will train other staff and interns to assure fidelity. In addition one .4 FTE case manager will work in conjunction with the clinical staff to serve identified families. Data Systems Specialist will be used to track data and make other resources available to staff.

In addition to specific CFTC Clifford Beers Clinic has 11 full time Clinical Employees, 4 part-time psychiatrists, 1 APRN and 1 Pediatrician., 5 or more part time clinical staff a part-time case manager and an internship training program which provides 6-8 full time clinical hours of MA and PhD students. Referrals come from community organizations, DCF, pediatricians, other clinicians, hospitals courts, and patients themselves.

**NETWORK AND EVALUATION INITIATIVE**

**Needs Statement:** Links to national sites and research on trauma informed practices for children is not available to the social service agencies in the New Haven area. Resources to link to trauma initiatives are imperative to improve treatment practices and coalition building.

**CBC will contribute to the National Child Traumatic Stress Network Initiative (NCTSN).**
Clifford Beers Clinic will contribute to the knowledge base of trauma-informed interventions in the community and in clinical practice.

**CBC will contribute to State-Wide NCTSI activities**

**CBC will promote and engage a local NCTSI network in the Greater New Haven Region**

**Long-term Outcomes**
- Identify people and Organizations working with children affected by trauma, articulate commonalities and identify holes in communication as well as with best practices in the local and state community. Collaboration will occur with other initiatives and training evaluation activities in place for community and service system setting.

**Intermediate Outcomes**
- Finished Networking Plan for National, State and Greater New Haven services that treat children affected by trauma.
- Evaluation plan designed and implemented

**Initial Outcomes**

**Outputs**
- **Sort-term Output:** Goals for Network Plan created
- **Mid-Term Output:** Resource Guide for services for children affected by trauma; white paper that details resource holes and commonalities of practice.
- **Long-term Output:** Increased level of activity on National, State and local levels on all NCTSNI activities.

See evaluation outputs on Outcome Measurement of Logic Model

**Inputs**
- The clinic will have a Community Outreach Organizer and Data Systems Manager to manage communications and networking plan. Data systems manager, Clinical Staff, Clerical Assistance, etc.
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<tr>
<th>Outcome Measurement Statement</th>
<th>Key Activities</th>
<th>Data Source/Data Collection methods</th>
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Community Initiative
As a result of the NCTSN Grant, New Haven will have a trauma-informed coalition of all existing task forces, the public and community agencies dedicated to the effort to provide trauma informed treatment as well as an active and viable family advocacy coalition dedicated to promote public awareness of the impact of trauma on children and families.

Treatment Initiative
Clifford Beers Clinic will become a center for training and service provision, advocacy and family strengthening for children and families affected by trauma in the New Haven and Greater New Haven community.

CBC will help children and families affected by trauma by offering a trauma treatment program that will help a decrease in identified children’s and parent’s PTSD symptoms, depression and anxiety, decrease in sexually acting out behaviors, feelings of shame, and mistrust in others.

OUTCOME STATEMENT

Network Initiative
Clifford Beers will be a lead contributing member of the National Child Traumatic Stress Initiative, organizing network meetings and referrals made to treatment program for parents and children if needed.

B. Publication of Greater New Haven Family Trauma Resource guide at the end of August 2006.

C. Monthly meetings of Families Affected by Trauma; parent advocacy group will form and receive support from CBC staff and the state-wide family advocacy group, FAVOR (see letter of support, APPENDIX 1).

D. CBC Staff will attend the monthly meetings of: The Greater New Haven Domestic Violence Task Force; The City Wide Child Youth Coalition; The Multi-Disciplinary Task Force (Child Abuse); work closely with Yale-New Haven Hospital’s Child Sexual Abuse Clinic (YCSAC): The Prevent Child Abuse CT, part of the Governor’s Prevention partnership; Connecticut Coalition for the Advancement of Prevention Work Group, Women’s Consortium, family Service Office of New Haven Police Department. Presentation at each of the coalitions about the NCTSN and evidenced based practices being used at CBC. Attendance report provided quarterly.

D. Annual conference/Think Tank for the CBC Coalition of “Persons Concerned about Trauma and Families” PCTF. This meeting will be held for Child Trauma Treatment Providers and organizations. Families and Children Affected Meetings

Key Activities

Network Initiative

A. Needs Assessment- Ongoing- Years One-Four
a. Network Plan that articulates resources and systems of care for trauma affected families in the Greater New Haven region
b. Work closely with the Yale Child Study Center’s National Center for Children Exposed to Violence to disseminate and collect information about trauma informed practice in New Haven area.
c. Produce a white paper articulating the gaps in services as well as a “Parent University” classes that focus upon the affects of trauma on children and families. Meetings will be open to New Haven Community and referrals made to treatment program for parents and children if needed.

B. Publication of Greater New Haven Family Trauma Resource guide at the end of August 2006.

C. Monthly meetings of Families Affected by Trauma; parent advocacy group will form and receive support from CBC staff and the state-wide family advocacy group, FAVOR (see letter of support, APPENDIX 1).

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D. Annual conference/Think Tank for the CBC Coalition of “Persons Concerned about Trauma and Families” PCTF. This meeting will be held for Child Trauma Treatment Providers and organizations. Families and Children Affected Meetings

Treatment Initiative

A. Training given for all clinical program staff as well as other interns and clinicians working of SATT Team from Approved trainers from TF-CBT, and CFTSI.

B. Year One: Pilot TF-Cognitive Behavioral Treatment program (Cohen et al) 25 Children ages 7-18 and their families Year 2-4: Implement TF-CBT for 25 7-18 year old children and families. Year 3, up to 40 families; Year 3&4 up to 60 families per year.

C. Child and Family Traumatic Stress Initiative (Yale Child Study Center)

a. Train with Staff from Yale Child Study center in program and use of data instruments.

b. Determine appropriate sites and or client population after potentially traumatic events.

c. Pilot program of Child and Family Traumatic Stress Initiative (Yale Child Study Center), Year 1;

Implement program for years 2-4.

d. Sponsor an Annual conference/Think Tank for the CBC Coalition of “Persons Concerned about Trauma and Families” PCTF. This meeting will be held for Child Trauma Treatment Providers to learn about trauma informed evidenced based practices. Clinical staff, Community Outreach, program Director, Parent Educator, Data Systems Manager

EVALUATION INITIATIVE

Data Source/Data Collection methods

Network Initiative

A. Process recordings of all materials published.
Section C: Proposed Implementation Approach - Provide a realistic time line for the project:

Clifford Beers Clinic would be ready to begin the programs proposed, once the grant notification is given. We have experienced staff who would be trained immediately in the proposed interventions. The additional resources that the grant will give us to hire a data systems manager and a community outreach coordinator; but because we have a Youth Violence Prevention grant from SAMHSA already in existence, we are already building networks and resources in the community for trauma affected children and families.

Describe proposed community planning and consultation efforts to build consensus: In this grant, we propose to connect the already viable and interested community concerned about working with children and families affected by trauma in the New Haven and in the State of Connecticut. With the resources the Category III grant we will build upon these connections, and promote our mission of this grant. Our mission is to create a community based, clinical center for excellence for the treatment of children and families who have been exposed to trauma, for example, sexual abuse, domestic violence, community violence and traumatic bereavement. We have a three point strategy for community planning and consultation on consensus: connection of all existing coalitions, increasing public awareness and helping form a trauma-affected parent and child advocacy coalition. New Haven is resource rich in active coalitions and CBC has a leadership role in many (see collaboration Chart 1, Appendix 1 in Section A of the Narrative). Our plan is to offer to the existing coalitions to share our connections to the National Child Traumatic Stress Network as well as offer trainings and in-services open to these groups. In addition, in Year Two, we plan on offering a day long conference at one of the many universities in the New Haven area for treatment providers, agencies and children and families affected by trauma. This conference which we will then hold annually after Year 2, will be a networking opportunity for both consumers and therapists, and the publicity from such a conference will increase public awareness of issues related to children and trauma. Clifford Beers Clinic has a long history of offering conferences and informational sessions to the community. For example, our Annual Builders of Hope Breakfast usually has over 250 community members gather to hear about issues of trauma that affect children in our community. Clifford Beers Clinic as part of a training consortium with the Post Traumatic Stress Center offer workshops and supervision for members of the community to promote the identification and treatment of Post Traumatic Stress Disorder. Our proposed creation of a resource guide will allow CBC staff to collect data on current resources in the community in addition to the gaps in services. A communication strategy plan on how to distribute the guide will also allow for increased attention to trauma related services in the community. Finally, building upon an already strong powerbase of children and families affected by trauma, for example, on a recent open house to solicit participants for recreational activities to offer our trauma-affected families (i.e., yoga classes, drumming lessons and/or a Girl Scout program) we had over 70 children and families. As part of our SAMHSA Youth Violence Grant (2003-2005) we have built a strong coalition of mental health consumers affected by violence. We plan on inviting families to participate on the Trauma Center’s Advisory Board as well as to help them form their own independent family advocacy group to meet weekly. As mentioned in previous sections, Clifford Beers Clinic is a member of the Connecticut Community Providers Association and the Department of Children and families work group to explore and assist in implementation of evidenced based practice for children and families in Child Guidance Clinics across Connecticut.

The letter of support from Robert Plant, PhD, Director of Community Mental Health Programs and Services, (see Appendix 1), states clearly that The Department of Children and Families (DCF) has embarked upon a statewide initiative to integrate trauma informed approaches to care into child protective and foster care practice. The Department’s Trauma Initiatives a priority component of the state’s efforts to improve the care to its most vulnerable children and families. Over 57% of our children and families in
treatment at the clinic have been involved with DCF; 18% are in the protective custody of the state. The letter of support from Michael Steers, MS, MSW, Area Director (New Haven) states that DCF has worked closely with Clifford Beers in serving the same population. They have seen the need for trauma informed practices and they support the grant, and desire to work collaboratively with the Clinic if the initiatives funded.

**Describe how the project will mobilize or develop existing expertise and resources:** As mentioned in previous sections, Clifford Beers Clinic has many collaborative relationships within the New Haven community, CBC assumes a leadership role in promoting and serving children’s mental health. Our Board of Directors, our Administrative, Clinical and Clerical staff, many of who have been at the agency for over 15 years, are dedicated to our mission, and committed to serve those who may have difficult serving themselves, and to help the New Haven community grow. Clifford Beers Clinic does not exist alone as an island in New Haven. Chart 1, Appendix 1 in this narrative section shows the multiple links and positions of influence Clifford Beers has within the community. In addition, New Haven, with a Category II site already existing, is a city and county that are fully aware of the dangers and affects of violence on our children. We know the needs of our community; we need additional resources to create a change. CBC can access many resources for the NCTSN: we are the mangers of the county’s Multidisciplinary Investigating Team (MIT), we are co-chairs of the children’s subcommittee of the Domestic Violence Task Force, CBC has multiple connections and access to a research university (Yale University) and research hospital on PTSD (West Haven Veterans Affairs Hospital) within a few miles of its doors. CBC has the respect and support of the community leaders as well as the parents and families we serve.

There are key collaborations that Clifford Beers Clinic (CBC) currently has that will allow our center to serve as a resource and seen as an expert in child and adolescent trauma. The first is the long standing training consortium CBC has with the Post Traumatic Stress Center (PTSC). CBC and the PTSC have had the APPIC approved training center since 1998, and staff and students are trained at both facilities in working with children who have been traumatized. The Director of the PTSC, David Read Johnson, PhD, is on the faculty at Yale University School of Medicine and was the director of outpatient services at the National Center for PTSD, West Haven, CT from 1993-1996. Dr. Johnson, who is a clinical supervisor at Clifford Beers Clinic, will sit on the advisory board for the CBC CFTC. The consortium between the two programs has helped bring efficacious trauma treatments to CBC. For example, all staff were trained in the evidenced based trauma treatment Counting Method (Ochberg, Johnson & Lubin, 1995) and CBC has adapted the Interactive Psychoeducational Group Therapy (Johnson & Lubin, 1998) program for adolescents. Clifford Beers Clinic has a long standing collaborative relationship with Yale Child Study Center and the National Center for Children Exposed to Violence (NCCEV) Child Development- Community Policing Program (CDCP). The directors of the center, Steven Marans, PhD and Steven Berkowitz, MD wrote a letter of support highly recommending that CBC be chosen as a Category III site (Appendix 1) in order to deepen the already strong collaboration between the two sites. The proximity of the centers will allow for us to capitalize on our existing strengths: the CDCP program sees children and families immediately after a family violence incident. Clifford Beers runs an emergency mobile crisis unit, a sexual abuse treatment team and a domestic violence program that also address children and their families who have been recently exposed to trauma and abuse. Clifford Beers is ready and willing to expand and implement a field test of the acute trauma curriculum designed by the NCCEV Child and Family Trauma Program. This collaboration of the Category II and III sites will contribute to the creation of new and innovative treatment interventions for multiple categories of trauma exposure.

**Describe the key stakeholders for the project, how they will be recruited:** We see the key stakeholders of this project as the children and families of New Haven, and on the new advisory board for
this NCTSN site we will have at least two parents participate on the board. Clifford Beers Clinic has a long history of serving children and families in the New Haven area. We are the oldest outpatient mental health clinic in Connecticut. The recruitment and selection of the children and their parents for our treatment program will come from the clinic’s large clinical population of families affected by trauma. In the fiscal year 2003-2004 Clifford Beers Outpatient Services admitted 395 new cases, and served in our outpatient clinic over 2552 children and families, and provided 21,280 units of service. In the last year children presented with multiple problems such as: 44% of the families reported at intake that their child has experienced or witnessed domestic violence or sexual assault. 65% of the children at the Clinic have experienced or witnessed severe abuse, trauma or loss. 44% of the children report depression and 36% report anxiety as presenting problems. 55% of the presenting problems are related to family issues, including severe parent/child conflict, sibling conflict, and parenting issues. 22% of the children present with school behavioral difficulties, including expulsion, academic problems or phobias.

Our children and families are the center of our clinic. Our treatment philosophy centers upon strengthening families, and we offer a broad range of resources and services for our families from a 24/7 emergency mobile crisis unit to hosting a Girl Scout Troop on Thursday evenings. Our families remain connected to the clinic, and depend on their connection to CBC well beyond their clinical treatment. We have served generations of families at the clinic; parents report that they came to the clinic when they were children. Our families care for and feel connected to the clinic. One mother reported to the reviewers at the last United Way site review: “I don’t know where me and family would be without the help the clinic gave to us- I think my son would have died if it hadn’t been for the help he received for his depression. And the help I got to understand his problems. They helped me with that, with the courts to help get my husband to pay child support, (my clinician) helps me when I call her and tell her I had a bad day!” CBC runs a parent satisfaction survey quarterly and the results of the last survey (132 parents surveyed) showed that the help received at CBC has assisted the parent/custodian to feel empowered and respected when coming to the clinic. For example: 78% of parents indicated that they helped choose their child’s treatment goals; 92% of parents reported being involved in their child’s treatment; 97% of parents surveyed indicated that they felt that they were treated with respect at the clinic. In addition, parents report that they felt that the clinic has helped their child: 70% reported that their child is better able to handle daily life; 66% of parents reported that their child’s relationships with family members has improved, while 68% of parents reported that their child is doing better at school; 92% of parents indicated that the services they received were helpful to them, and 93% reported that they would use these services again if their child needed assistance in the future. Our other key stakeholders are members of the community who serve children and families affected by trauma. We have received overwhelming support from the New Haven community for our application to the NCTSN, as evidenced by the letters of support (LOS) we have received. We have the strong support of John M. Leventhal, Medical Director of the Child Abuse program at Yale University (see LOS, Appendix 1), lead researcher of child sexual abuse and the and Editor of the Journal of Child Abuse and Neglect. Dr. Leventhal says in his LOS that Yale Sex Abuse Clinic has worked with CBC for over 15 years, and he is greatly impressed with the high quality of services and the efforts to provide evidenced-based care, and that he and his clinic staff support the need for the quality of service provided by the clinic to traumatized children.

Describe how the project will invite and utilize input from consumer constituency groups: Clifford Beers Clinic also has a strong history of inviting and utilizing consumer input, and in the proposed Child and Family Trauma Center, affected children and families will be the center of our advisory board. CBC has built a strong community of consumers who are not only interested in their own well being, but interested in supporting services for others. We will utilize consumer input by: 1. Having two positions on our advisory
board open to consumers; 2. Hold focus groups once the grant is received to present the Center, and asking for input and suggestions; 3. Continue to collect client satisfaction survey information in particular on the new center; 4. Use the new grant to build upon the already grass root coalition of our families affected by trauma to help them access resources and funding within the state to become their own family advocacy group. CBC will continue to build upon their development of systems of care for children and families. The Clinic has a long history of collaboration with child and adult serving agencies. The Clinic has been a leader in the development of the DCF System of Care initiative in the Greater New Haven area by organizing, attending and chairing the monthly meetings. The Clinic has acted as the fiduciary since 1998 when the Department of Children and Families of Children and Families first funded the initiative. The New Haven Collaborative in particular has a membership of nearly 20 providers, advocates, City staff, school representatives and parents. CBC also has access to outlying towns and their collaboratives, we participate in the West Haven Interagency Network for Children (WHINC). These are local consortiums of public and private health care providers, parents of children with behavioral health needs and service and education agencies organized to develop coordinated comprehensive community services, in collaboration with identified children and their parents, to prevent out of home placements or to ensure successful community re-entry for residential placements. In August 2004, the Clinic acting as a “lead agency” and the State of Connecticut-DCF, began to implement a Managed Service System to ensure that children returning to the community from residential care have comprehensive community discharge plans. This initiative has required strong collaboration with all DCF contracted child-serving agencies in the area. CBC also has experience in developing a program strongly based on consumer input. CBC is a recipient of a 2003-2005 SAMHSA Youth Violence Prevention Project (YVVP). The YVPP approached violence prevention from a coalition building, multi-level perspective. We have done so by engaging parents, young people, school personnel, and community providers of Fair Haven. YVPP has built a broad collaborative with public and charter schools in Fair Haven, the New Haven Housing Authority, Farnam Neighborhood House, other community organizations and residents of all ages to plan for and create a multi-ethnic culturally competent community intervention to address and reduce violence. The intervention involves an educational theater group, who took all that community and to say and convert it into a play to bring back to the community that will inspire more conversations and education about community violence. CBC ran multiple focus groups within the community to understand their perceptions of violence. The Coalition built from this YVPP SAMHSA project will be utilized to build this SAMHSA NCTSN Grant.

Describe how NCTSN will be used to increase the trauma expertise of the Center: As discussed in the section above, the proximity of a NCTSN Category II site in New Haven at Yale Child Study Center can be described as fortuitous and fortunate. CBC and Yale’s commitment to collaborate on deepening trauma treatment and research will truly represent the intentions of the Department of Health and Human services and SAMHSA’s to promote collaboration and best practices in the local community, across the State and within the Country. CBC has also been in contact with and has a letter of support from Dr. Judith Cohen, the lead researcher on the TF-CBT. Dr. Cohen, and the Project Director, Dr. Forrester, and the project Evaluator, Dr. Vaughn, have all spoken about the potential of CBC working with the TF-CBT curriculum, and have discussed the desire to collaborate and be trained to provide the treatment modality (and possibly the other modalities Dr. Cohen has authored). Not only the project staff but all the trauma therapists at both CBC and at least one staff from our consortium at the Post traumatic Stress Center will train in the TF-CBT as well as develop expertise to train other clinicians both locally and within Connecticut.

Describe a plan to develop and implement a multifaceted sustainability plan: CBC will develop a five point sustainability plan for each component of the project. The components are: the Community Initiative, the Treatment Initiative, the National Network Initiative and Evaluation Initiative. Each part of the
The sustainability plan will interrelate with each other thought-out each stage and year of the project. The five-point/interrelated plan is as follows: 1. Assessment, by which we will organize the community to profile needs, including community readiness. A project vision will be created from each Initiative; the vision will be re-visited and re-articulated at every stage of plan re-evaluation; 2. Capacity, by which we will mobilize the community and build capacity to address the needs of the community. At this point, the community will be engaged in the design of the trauma center. Focus groups will be held with consumers of trauma services at CBC, and advisory board will be formed. 3. Planning, by which we will develop the intervention, that is the activities, programs and strategies.; 4. Implementation, of the plan; and during the implantation of each activity, an evaluation will be completed by both the parents and families, community members or staff involved in each activity. Marketing strategies will be combined with public awareness campaign, and the social network of CBC will be utilized to expand the reach of the trauma center. and 5. Evaluation; by which we will evaluate each intervention and examine the results and consider sustainability. The support for the sustainability plan will be on every level of the intervention; there will be weekly meetings of the Child and Family Trauma Center Team, and with the assistance of the Project Director and the Project Evaluator, and Project Developer, the team will review the sustainability plan, and reflect upon the assessment of the needs, our ability to address the capacity to address the needs, review our planning and the activities of each Initiative and their implantation. CBC administration has committed to the development of the Trauma Center; receiving the grant will be the culmination of 10 years of work of the administration and staff in placing trauma treatment in the forefront of CBC. Deepening our treatment practices, strengthening our position within the community as consultants and educators about trauma-informed practice as well as building and modeling a network dedicated to children and families have been key strategic initiatives of CBC. CBC has been developing the trauma center strategic initiative over the last few years, grants that have been written have focused specifically on increasing trauma treatment resources; and there will be, once the grant is given, a meeting of our development team to build on the strategic resources of the clinic and to develop a plan for sustainability in our grant writing department.
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<tr>
<th>ACTIVITY</th>
<th>TIMELINE</th>
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<tr>
<td><strong>Parent Education Groups</strong></td>
<td><strong>ACTIVITY</strong> Weekly Family Linkage groups and monthly &quot;Parent University&quot; classes</td>
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<tr>
<td><strong>ACTIVITY</strong> Parent Education Program</td>
<td><strong>TIMEFRAME</strong> October 2005-September 2009- Parent Education Program 10 Parent Universities; 2 Family Linkage Programs (12 sessions, 12 weeks)</td>
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<tr>
<td><strong>ACTIVITY</strong> Monthly &quot;Parent University&quot; classes</td>
<td><strong>TIMEFRAME</strong> October 2005-September 2009- Parent Education Program 10 Parent Universities; 2 Family Linkage Programs (12 sessions, 12 weeks)</td>
</tr>
<tr>
<td><strong>Milestone</strong></td>
<td><strong>Milestone</strong> 50 Parents per year will attend Parent University; 20 parents per year and 25 children will attend Family Linkage Groups. Total to be served 200 adults; Staff: Parent Educator, Clinical Staff, Case Manager</td>
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<td><strong>Public Relations</strong></td>
<td><strong>ACTIVITY</strong> Publication of Greater New Haven Family Trauma Resource guide at the end of August 2006. <strong>TIMEFRAME</strong> Updated annually. Begin August 2006 Milestone: 3 (total) Resource Guides published Staff: Community Outreach Coordinator</td>
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<td><strong>ACTIVITY</strong> Conduct resource assessment for trauma affected clinical and case management services for children and families in Greater New Haven community. Design potential web site and produce resource directory by August 2006. Send our Press releases and present information to community about directory. <strong>TIMEFRAME</strong> Year 1: October 2005-January 2006- Conduct resource assessment for trauma affected clinical and case management services for children and families in Greater New Haven community. Design potential web site and produce resource directory by August 2006. Send our Press releases and present information to community about directory. Year 2-4: Continue to collect and update resource data, revise directory annually</td>
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<td><strong>Family Advocacy Groups</strong></td>
<td><strong>ACTIVITY</strong> Group formed and running meetings by October 2006, to completion and beyond of grant. Milestone: Meetings of a Family Advocacy Group of Families Affected by Trauma. (10 per year, total 40 per 4 year grant) Staff: Community Outreach Coordinator, Parent educator, Case manger</td>
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<td><strong>Year 1: October 2005-Initial meetings with families; Group formed by June 2005</strong></td>
<td><strong>Year 2: Meetings held throughout all years</strong></td>
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<td><strong>Year 2: October 2006- September 2009-  Parent Education Program 10 Parent Universities; 2 Family Linkage Programs</strong></td>
<td><strong>Year 3: October 2007- September 2008; Year 4: October 2008- September 2009</strong></td>
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<tr>
<td><strong>Milestone</strong></td>
<td><strong>Milestone</strong> 50 Parents per year will attend Parent University; 20 parents per year and 25 children will attend Family Linkage Groups. Total to be served 200 adults; Staff: Parent Educator, Clinical Staff, Case Manager</td>
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<td><strong>Attendance of all trauma affected coalition groups</strong></td>
<td><strong>Year 1-4 attendance to at least 10 meetings per year; presentation at 3 meetings, one per year about CBC CFTC, NCTSN and trauma-informed practice.</strong></td>
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<td><strong>Time Frame</strong> Begin October 2005- through completion of grant and beyond. Milestones: Presentation of NCTSN goals and CBC’s trauma center at 3 coalitions meetings per year. Staff: All Staff on grant: Clinical staff, Community Outreach, program Director, Parent Educator, Data Manager</td>
<td><strong>Time Frame</strong> End of Year Two, September 2006. Hold Conference yearly, September 2007, 2008. Milestones: Annual Conference held at a University in greater New Haven. Staff: All Staff on grant</td>
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<tr>
<td><strong>Year 1: Planning and Preparation</strong></td>
<td><strong>Year 2: Think Tank/Conference held September 2007, total of 2 conference/think/tanks until 2009</strong></td>
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<tr>
<td><strong>Year 2: Think Tank/Conference held September 2007, total of 2 conference/think/tanks until 2009</strong></td>
<td><strong>Year 3: October 2008- September 2009; Year 4: October 2009- September 2010</strong></td>
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<tr>
<td><strong>Year 3: October 2008- September 2009; Year 4: October 2009- September 2010</strong></td>
<td><strong>Year 4: October 2009- September 2010, 20-25 families; Year 5: October 2010- September 2011, 25-30 families</strong></td>
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<tr>
<td><strong>Milestone</strong></td>
<td><strong>Milestone</strong> 50 Parents per year will attend Parent University; 20 parents per year and 25 children will attend Family Linkage Groups. Total to be served 200 adults; Staff: Parent Educator, Clinical Staff, Case Manager</td>
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<td>Year One: Conduct resource assessment for trauma affected clinical and case management services for children and families in Greater New Haven community. Design potential web site and produce resource directory by August 2006. Send our Press releases and present information to community about directory. Year 2-4: Continue to collect and update resource data, revise directory annually</td>
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<td><strong>ACTIVITY</strong> Implement program for years 2-4. Time Frame: Year One- October 2005- September 2006. 10 families total in pilot program Year 2: October 2006- September 2007, 15 families ; Year 3: October 2007- September 2008, 15-20 families; Year 4: October 2008- September 2009, 15-20 families Milestones: Estimate number of families served = 50 families with an estimate of 100 individuals from greater New Haven Area Staff: All Staff on grant: Clinical staff, Program Director, Case Manager, Parent Educator, Data Manager</td>
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<td><strong>EVAULATION</strong></td>
<td><strong>ACTIVITY</strong> A. Collect and record all data; evaluation reports to be produced every 6 months B. Create publishable about findings in peer-review journals.</td>
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**Plans for sustainability:** The CBC Child and Family Trauma Center will undertake a number of activities which will ensure the sustainability of the program after the funding period ends. Activities include: **Other Funding Sources:** The CBC Child and Family Trauma Center will seek foundation, state, and federal funding. Based on the existing collaboration for the proposed project, there is a strong commitment on the part of the partnering organizations to continue and expand trauma-informed services. The Clinic has many years of successful grant seeking and developing experience to assist in this process, and has qualified grant writers on staff. In this regard, it should be noted that the statistics kept by the program will provide compelling evidence to grant funding agencies and organizations. **In-kind resources:** The applicant (The Clinic) has the strong support of key decision-making staff for this effort and the trauma-informed program to be delivered. With an annual budget of over $4.5 million, the Clinic will seriously consider the possibility of providing in-kind resources to the project. In addition, the program will have an active Advisory Board, who will continue to contribute time, expertise and resources to the project. **Integration into existing programs:** The Clinic has experience integrating new services, methodologies and staffing into existing operations. For the proposed project, an example of this would be the integration of the trauma-informed training to Clinic staff in its other programs and services, as well as other providers in the New Haven area, which will lead to enhanced trauma-informed capabilities. This will help to ensure that such activities will become critical mental health activities.

**Section D: Management Plan and Staffing** Discuss the capability and experience of the applicant organization: Established under the Connecticut General Statutes as a Child Guidance Clinic to serve the mental health needs of Connecticut children and youth, it is dedicated to the prevention, evaluation and treatment of mental illness in children, adolescents, and their families. It provides a broad range of mental health services, from outpatient treatment to emergency 24-hour crisis intervention services. Recruitment, successful hiring, and retention of culturally competent staff are of utmost importance in ensuring that the staff is culturally sensitive to the diverse client population that is served. CBC runs one of two of the only outpatient treatment programs for children and adolescents with problem sexual behaviors in Connecticut. Other services include psychopharmacology, medication monitoring and referral services. The Clinic also provides 24-hour/7 day a week emergency service to children, youth and families in crisis. Staff regularly consult with local school personnel and participate in PPT meetings to advocate for needed educational services for children. The Clinic strives to provide culturally sensitive services to its client population.

**Describe the applicant organization’s prior community and service systems:** As described in Section A, Clifford Beers Clinic has been a “hub” for many community human service organizations dedicated to treating children and families with mental health and behavioral issues (see Chart 1, Appendix 1). Clifford Beers Clinic has ensured the provision of accessible and most appropriate services to children and families, and thus enhancing the probability of successful outcomes. Clifford Beer’s treatment bio-psychosocial treatment philosophy is grounded in collaboration. The Clinic has worked to remove barriers to accessing services and tailors its services to both individual and community needs. To ensure that clients find services accessible and acceptable, services are offered in non-traditional, community-based and outreach settings; the program offers accessible hours, including walk-in appointments, and flexible and extended hours of operation. For the target population, the intervention is culturally competent: Providing culturally competent services means that clients perceive services as relevant to their problems, helpful in achieving the desired outcomes, and comfortable. The Clinic ensures that the services it provides are culturally competent by: 1) adapting services to differences in family structures, expectations, preferences, help-seeking behavior, world-views, and class backgrounds; 2) eliminating geographic, linguistic and other barriers that restrict access to services by clients of diverse ethnic and cultural backgrounds; and 3) providing ongoing cultural competence training for staff in such areas as cultural identity development, and culturally-specific interventions. For the target population, the intervention is developmentally appropriate, and program staff is responsive to the needs of the target population.

**Provide a list of staff members who will conduct the project:**

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<tr>
<th>Staff Members</th>
<th>Name</th>
<th>Qualifications</th>
<th>Level of Effort</th>
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<tbody>
<tr>
<td>Project Director</td>
<td>Alice Forrester</td>
<td>PhD</td>
<td>0.70</td>
</tr>
</tbody>
</table>
Provide evidence that the service staff proposed have the level of abilities and experience: See Biographical Sketches of proposed staff. All MA level staff who will be hired specially for this grant will be trained in the two treatment modalities will be licensed or licensed eligible in their specific fields of study.

Describe the experience of the applicant organization and staff in community education, service provider training and consultation: As discussed in previous section, CBC has served as community clinical consultant s for multiple human service agencies (see Chart 1, Appendix 1) over its 92 year history. These are the following organizations CBC staff have consulted with and for over the last five years: Department of Children and Families, New Haven Board of Education, with formal residencies in the Clinton Avenue Middle School, Martin Luther King Schools, Highville Mustard Seed School Corporation; Life Haven, a homeless shelter for children and families, Youth Continuum, a residential and independent living program for youth; The West Haven School Readiness Program, United Way Success by Six Program; Office of Victim Services, Connecticut Advisory Council for Victims of Crime; CBC staff train staff and consult for the Connecticut Juvenile Justice Center; Long Lane Correctional Facility; Connecticut Children’s Place; High Meadows; Executive Staff at CBC sit on the DCF New Haven Advisory Council, DCF Behavioral Health Partnership Advisory Council, are Board members of the West Haven School readiness council; CBC staff are on the City Wide Youth Coalition, New Haven Arts Council and Connecticut Community Providers Association.

Clifford Beers Clinic has a well-developed parent education curriculum that includes a creative arts therapy program, a family violence prevention group, and a psycho-educational parents program that is designed for both families and children affected by substance abuse, in relative/foster placement and/or affected by abuse, neglect or HIV/AIDS. Our monthly Parent University psycho-educational program focuses on special topics such as working with state assistance agencies and child development, Clifford Beers has run this program since the Fall of 2000 and over 60 families have participated in the program. Our monthly Parent University psycho-educational program focuses on special topics such as working with state assistance agencies and child development. Clifford Beers has run this program since the Spring of 1998 in various community settings, and over 65 families have participated in the program. This program is also useful for caretakers of children who have experienced trauma.

Identify the project staff or contractor(s) who will develop the implementation manual: The Project Director, Dr. Alice Forrester and Dr. Amy Sceery, along with program staff will train in the use of the treatment with the authors of the identified treatment programs, (CFTI) Dr. Steven Marans and Dr. Steven Berkowitz, Yale Child Study Center and with trainers from Allegheny Children’s Hospital, and or with Dr.
Judith Cohen for the TF-CBT. Describe the racial/ethnic characteristics of key staff and indicate if any are members of the target population/community: Out of the key staff identified for this project (total of 11), 6 staff are currently employed at the clinic. Out of that number, 3 are Caucasian, 2 are African American and one is bilingual/bicultural Hispanic. If we receive the grant we will hire at least one bilingual/bicultural Hispanic clinician and a bi-lingual/bicultural Hispanic case manager. If you plan to have an advisory body, describe its composition, roles, and frequency of meetings:

We do plan on having an Advisory Board for the Children and Family Trauma Center. It role will be one of advising and reflecting upon needs and trends of treatment for children and families affected by trauma. We propose that the group meet quarterly, and the CFTC staff will be charged with updating the Board of its efforts over the quarter, and to conduct a sustainability review at least one time per year of the grant. At this point we will have two consumers of CBC services (parents/caregivers, or adolescents) one member from the Department of Children and families, and two established researchers about trauma in the community. Although the advisory board is not formed as of yet, John M. Leventhal, MD, Medical Director of the Child Abuse program at Yale University, lead researcher of child sexual abuse and the and Editor of the Journal of Child Abuse and Neglect has agreed to be on the board. In addition David Read Johnson, PhD, has agreed to also be on our advisory board. Dr. Johnson is the Director of the Post Traumatic Center and Women's Trauma Program in New Haven, who is also on the faculty at Yale University School of Medicine and was the director of outpatient services at the National Center for PTSD, West Haven, CT from 1993-1996. Dr. Johnson, who is a clinical supervisor at Clifford Beers Clinic, will sit on the advisory board for the CBC CFTC.

Describe the resources available for the proposed project (e.g., facilities, equipment): CBC is the owner and manger of a building in New Haven where the CFTC will reside. All equipment (office equipment, computers, heat/air conditioning, etc) is ADA accessible, and is centrally located for our target population, easily accessed by public transportation. Describe in your budget the resources: Every person on the grant will devote at least 25% of their time on Network activities, participating in committees, collaboration with other centers and participation on cross-site evaluations.

Section E: Evaluation Design and Analysis

Performance Evaluation Plan for the Proposed Approach: The evaluation design was developed with the logic model as its framework depicting the interrelationships among the goals, objectives, intervention activities and evaluation outcomes. The evaluation team, along with the Clifford Beers Clinic(CBC) and the partner organizations, will use collaborative planning to monitor of all aspects of this National Child Traumatic Stress Initiative, the Child and Family Trauma Center (CFTC). The evaluation of CFTC-specific activities is viewed as a continuous process whereby information gained from the evaluation will be fed back to the project and the community. Modifications to the evaluation design will be determined by the evaluator, program staff with input from key stakeholders such as family and youth Coalition members. This will incorporate on-site establishment of data systems, regular meetings to discuss of all aspects of the project (including outcome objectives), collaborative interpretation of findings, and dissemination of results.

The evaluation will incorporate both process and outcome data collection activities in order to: 1) Document process objectives including; needs assessment, community partnering, coalition building process, psycho-educational programs and provider training 2) Identify the implementation strategies used by the project including strengths and limitations of key components of the program 3) Document the effectiveness (outcomes) of key evidence-based treatment modalities –clinical treatment, and acute intervention, 4) Monitor, provide feedback and recommendations regarding implementation of project’s goals, objectives and activities.
The process evaluation of the Community Initiatives including the formation and functioning of the Trauma-informed Coalition of Task Forces & the New Haven Parent and Child Advocacy Group will include a review of meeting minute notes, observations, key informant interviews, and focus groups. The process evaluation of the task force/coalition will involve an assessment of the macro-environment, consensus building, decision making process, management of conflict and disagreement, consideration of cultural sensitivity, level of adherence to program objectives, and factors that facilitate or hinder the functioning of the infrastructure. The outcome evaluation design will focus on three key questions. Is there a decrease in PTSD and other trauma related symptoms in parents and children after treatment? Is there a change in knowledge, attitudes, intentions and behaviors of children and parents who are involved in the program? What were the contextual and individual factors that were associated with client outcomes? A pre - post design will be used (the program will use an evidence-based intervention that has already been subjected to more rigorous evaluation methods). Potential sources of comparison data will be identified among clients who do not receive this treatment, as well as data from other network centers. Data will be collected on intervention participants at intake, prior to the intervention, and post-intervention.

CBC - CFTC — Evidence Based Treatment Sample Size

<table>
<thead>
<tr>
<th></th>
<th>Year 1</th>
<th>Year 2</th>
<th>Year 3</th>
<th>Year 4</th>
<th>TOTAL</th>
</tr>
</thead>
<tbody>
<tr>
<td>TF-CBT</td>
<td>25</td>
<td>40</td>
<td>60</td>
<td>60</td>
<td>185</td>
</tr>
<tr>
<td>CFTSI</td>
<td>10</td>
<td>15</td>
<td>20</td>
<td>20</td>
<td>65</td>
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</table>

Plans to assess Project Implementation and Fidelity: The evaluation team will focus on the project’s adherence to: core program components, minimal training/instructional hours suggested by the model’s developer, and adaptations made to programmatic- materials, dosage, structure, or role/behavior of the facilitators. In addition, staff familiarity and sensitivity to the concerns, culture, and needs of the target population will be assessed.

Logic Model - Evaluation of the Pilot Test of Best Practice & other Implementation Activities

<table>
<thead>
<tr>
<th>Objectives</th>
<th>Evaluation Questions</th>
<th>Data Source/ Methodology</th>
<th>Anticipated Outcomes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Evidence Based Treatment Initiatives</td>
<td>Did all designated staff, clinicians and interns receive training from approved trainers in TF-CBT and CFTSI? Did 25 children ages 7-18 and their families participate in the Pilot of the TF-CBT program by September 2006? Were children and families satisfied with the treatment? To what extent do children and families improve after treatment? What steps were taken to adapt?</td>
<td>Training attendance records, Training Evaluation Forms, Number of staff certified in evidence based practice. TF-CBT data collection &amp; adherence instruments (baseline &amp; at exit – 3 months): Child Behavior Checklist(CBCL); Children’s Attributions and Perceptions Questionnaire, Parent’s Emotional reaction Questionnaire, Parental Support Questionnaire, Parenting Practices Questionnaire, Beck Depression inventory (parents); UCLA PTSD Index: AGH TF-CBT Adherence Checklist. Staff interviews, parent &amp; youth interviews/focus groups. CFTSI data collection &amp; adherence instruments (baseline &amp; at exit – 1 month): PTSD-RI; Mood and Feelings Questionnaire, The Parent Behavior Inventory; Social Support-Family instrument. Staff interviews, parent &amp; youth interviews/focus groups.</td>
<td>Staff report satisfaction with training. Trainers report staff meet training standards. Supervisors report staff meet practice adherence standards. Decrease in identified children’s and parent’s PTSD symptoms, depression and anxiety; decrease in sexually acting out behaviors, feelings of shame, and mistrust in others. Staff, children &amp; families report satisfaction with the treatment.</td>
</tr>
<tr>
<td>Clinical treatment approach</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Trauma Focused Cognitive Behavioral Treatment (TF-CBT) (Cohen et. al.)</td>
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<tr>
<td>Acute Intervention</td>
<td>Did 10 families participate in the Pilot of the CFTSI program by September 2006? To what extent do children and families improve after treatment? Were children and families satisfied with the treatment? What steps were taken to adapt the model?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Child &amp; Family Traumatic Stress Initiative (CFTSI) (Yale Child Study Center)</td>
<td>Staff report satisfaction with training. Trainers report staff meet training standards. Supervisors report staff meet practice adherence standards. Decrease in identified children’s and parent’s PTSD symptoms, depression and anxiety; decrease in sexually acting out behaviors, feelings of shame, and mistrust in others. Staff, children &amp; families report satisfaction with the treatment.</td>
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</table>

Community Based Initiatives

| Training Service Providers & Community Outreach | Did CBC staff attend monthly meetings at each of the 7 designated task forces/coalitions? Did CBC staff make 3 presentations to these groups by October 2006? What are the local | Attendance records, Meeting minutes, Staff participant’s reflections/notes | New Haven will have a trauma-informed coalition of all existing task forces. Conference participants report satisfaction with training. |
| Did CBC staff attend monthly meetings at each of the 7 designated task forces/coalitions? Did CBC staff make 3 presentations to these groups by October 2006? What are the local | Conference attendee list, Conference | | |
| | | Conference | |
### Psychoeducational Programs
- **New Haven Parent & Child Advocacy Group** (Deliverables = Community Resource Fair)
- **Multi-Ethnic Family Strengthening/Family Linkage Program**
- **Parent University Classes**

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<thead>
<tr>
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<tbody>
<tr>
<td>Recruitment activities, attendance records, observation logs, participant surveys,</td>
<td>Recruitment activities, attendance records, observation logs, pre-post participant surveys</td>
</tr>
<tr>
<td>Observation logs, participant surveys</td>
<td></td>
</tr>
</tbody>
</table>

### Network Initiatives
- **Networking Plan for National, State and Local Services**
- **“White Paper” documenting practice and service gaps**
- **Increased NCTSN activities**
- **Participate in National Child Traumatic Stress Initiative Cross-site Evaluation**

<table>
<thead>
<tr>
<th>Attendance records, Meeting minutes, Staff participant’s reflections/notes, key stakeholder interviews, observations</th>
<th>National Child Traumatic Stress Initiative Cross-site data collection outcome &amp; process instruments (baseline &amp; at exit – 3 months) (CBCL, TSCC-A, PTSD-RI)</th>
</tr>
</thead>
<tbody>
<tr>
<td>An action plan is developed that reflects collaboration across academic/practice/discipline boundaries.</td>
<td>Knowledge and results are disseminated and reported on local, state and national levels.</td>
</tr>
<tr>
<td>Services are delivered to children and families impacted by trauma that are developmentally appropriate, family-centered and culturally competent.</td>
<td>Improved outcomes for traumatized children and families.</td>
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**Plan for Data Collection, Management, Analysis, Interpretation and Reporting**

Team meetings involving the Evaluator, Data Manager and Project Director will be held regularly (weekly at the beginning, and bi-weekly thereafter) in order to assess the adherence of the proposed program activities with actual activities. Treatment and Evaluation consent forms will be obtained from participants and parents or guardians prior to data collection. Instruments will be administered individually by clinical staff. The interview will be conducted in Spanish for Latino clients who are more comfortable speaking Spanish. Demographic data will be collected during all interventions including: race/ethnicity, age, and gender. Project staff will be responsible for documenting the number of clients served for each intervention activity.

The Data Manager at Clifford Beers will maintain all primary data and the Evaluator at the Vaughn Associates will maintain the secondary data. An identifier will be assigned to each youth and parent participant so that data collected at various points in time can be linked. Names and personal identifying
information will not be put on questionnaires. Identifier lists well be kept separate from questionnaires. Data will be stored in a locked file in the office of the Clifford Beers Data Manager.

All data and listings that exist on computer files will have limited access, through password protection. A computer storing program data will be located in offices that will be locked when unoccupied.

**Plans to Participate in the National Child Traumatic Stress Initiative Cross-site Evaluation**

The evaluation will be subcontracted to Gretchen Chase Vaughn, Ph.D., of Vaughn Associates. Dr. Vaughn as a program evaluator and behavioral science consultant has devoted more than twenty years to national efforts in community-rooted prevention and mental health services for under-served populations, particularly ethnically diverse youth. Her experience as a clinician/researcher uniquely qualifies her to forge links between community organizations, services providers and researchers. Dr. Vaughn has evaluated prevention and treatment programs for high risk youth and families funded by SAMHSA & DOJ. In addition, she along with evaluation consultant Marta Elisa Moret, MPH. and statistical consultant Connie Heye, MPH., have provided behavioral science consultation, technical assistance, and program evaluation training to CBO’s and ASO’s through the state of Connecticut. Vaughn Associates provides an evaluation team that is linguistically and culturally competent to work with a population of ethnic minority and urban families and youth.

**Capacity and plans to collect and report National Child Traumatic Stress Initiative Cross-site Data**

The evaluation team of Vaughn Associates has worked extensively with similar outcome data sets on several other projects. Specifically, the evaluation team has successfully collected and reported on data for programs funded under SAMSHA & DOJ grants for the past 15 years, including Government Performance and Results Act (GPRA) data, Core Client Outcome Measures, and National Cross-site instruments. The CBC and evaluation team are committed to participate in the cross-site evaluation and performance monitoring activities in collaboration with other centers in order to support the evaluation of Network intervention planning and outcome assessment.