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TECHNICAL REPORT

How Schools Can Help Students Recover from Traumatic Experiences

A Tool Kit for Supporting Long-Term Recovery

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RAND GULF STATES POLICY INSTITUTE

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Preface

This tool kit is designed for schools that want to help students recover from traumatic experiences such as natural disasters, exposure to violence, abuse or assault, terrorist incidents, and war and refugee experiences. It focuses on long-term recovery, as opposed to immediate disaster response.

To help schools choose an approach that suits their needs, the tool kit provides a compendium of programs for trauma recovery, classified by type of trauma (such as natural disaster or exposure to violence). Within each trauma category, we provide information that facilitates program comparisons across several dimensions, such as program goals, target population, mechanics of program delivery, implementation requirements, and evidence of effectiveness. We explain how to obtain each program's manuals and other aids to implementation and also discuss sources of funding for school-based programs.

Developed after hurricanes Katrina and Rita struck the United States in the fall of 2005, the tool kit was used as part of a research project aimed at helping students displaced by these natural disasters. It was subsequently revised to reflect lessons learned about the kind of information schools needed most and updated to include additional programs uncovered during the research project.

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Section 1: Introduction

On any given day, almost 60 million people (more than one in five Americans) participate in K–12 education (President's New Freedom Commission, 2003). Moreover, the reach of schools extends far beyond school campuses. Parents and others responsible for children often look to schools to keep children safe and to provide direction about how best to support them, especially in times of crisis. Thus, schools play a critical role in the life of communities that extends well beyond classroom schooling, narrowly defined. Part of this role involves meeting the emotional and behavioral needs of children and their families. Schools are called on to address these needs both within the context of their educational mission—promoting and facilitating student academic achievement—and in responding to student behavioral problems (poor attendance, attention or conduct problems, etc.). Schools also play a broader role in community-based mental health (Weist, Paternite, and Adelsheim 2005). Within communities, schools have become a key setting for delivering mental health programs and services. For example, mental health professionals working in schools constitute the largest cadre of primary providers of mental health services for children (U.S. Public Health Service, 2000).

The role of schools in providing community mental health support has been vividly demonstrated in the wake of recent large-scale disasters, including terrorist incidents, mass violence, hurricanes, and other community crises (Weist et al., 2003; National Advisory Committee on Children and Terrorism, 2003) Schools have been used as places of shelter and as sites or points of distribution for needed resources.

In addition, schools have typically been among the first institutions to reopen in a traumatized community. For example, after the bombing of the Murrah Federal Building in Oklahoma City, the Oklahoma City Public School District screened thousands of students and provided psychological support services to many students and school staff (Pfefferbaum, Call, and Sconzo, 1999; Pfefferbaum et al., 1999). In the aftermath of the September 11, 2001, attacks on the World Trade Center and the Pentagon, schools actively provided support services to students. In New York City, more than half of the students who received counseling in the months following September 11 received it through the schools (Stuber et al., 2002). These early

interventions are designed to promote the psychological recovery of students and staff after a range of traumatic events, including natural disasters and terrorism (Chemtob, Nakashima, and Hamada, 2002). But in addition to addressing the acute crisis-response phase, more and more programs have been developed to address longer-term mental health needs of traumatized students, including students exposed to "everyday" traumas such as community and family violence. This tool kit is intended to help schools and districts meet these longer-term needs. It is designed for schools that want to help students recover from traumatic experiences such as natural disasters, exposure to violence, abuse or assault, terrorism incidents, and war and refugee experiences. It focuses on long-term recovery, as opposed to immediate disaster response. In an appendix, we also list programs that focus on short-term intervention and recovery, as well as resources for helping teachers and other school staff get help for their own mental health needs.

The Need to Help Students Recover from Traumatic Experiences

What do we mean by *trauma* and *traumatic events*? *Traumatic events* are extremely stressful incidents, usually accompanied by a threat of injury or death to the person who experiences them or to others in close proximity. The person exposed to the event feels terrified, horrified, or helpless.

There are a large number of potentially traumatic events. These might include:

- natural disasters
- the sudden or violent death of a loved one
- witnessing violence in the home, at school, or in the community
- physical or sexual assault
- child abuse (emotional, physical or sexual abuse
- medical trauma (a sudden illness or medical procedure)
- refugee or war-zone experiences
- terrorist incidents

In recent years, the number of students exposed to these kinds of traumas has increased substantially, and it seems unlikely to diminish. Neither does the importance of helping students cope with the long-term consequences of traumatic events.

Exposure to traumatic events can have significant long-term consequences for students. Reactions to traumatic events vary, but they usually include anxiety and nervousness as well as sadness or depression. In addition, some students act out more in school, with peers, and at home. Some of these consequences directly interfere with performance in school.

Research has shown that exposure to violence leads to:

- decreased IQ and reading ability (Delaney-Black et al., 2003)
- lower grade-point average (Hurt et al., 2001)
- higher absenteeism (Beers and DeBellis, 2002)
- decreased rates of high school graduation (Grogger, 1997)
- significant deficits in attention, abstract reasoning, long-term memory for verbal information, decreased IQ, and decreased reading ability (Beers and DeBellis, 2002)

These changes in student performance and behavior result from the emotional and behavioral problems that people experience following traumatic events. For instance, classroom performance can decline because of an inability to concentrate, flashbacks or preoccupation with the trauma, and a wish to avoid school or other places that might remind students of the trauma. In addition, school performance and functioning can be affected by the development of other behavioral and emotional problems, including substance abuse, aggression, and depression**.**

The way students show their distress can vary by age. For instance, *preschool students* sometimes act younger than they did before the trauma, and often reenact the traumatic event in their imagination play. They may have more temper tantrums or talk less and withdraw from activities. *Elementary students* often complain of physical problems, like stomach aches and headaches. They too might show heightened anger and irritability, and may do worse on their assignments, miss school more often, and have trouble concentrating. Some may become more talkative, and talk or ask questions excessively about the traumatic event. *Middle- and high-school students* may be absent from school more often and may engage in more problem behaviors (such as substance abuse, fighting, and reckless behavior). School performance may decline, and interpersonal relationships can be more difficult (National Child Traumatic Stress Network, 2006).

In the aftermath of a traumatic event, as those affected begin to rebuild and recover, emotional and behavioral difficulties may begin to subside. However, many victims continue to suffer difficulties for several months. In addition, the challenges associated with returning to "normal" may create more anxiety and emotional difficulty.

Fortunately, a number of programs have been developed to help children deal with traumatic events, and some of these have been developed specifically for use in schools. Most of these school-based programs attempt both to reduce emotional and behavioral problems related to trauma exposure and to foster resilience in students for the future. Although many of the programs have not yet been evaluated, a handful have been shown to yield positive results, and many draw on evidence-based techniques.

Schools are logical venues for such programs. Over the last few decades, mental health programs in schools have grown dramatically (Adelman and Taylor, 1999; Comer and Woodruff, 1998; Evans, 1999; Foster et al., 2005). For instance, many special education students have mental health interventions written into their Individualized Education Programs (Policy Leadership Cadre for Mental Health in Schools, 2001), schools have launched school-based health centers that incorporate mental health programs (Center for Health and Health Care in Schools, 2003), community mental-health providers are sometimes co-located in schools, and expanded school mental-health programs have been developed to pool local resources for students (Weist, 1997, 1998; Weist and Christodulu, 2000). This emphasis on mental health in the schools is seen as important by many and is likely to continue. For instance, the Surgeon General's National Action Agenda for Children's Mental Health (U.S. Public Health Service, 2000) and President's New Freedom Commission on Mental Health (2003) both call for increases in school mental-health programs.

However, despite this embrace of mental health programs, information about evidence-based resources for long-term trauma recovery has not yet been well-disseminated to schools, and thus many school administrators are unaware of the resources currently available for long-term trauma recovery or their effectiveness. Furthermore, successful implementation of such programs depends on school system access to program developers and other personnel with

experience in implementing programs such as these. We offer this tool kit as a step toward filling this information gap.

Purpose and Organization of the Tool Kit

This tool kit is intended to assist school administrators in deciding how to promote the mental-health recovery of children and adolescents following a traumatic experience. The tool kit contains information about a range of long-term recovery programs that schools and districts can implement. It was compiled following hurricanes Katrina and Rita, but it is also broadly applicable to planning responses to other types of trauma and disaster.

The development of this tool kit and the selection of programs were guided by important groundwork from the National Child Traumatic Stress Network (NCTSN), which is funded by the Substance Abuse Mental Health Services Administration (SAMHSA). This network has identified programs and examined the evidence supporting their use: the work is summarized at: www.nctsnet.org/nctsn_assets/pdfs/promising_practices/NCTSN_E-STable_21705.pdf.

We include here programs from their list that have been developed for or used in schools. In addition, we asked experts from the NCTSN and program developers for nominations of additional programs, and we searched the published literature for appropriate programs to include. Finally, through our work in the Gulf states, we learned of additional programs in use in affected schools and included those. Given that most of these programs are relatively new and many have not yet been evaluated, we did not attempt to screen programs on the basis of effectiveness. The level and types of evaluations that have been conducted to date are, however, presented in the tables for consideration. While we aimed to include all appropriate programs documented in the summer of 2006, we may have overlooked some programs that are in development.

We excluded certain types of programs whose goals differed from the original intent of the tool kit: programs for preschool children, programs that are not specifically oriented to trauma, programs that are no longer supported or available, and programs designed for immediate crisis intervention or psychological first aid rather than the longer-term recovery from trauma. We list some of these crisis-response resources in **Appendix A** but do not discuss them

in depth. We also list some tools for helping support schools staff who are working with traumatized children in **Appendix B**.

How to Use This Tool Kit

The tool kit is designed to provide information to help in choosing and implementing a program focused on trauma. Of course, getting a school-based mental-health program up and running is not as simple as pulling a manual "off the shelf." Successful school-based mental health programs involve many people and are often the result of a careful process that includes needs assessment, resource mapping, full and active stakeholder involvement, the development of coordinating teams, the connection of school and community efforts, staff training and support in evidence-based practices, systematic quality assessment and improvement, program evaluation, and public involvement (e.g., Robinson, 2004; Weist, Evans, and Lever, 2003).

We recommend that a small team, including a school mental-health professional, school counselor, or student support personnel, a school administrator, and a community stakeholder use the tool kit to choose a small number of candidate programs and then request input from a larger number of decision makers and mental health professionals. Support from all levels of the school structure and from the community is key to the successful implementation of a program and should be sought before a final selection is made.

We have divided the description of programs into two sections and grouped the programs within each by the type of trauma that they address. We suggest that you use the tool kit in the following way:

1. Begin by selecting the type of trauma that you want the program to focus on. The tables in Section 3 comparing programs are organized by type of trauma: nonspecific (any trauma), disaster, traumatic loss or death of loved one, exposure to violence, and complex trauma (exposure to multiple or prolonged traumatic events as a child, particularly abuse by a caregiver).

2. Look at the various programs for the characteristics that best meet your school's needs and resources. Consider the following questions:

- What specific needs of our students do we want to focus on?
- Is there evidence that this program is effective?
- Has this program been used or tested with a group of students similar to ours?
- Do we have the right kind of expertise within our system to implement a program like this?
- How much would it cost to get this program running in our schools?

3. Consult the program description in Section 4 for details of programs that seem to match your needs and resources. An alphabetical index of programs described in the tool kit can be found in Appendix C.

4. Contact the developers of programs that seem right for you. Talk to them directly about options in your community, including how to successfully implement the program within your school system. All the program contacts listed in this tool kit have agreed to field such calls.

5. Consider funding options in Section 5 that would help support the program that best meets your needs.

Section 2: How to Select Students for Targeted Trauma-Recovery Programs

Some of the programs listed in this tool kit target the entire school population, whereas others use a screening or referral process to identify students who might benefit. All programs usually require some level of parental consent and student assent for participation, with the details of how that happens varying from school to school. Distributing informational materials to parents, obtaining permission to screen children or to implement a program, and communicating with parents throughout the program, all require considerable resources and staffing and should be taken into account during planning.

For programs targeting a particular subset of students, schools need a method of selection. The four primary methods in current use are described below: referral by counselor or teacher, parent nomination, targeted school screening, and general school screening. Which one is right for your school depends on focus of your program, likely parental and child reaction to the mode of selection, ease of administration, staff training required to select students, availability of trained staff, and general administrative burden (including protecting confidentiality). Many of the programs described here include selection guidelines. Thus, once a potential program is selected, schools can ask program developers about the best way to identify students. Just as careful consideration is needed in selecting a program that matches your needs, careful consideration is also needed in selecting students for the program.

1. *Counselor or teacher referral*. School counselors or teachers can be asked to nominate students perceived as needing the intervention program. This approach requires orienting the teachers and counselors to the kinds of problems the program addresses. Because counselors and teachers tend to notice behavior problems more readily than they notice withdrawn or anxious students, this method may not identify all students in need. A brief one-on-one meeting with the student to verify that the program might be appropriate is recommended.

2. *Parent nomination*. Schools may also describe the program to parents and ask them to nominate their own children if they feel it is appropriate (or give permission for an assessment). The limitation to this method is similar to that of counselor or teacher referral: parents do not

always notice withdrawal or anxiety in children as easily as they notice behavioral problems. Again, a brief one-on-one meeting with the student to verify need and interest is recommended.

3. *Targeted school screening*. Students known to have been affected by a traumatic event can be assessed with a screening tool to determine their level of potential need for a trauma-focused program, and those with high scores, indicating distress, can be invited to participate. Parental permission for such assessment is usually required, and confidentiality of the screening results must be protected. Assessments for referral to the programs described in this tool kit should take place at least a few months (usually about 3 months) post-trauma, as the majority of students are likely to be distressed in the immediate aftermath, but for many students symptoms may decrease within this period without any intervention.

4. *General school screening*. Another option is to screen all students in the school, with parental permission. This approach is potentially less stigmatizing and may reveal high rates of trauma exposure that sometimes go undetected by parents, teachers, and counselors. For instance, while some students may be affected by a hurricane or natural disaster, others may be affected by exposure to violence in their community, and some will have both types of experiences. A one-on-one meeting with each student whose assessment shows high levels of distress may still be recommended in order to verify need for the program (as screening can sometimes yield "false positives"), but more students may be detected who are in need than via school staff referral or parent nomination. Usually some training is required to administer screening questionnaires, so that the staff understand the reliability and validity of the measures and how to interpret the scores.

Section 3: Comparing Programs

This section of the tool kit provides a comparison of 24 trauma-focused programs developed for use in schools. They compare the programs on dimensions related to the needs of the students and the time and resources required. Each program has an entry in the table along with listings of several types of information. These include:

- intended population (type of trauma, age or grade level, and method of selection)
- symptoms or issues targeted
- format (group, classroom, etc.)
- information on prior implementations in schools
- evaluation or evidence base to support program use
- materials available
- training requirements
- contact information

The tables are organized by the type of traumatic experience the programs target, with the first table describing programs that address all sorts of traumatic life events. In reviewing these programs, some key questions to keep in mind are:

- What specific needs of our students do we want to focus on?
- Is there evidence that this program is effective?
- Has this program been used or tested with a group of students similar to ours?
- Do we have the expertise within our system to implement a program like this?
- How much would it cost to get this program running in our schools?

Programs for non-specific (any type of) trauma

Program	Who is this program for?			What problems does this program target?	How is the program delivered?	Schools in which the program has been implemented	Evaluation / Evidence Base	Implementation Resources and Requirements		
	Type of trauma	Targeted population and selection process	Age or grade targeted					Materials available	Training requirements	Contact information
Better Todays, Better Tomorrows for Children's' Mental Health (B2T2) (formerly Red Flags Idaho)	Any traumatic life events	All adult school employees and volunteers, parents, and community groups. No selection.	Adults	Awareness of treatment stigma, prevention of traumatic symptoms and mental illnesses	School employees are instructed on signs and symptoms of trauma and mental illnesses in youth and barriers to treatment at a 1-day training program supplemented by online information and a free in-state telehealth program.	Implemented in the majority of Idaho's public school systems and under review for implementation in Oregon.	Surveys of people who have been trained: 70% of participants indicated they felt the program had improved their knowledge of treatment-seeking information and had reduced stigma of mental health problems in the school environment. Designated as a "promising practice" by the NCTSN.	Informational packet on trauma and mental illnesses, treatments and interventions, and stigma as a barrier (customized to each school's needs). Other information online.	Idaho State has conducted all programs to date.	Ann Kirkwood (208-562-8646, kirkann@isu.edu), Institute of Rural Health, Idaho State University (www.isu.edu/irh/bettertodays)
Cognitive-Behavioral Intervention for Trauma in Schools (CBITS)	Any traumatic life events. Program usually screens for exposure to community violence, but in group sessions students focus on any trauma except child sexual abuse.	Students with exposure to trauma and elevated symptoms of PTSD. Students screened via survey and then by meeting with mental health staff.	Grades 5–9	Reduction of PTSD and depressive symptoms and behavior problems. Provision of peer and parent support and improvement in coping and cognitive skills.	10 group sessions held weekly for 45–60 minutes, 1–3 individual sessions, 2–4 optional parent sessions, and 1 teacher-education session.	Implemented extensively within Los Angeles Unified School District (for recent immigrants and general student population). Training and implementation are occurring in Maryland, Wisconsin, Illinois, Washington, New Mexico, and Montana. Training beginning in New Orleans region.	Two published studies to date indicating positive impact on PTSD symptoms, depressive symptoms, and parent (but not teacher) reports of decreased behavior problems. Designated "supported and probably efficacious" by the NCTSN.	Manual, screening measures, implementation guide, handouts. Parent materials available in Spanish.	For mental health clinicians: 2-day intensive training. Ongoing consultation and supervision with local CBT expert or developers is recommended.	For training inquiries: Audra Langley, UCLA (310-825-3131, ALangley@mednet.ucla.edu). Manual available at www.sopriswest.com.
Community Outreach Program—Esperanza (COPE)	Any traumatic life events (physical abuse, sexual abuse, witness to murder, loss from September 11, natural disasters)	Students with behavioral and social and emotional problems who face barriers to accessing and remaining in traditional mental health services. Selection by school counselors or teachers.	All (grades pre-K–12; ages 4–17)	Reduction of behavioral, social, and emotional problems. Improved coping skills. Provision of basic needs.	12–20 individual (parent and student) and joint sessions held weekly or biweekly for 45–90 minutes, with case management and outreach.	Implemented extensively in 3 counties in South Carolina and in other schools throughout the U.S. Plans for implementation in New York and San Diego.	Not yet evaluated except for case studies, but systematic review planned for next year. Uses Trauma-focused CBT and Parent-Child Interaction Therapy, both efficacious elements. Combination with intensive case management not yet evaluated. Designated "supported and acceptable" by the NCTSN.	Background reading, treatment manuals, and journal articles. Manuals available in Spanish.	For program employees, NYC Department of Mental Health clinicians, and potentially other mental health clinicians: 1 full day of training, reading, supervision (2–3 hours of joint and/or individual supervision each week for 6–10 cases).	Michael de Arellano, director, COPE (843-792-2945, dearelma@musc.edu), National Crime Victims Research and Treatment Center, Medical University of South Carolina in Charleston, S.C. www.musc.edu/ncvc
Multimodality Trauma Treatment (MMTT) or Trauma-Focused Coping	Single-incident trauma (disaster, exposure to violence, murder, suicide, fire, accidents)	Students with a history of trauma, diagnosis of PTSD, depression, anger, or other sub clinical symptoms. Selection by school staff.	Grades 4–12	Reduction of PTSD symptoms, depression, anger and anxiety. Improvement of grief management and coping	14 group sessions, held weekly for 45–60 minutes, and 2 individual sessions.	Implemented in several school districts; original testing of the program in North Carolina.	2 published articles and related studies show significant improvements in PTSD, depressive, and anxiety symptoms. Designated "supported and acceptable" by the NCTSN.	Manual (available free of charge), organizational readiness assessment	For mental health clinicians with a master's degree or higher: 1–2 days intensive skills-based training, ongoing expert consultation, advanced training on request to build capacity for training and supervision for schools that plan long-term use and widespread dissemination.	Ernestine Briggs-King, PhD, director, Trauma Evaluation and Treatment Program (919-419-3474, x 228, Ernestine.Briggs@mc.duke.edu) OR Robert Murphy, PhD, executive director (919-419-3474, x 291, Robert.Murphy@duke.edu), Center for Child and Family Health, Durham, N.C. (www.ccfhnc.org)

Programs for non-specific (any type of) trauma (continued)

Program	Who is this program for?			What problems does this program target?	How is the program delivered?	Schools in which the program has been implemented	Evaluation / Evidence Base	Implementation Resources and Requirements		
	Type of trauma	Targeted population and selection process	Age or grade targeted					Materials available	Training requirements	Contact information
School Interaction Project (SIP)	Any traumatic life events	Whole classroom: both traumatized children and those without a known history of trauma. No selection.	Head Start, elementary, and middle school. Adaptable to high school.	Establishment and maintenance of safety. Improvement of relational-engagement and self-regulation skills.	Manual and materials integrated into the classroom throughout the school year.	SIP has been implemented in 2 elementary schools and 2 middle schools in Kalamazoo, Mich. For 2006-07, SIP will be implemented in 6 elementary regular-education classrooms, 4 special-education, and 1 regular-education middle school classrooms, and a charter academy for adolescents.	Qualitative data have been gathered through reflective writing and exit interviews, revealing reports of decreased behavioral problems and increased student problem solving throughout school settings. Limited quantitative data are also being analyzed.	Manual	For teachers: 2-day workshop that focuses on complex trauma and neurodevelopmental considerations. In addition, teachers are introduced to the SIP manuals and engaged in learning activities that address common classroom behavior as well as strategies for prevention and intervention.	Mary Blashill (269-387-7025, BlashillM@certauth.cc.wmich.edu); Jim Henry (269-387-7073, james.henry@wmich.edu), Southwest Michigan Children's Trauma Assessment Center, University of Western Michigan (www.wmich.edu/traumacenter)
Trauma-Focused Cognitive Behavioral Therapy (TF-CBT)	Any traumatic life events (e.g., sexual abuse, other interpersonal violence, traumatic grief and loss).	Students with significant behavioral or emotional problems related to traumatic life events (depression, PTSD, anxiety, shame, mistrust). Selection by school counselors or screening tool.	All (Grades pre-K–12; ages 4–18)	Alleviation of depression, anxiety, shame, mistrust, and other symptoms. Improvement of emotion management, social competence, and family communication.	12–16 sessions: individual (caretaker or student), joint, or group. Sessions held weekly for 60–90 minutes.	Some school-based implementation with adaptations to group format.	In school settings: not yet evaluated. In clinical settings: 12 published articles that cover initial findings,1- and 2-year follow-ups, and randomized controlled trials, focused on treatment of sexually abused children, show reduction in symptoms and results superior to those of other treatments. Designated "well supported and efficacious" by the NCTSN.	Fact sheet, program developers' treatment book(s), readiness assessment. Spanish version of program is under development.	For mental health clinicians with master's degree or higher: 1 to 2 days of intensive skills-based training followed by 1 to 2 days of advanced training, plus ongoing consultation for 6 months. Introductory training available on website (includes 10 hours of continuing medical education credit).	Noelle Davis (davisno@umdnj.edu), Child Abuse Research Education and Service (CARES) Institute, University of Medicine and Dentistry, New Jersey School of Osteopathic Medicine; Anne Marie Kotlik (akotlik@wpahs.org), West Penn Allegheny Health System and Medical University of South Carolina (www.musc.edu/tfcbt)
UCLA Trauma/ Grief Program for Adolescents	Moderate to severe trauma, bereavement, accidents, community violence, natural and man-made disasters, war, terrorist events.	Students with anxiety, depression, complicated grief, PTSD, or related symptoms. Students screened by survey and then by meeting with mental health staff.	Middle and high school, ages 11–18. Adaptable to younger students.	Alleviation of antisocial, aggressive, and risk-taking behavior and trauma symptoms. Improvement of emotion-management and coping skills.	16–20 50-minute group sessions, held weekly. Also provided in individual and family format.	Implemented in primary and secondary schools in various states and countries, including 5 school districts, as an ongoing trauma- and grief-recovery program for schools in communities with high levels of community violence; numerous schools across New York City following September 11; secondary schools across postwar Bosnia.	Evaluated in domestic and international school settings, including a large sample of schools in postwar Bosnia. Results indicate significant treatment reductions in PTSD and depression, and improvements in academic performance and classroom behaviors. Other pre- and post-program studies with similar results have been conducted in schools in California. Designated "supported and acceptable" by the NCTSN.	Screening measures, interview protocol, manual, workbook	Mental health clinicians: 2 days of training, ongoing supervision and consultation.	Bill Saltzman (wsaltzman@sbcglobal.net), UCLA Trauma Psychiatry Program

Programs for disaster-related trauma

Program	Who is this program for?			What problems does this program target?	How is the program delivered?	Schools in which the program has been implemented	Evaluation / Evidence Base	Implementation Resources and Requirements		
	Type of trauma	Targeted population and selection process	Age or grade targeted					Materials available	Training requirements	Contact information
Enhancing Resiliency Among Students Experiencing Stress (ERASE-S)	Any stressful or traumatic situations	Students experiencing high stress. No set selection process.	Grades 3–12	Reduction of PTSD symptoms, depressive symptoms, somatic complaints, functional impairment, separation anxiety, and generalized anxiety. Improvement of coping and resiliency skills.	12 90-minute classroom sessions, held weekly	Implemented in schools in Israel, Palestine, Turkey, and Sri Lanka.	An evaluation in Israel and Palestine showed significant reductions of PTSD symptoms and generalized anxiety. A randomized controlled trial is in progress in Sri Lanka.	Teacher's manual, psycho educational booklet, and student handouts	For teachers and guidance counselors: 28–32 hours of training, including 5 3-hour supervisory sessions of the program given by the trainer.	Rony Berger (riberger@netvision.net.il), NATAL, Israel Trauma Center for the Victims of Trauma and War, Tel Aviv, Israel
Friends and New Places	Any traumatic life, such as those brought about in part by hurricanes Katrina and Rita	Students experiencing traumatic changes in their lives, such as those brought about in part by Hurricanes Katrina and Rita. Selection by school staff.	Grades K–12	Improvement and reframing of how children think about their experiences in a new environment, both at school and at home. Emphasis on making therapy culturally appropriate and fun.	6 60-minute group sessions, held weekly	Given to 1,100 students displaced from areas impacted by Hurricane Katrina to the Dallas Independent School District in the school year 2005–06; will be given again in 2006–07.	Not yet formally evaluated.	Contact program developers for information.	For 2 co-leaders, one a psychologist or social worker and one a school counselor: 1 full day of training	Jenni Jennings, (972-502-4194, jjennings@dallasisd.org), Youth and Family Services, Dallas Independent School District, Texas
Healing After Trauma Skills (HATS)	Natural or man-made trauma or disaster (developed after 1995 Oklahoma Bombing and altered after 9/11 and Florida hurricanes).	Students experiencing anxiety, PTSD, fear, numbing, avoidance, clingy behavior, mood changes, or arousal. Not for those who have lost a loved one. Selection by school staff. Screening measure in development.	Grades pre-K–7, ages 4–12	Alleviation of trauma-related symptoms. Improvement of coping skills.	12–15 classroom or small-group sessions held weekly for 30–90 minutes. Can be broken into shorter segments; adaptable to individual or clinical settings.	Implemented in schools in the United States and worldwide.	Evaluation only qualitative so far; more rigorous evaluation in progress.	Manual available free of charge by request, and online.	For teachers, mental health professionals, or other professionals with background in child development: manual supplied, in-depth training available on request.	Dr. Robin H. Gurwitch, (405-271-6824, x 45122, robin-gurwitch@ouhsc.edu), University of Oklahoma Health Sciences Center and Terrorism and Disaster Center of National Child Traumatic Stress Network
Journey to Resiliency: Coping with Ongoing Stress	Traumatic stressors, including threat of or exposure to: terrorism, war, and natural disasters	Students with PTSD-related symptoms who have experienced traumatic stressors. Participants selected through several screening instruments administered by a psychologist.	Grades 6–12	Reduction of PTSD-related symptoms, such as recurrence of event, avoidance, numbing, hyperarousal, somatic complaints, functional impairment, and generalized anxiety. Improvement of coping skills.	6 2-hour group sessions	Implemented in schools in Israel.	In a pilot study in Israel, participants in the program showed significant reductions of PTS symptoms, somatic complaints, and generalized and separation anxiety symptoms compared to 2 control groups. Follow-up data are being collected.	Guidance-counselor manual and student handouts	For guidance counselors: 24 hours of training, including 4 2-hour supervisory sessions of the program given by the trainer.	Rony Berger (riberger@netvision.net.il), NATAL, Israel Trauma Center for the Victims of Trauma and War, Tel Aviv, Israel

Programs for disaster-related trauma (continued)

Program	Who is this program for?			What problems does this program target?	How is the program delivered?	Schools in which the program has been implemented	Evaluation / Evidence Base	Implementation Resources and Requirements		
	Type of trauma	Targeted population and selection process	Age or grade targeted					Materials available	Training requirements	Contact information
The Maile Project	Natural or man-made trauma or disaster (developed in aftermath of Hurricane Iniki in Hawaii and adapted for terrorism).	Students who have experienced a disaster and who have been identified through self-reported screening as showing PTSD symptoms	Grades 2–12	Restoration of a sense of safety. Ability to grieve losses, renew attachments, adaptively express disaster-related anger, and achieve closure about the disaster in order to move forward.	4 individual or group sessions held weekly for the length of a class period (40–60 minutes)	Given to children from all 10 elementary schools on the island of Kauai, Hawaii, 2 years after Hurricane Iniki.	In a randomized 3-cohort study, project showed reductions in trauma-related problems among participants in either group or individual versions of the program. The group version was as effective as the individual format but had a better retention rate.	Two treatment manuals are available, grades 2–7 and 8–12, with individual and group format session-by-session protocols. Standard play-therapy kit with play and art materials also available.	For school counselors, clinical psychologists, or social workers experienced with working with children in schools: 3 days of training regarding post disaster trauma psychology and 1 1/2 days of didactic training specific to the treatment manual. Group supervision recommended weekly to ensure consistent delivery of the protocol.	Claude M. Chemtob (claude.chemtob@mssm.edu)
Overshadowing the Threat of Terrorism (OTT)	Threat of and/or exposure to terrorism, war, natural disaster, and potentially for daily stressors as well	Students experiencing PTSD symptoms following exposure to a traumatic stressor. Selection by school staff.	Grades 1–10	Reduction of PTSD-related symptoms, somatic complaints, functional impairment, separation anxiety, and generalized anxiety	8 90-minute classroom sessions, held weekly (grades 3–10). 10 45-minute sessions held weekly with homework, collaboration with parents (grades 1 and 2).	Implemented in schools in Israel with students exposed to ongoing missile attacks and following one of the worst bus accidents in Israel's history.	In 2 randomized controlled trials, participants showed significant reductions of PTSD symptoms, somatic complaints, and generalized and separation anxiety symptoms 1 and 2 months, respectively, after the intervention, as compared to controls. When OTT was applied to an entire school, without controls, after a severe bus accident, similar improvements were noted immediately following the intervention and maintained in a 6-month follow-up.	Teacher's and student's manual	For teachers: 20–24 hours of training, including 3 or 4 3-hour supervisory sessions of the program given by the trainer.	Rony Berger (riberger@netvision.net.il), at NATAL, Israel Trauma Center for the Victims of Trauma and War, Tel Aviv, Israel
Psychosocial Structured Activity (PSSA), or the Nine-Session Classroom-Based Intervention (CBI), and Journey of Hope	Natural or man-made trauma or disaster (adapted for Hurricanes Katrina and Rita from a program used for youth violence, natural disasters, and terrorism).	Students who have experienced a crisis and are having problems dealing emotionally with difficult experiences. Selection by school staff.	Ages 5–18	Improvement of coping skills, self-esteem, reactions to fearful events, and ability to use available resources and plan for the future.	9 60-minute large-group sessions, held 3 times per week for 3 weeks, in either classroom or summer-camp setting.	Post-hurricane program implemented in schools in Washington, Jefferson, East Baton Rouge, and Orleans parishes in Louisiana, and Hancock, Jackson, and Harrison counties in Mississippi.	CBI first used with gang members in the Boston area and has since helped children in Indonesia after the 2004 tsunami, in the Middle East, and in Nepal. Impact studies have demonstrated positive psychological changes. PSSA has not yet been formally evaluated but is undergoing monitoring and evaluation.	Teacher's manual and activity kit. Save the Children also offers informational packets with tip sheets for parents, teachers, administrators, and teens, as well as a compilation of cooperative games.	For those with previous counseling, social work, or clinical experience and experience working with children: 3-day training workshop.	Barbara Ammirati (bammirati@savechildren.org), Erin Spencer (228-863-3577, espencer@savechildren.org), or Yael Hoffman (225-803-5731, yhoffman@savechildren.org), www.savethechildren.org

Programs for disaster-related trauma (continued)

Program	Who is this program for?			What problems does this program target?	How is the program delivered?	Schools in which the program has been implemented	Evaluation / Evidence Base	Implementation Resources and Requirements		
	Type of trauma	Targeted population and selection process	Age or grade targeted					Materials available	Training requirements	Contact information
Resiliency and Skills-Building Workshop Series	For schools affected by disaster (e.g., New York schools after September 11) and for students with mild psychological distress	Whole school or classroom. No set selection process.	High school (adaptation for middle schools planned).	Reduction in acting-out behaviors; improvements in anger-management and stress-reduction skills.	5 consecutive 35-minute meetings in health class	Currently implemented in 1 school in Manhattan.	2 years of program evaluation underway; preliminary results indicate reduced anxiety levels and suspension rates.	Manual, supplemental materials (homework assignments, handouts, checklists). A middle-school curriculum is in development.	So far only NYU Center employees have conducted programs, but program hopes eventually to train other mental health clinicians.	Elizabeth Mullett (212-263-3682, elizabeth.mullett@med.nyu.edu), School-Based Intervention Program, New York University Child Study Center, New York, N.Y. www.aboutourkids.org
Silver Linings: Community Crisis Response	Crisis situations, such as natural disasters; death of a classmate, teacher or administrator; school closings; or violence in the school or community.	Students experiencing emotional turmoil due to a loss or change caused by a crisis situation. Selection by school staff.	All (grades K–12)	Provision of a safe place for students to express and explore feelings such as anger, sadness, and guilt. Improvement of coping strategies, in particular positive reappraisal.	6 30–45 minutes group sessions held over 2–6 weeks, with at least a day between sessions.	Implemented successfully with a variety of communities affected by flooding, troubled youth, violence, military deployment, September 11, and hurricanes Katrina and Rita in schools in Alabama, Mississippi, and Louisiana.	Not yet formally evaluated but collecting pre- and post-program information on participants and evaluations by facilitators.	3 editions (ages 5–8, 9–13, and adolescents), each with instructor manual, a reproducible participant booklet, and a coloring story booklet. May be able to provide materials free of charge.	For anyone who works regularly with children, including coaches, teachers, counselors, and youth-group leaders: training beyond familiarization with materials is optional.	Laurie Olbrisch (800-266-3206, x 12, laurie@rainbows.org) www.rainbows.org
UCLA Trauma/Grief Program, ADAPTED Enhanced Services for Post-hurricane Recovery: An Intervention for Children, Adolescents and Families	Hurricane-related trauma: injury, threat to life, witnessing of injury or destruction, injury to loved one, relocation, loss of contact with friends, family hardships	Students with PTSD and related symptoms and problems with separation anxiety, family conflict, and lack of support. Students screened by survey, then by meeting with mental health staff.	Grades 3–12, ages 8–18	Alleviation of anxiety, depression, and other symptoms. Improvement of emotional awareness and expression and coping, problem-solving, and communication skills.	10 50-minute individual sessions, held weekly, and 1–3 joint sessions.	Slated for use in various settings, including schools, in Gulf states affected by recent hurricanes.	No evaluation to date, but see evidence for the original UCLA Trauma/Grief Program listed in the section on any kind of trauma.	Manual, handouts, and screening materials. Handouts and screening materials available in Spanish.	For mental health clinicians: initial 2-day training with follow-up training recommended.	Bill Saltzman (wsaltzman@sbcglobal.net), UCLA Trauma Psychiatry Program

Programs for traumatic loss

Program	Who is this program for?			What problems does this program target?	How is the program delivered?	Schools in which the program has been implemented	Evaluation / Evidence Base	Implementation Resources and Requirements		
	Type of trauma	Targeted population and selection process	Age or grade targeted					Materials available	Training requirements	Contact information
Loss and Bereavement Program for Children and Adolescents (L&BP)	Simple and complicated bereavement	Students who have lost a parent, caregiver, or other significant family member of friend to death. Selection by school staff.	Grades 1–12, ages 6–adolescence	4 Tasks of Mourning; conversation about death, and alleviation of anxiety, heightened imagery, misconceptions about death, and scary dreams.	12 60–90 minute group sessions, held weekly; 1–2 joint sessions with surviving caregiver and child.	All New York City boroughs	Preliminary reports show improved attendance and student satisfaction.	Contact program for information.	For mental health clinicians: contact program for information.	Loss and Bereavement Program Office (212-632-4692), or Dr. Nina Koh, program director (212-632-4492 or 212-795-9888), Jewish Board of Family and Children's Services, New York, N.Y., www.jbfcs.org
PeaceZone (PZ)	Loss, whether from divorce, death, violence, or other cause	Students who have experienced some type of loss. Selection by school staff.	Grades K–5	Improvement of students' ability to make positive decisions, avoid risk-taking behavior, and heal from trauma and loss	24 30-minute classroom sessions, held over at least six weeks	Developed and implemented in 4 Boston public elementary schools, reaching 1,342 students.	Not yet formally evaluated, but pre- and post-program surveys conducted in grades 3–5 in 3 schools showed reductions in self-reported victimization (boys 28–37%, girls 30–39%) and self-reported mild to severe depression (boys 25–40%, girls 14–40%).	Separate teacher's and student's manuals for grades K–1, 2–3, and 4–5 are available. Contact Research Press Publishers, (800-519-2707rp@researchpress.com).	For teachers, administrators, and school counselors: day-long training session that presents information about grief and loss, how symptoms of grief and trauma can manifest themselves behaviorally, and how grief and trauma affect academic achievement.	Dr. Deborah Prothrow-Stith (617-495-7777, dphpdesk@hsph.harvard.edu), Harvard School of Public Health, Boston, Mass.
Rainbows	Loss from divorce, separation, or death of parents, or other experiences of loss and/or painful transitions	Students who have experienced loss. Selection by school staff.	All (grades pre-K–12; ages 3–18 and adults	Provision of grief support; emotional healing and improvement of self-esteem and coping mechanisms.	12 group sessions broken into 2 sets of 6 sessions with a Celebrate Me Day after each set. The length and frequency of each session depends on age group and curriculum used, but ranges from 25 to 120 minutes, 1–3 times per week.	Used throughout the United States and in 16 other countries.	Not yet formally evaluated, but Rainbows demonstrated high participant and parent satisfaction when studied in 2000 by Drs. Laurie Kramer and Gary Laumann of the University of Illinois at Champaign-Urbana.	Different instructor manuals, journals, games and activities for different age-group programs	For clinicians and non-clinicians with leadership skills, a motive of genuine care and concern, good listening skills, and the ability to maintain .Rainbows Registered Directors work with potential sites to complete an implementation process to become a Registered Rainbows Site	Laurie Olbrisch (800-266-3206, x 12; laurie@rainbows.org), www.rainbows.org.
Three Dimensional Grief (also known as School-Based Mourning Project)	Loss by death	Students who have lost a parent, caregiver, or other significant family member of friend to death. Selection by school staff.	All (grades K–12)	Facilitation of mourning and grief. Improvement of readiness to engage, emotional literacy, and sense of ego integrity.	8 or more 45–90-minute group sessions, held weekly	Used in 30 public, charter, and parochial schools in Washington, D.C., over past 6 years; currently in use at 12–15 schools.	Ongoing 3-year pre- and post-program study, 1 published article, and 1 book chapter all describe positive results.	Manual, references, resource lists	For mental health clinicians: 1–2 day training session (1/2 day clinical review, 1/2 day active practicing) with a follow-up day and monthly consultations.	Susan Ley (sley@wendtcenter.org) or Dottie Ward-Wimmer (dottie@wendtcenter.org), Wendt Center for Loss and Healing, Washington, D.C. (202-624-0010, www.wendtcenter.org)

Programs for exposure to violence

Program	Who is this program for?			What problems does this program target?	How is the program delivered?	Schools in which the program has been implemented	Evaluation / Evidence Base	Implementation Resources and Requirements		
	Type of trauma	Targeted population and selection process	Age or grade targeted					Materials available	Training requirements	Contact information
Safe Harbor Program and Relationship Abuse Prevention Program (RAPP)	All forms of violence and victimization (sexual violence, domestic violence). RAPP focuses on domestic and teen-relationship abuse.	Whole school or classroom for most services (room, workshops, schoolwide programs). Counseling restricted to students with exposure to violence and/or evidence of acting out, depression. Selection by school staff.	Grades 6–12	Alleviation of acting out, depression, and other trauma symptoms; improvement of coping skills (both for self and for interactions with others), communication skills, and positive self-talk and self-esteem.	11–17 individual or group sessions, held weekly; duration varies. Workshops in classroom setting also possible.	Safe Harbor is being implemented in several schools in Louisville, Ky.; Long Beach, Calif.; the U.S. Virgin Islands; New York City; and other parts of the United States. RAPP is being implemented in 30 schools (including 3 schools operated by Safe Harbor).	Only limited program evaluation conducted to date. Designated "supported and acceptable" by the NCTSN.	Counseling curriculum and facilitation manual	For social workers or mental health clinicians: 6 hours to 3 days, depending on trainee skill level.	Christian Burgess (212-629-6298, wburgess@safehorizon.org), Safe Horizon, New York, N.Y., www.safehorizon.org

Programs for complex trauma

Program	Who is this program for?			What problems does this program target?	How is the program delivered?	Schools in which the program has been implemented	Evaluation / Evidence Base	Implementation Resources and Requirements		
	Type of trauma	Targeted population and selection process	Age or grade targeted					Materials available	Training requirements	Contact information
Life Skills/Life Story (formerly known as Skills Training in Affective and Interpersonal Regulation/Narrative Story-Telling (STAIR/NST)	Complex, multiple, or sustained trauma related to sexual or physical abuse, community violence, domestic violence, or sexual assault	Female students with a history of abuse or violence and either PTSD symptoms or other trauma-related symptoms, such as depression and dissociation. Selection by school counselors.	Middle and high school and beyond, ages 12–21	Life Skills: improvement of resiliency and emotional and social competence. Life Story: resolution of depression, dissociation, and PTSD symptoms.	16 group or individual sessions held weekly; duration varies.	Implemented in residential school settings, after-school programs, and lunch periods in communities affected by September 11 attacks in New York City. Currently being implemented as an NCTSN Learning Collaborative at 6 sites, including school, outpatient community, outpatient hospital, and inpatient hospital settings.	In schools: a randomized trial is being conducted in a residential school setting. In clinical settings: results of a completed study indicate a reduction in PTSD and related symptoms and an improvement in emotion-regulation capacities and social skills. A randomized control study of adult women also showed positive results. Designated "supported and acceptable" by the NCTSN.	Manual, worksheets, and treatment materials (all provided at training). Video workbook in development.	For employees of NYU Medical Center (serving as mental health providers for NYC schools) and other mental health clinicians: 1-day workshop, weekly supervision by phone, and monthly in-person group supervision for clinician's first case.	Noelle Davis (davisno@umdnj.edu), Child Abuse Research Education & Service (CARES) Institute, University of Medicine and Dentistry, New Jersey School of Osteopathic Medicine or Marylene Cloitre, PhD, (212-263-2471, marylene.cloitre@nyumc.org), director, Institute for Trauma and Stress, NYU Child Study Center, New York, N.Y.
Structured Psychotherapy for Adolescents Responding to Chronic Stress (SPARCS)	Chronic traumatic stress (interpersonal violence, community violence, life-threatening illness).	Students with a history of trauma along with intrapersonal distress, somatic symptoms, and social and behavior problems. Selection by school counselors or via by screening tool.	Middle and high school and beyond, ages 12—19	Improvement of emotion regulation, self-perception, coping skills, and relationships	16 group sessions, held weekly for about 60 minutes or biweekly for 30 minutes. Individual format under development.	Currently being piloted in schools and outpatient settings in California, Georgia, Illinois, New York, North Carolina, and Wisconsin	Pilot in school for pregnant teens showed that physical confrontations decreased and student satisfaction was high. Further evaluation in progress. Designated "supported and acceptable" by the NCTSN.	Manual, session-by-session clinician's guides, and color activity handouts for group members available on request. Some handouts are available in Spanish.	For mental health clinicians: 2 1-day training sessions (1 prior to program implementation, 1 one month into program) and bimonthly consultations throughout.	Victor Labruna(516-562-3245, vlabruna@nshs.edu), North Shore University Hospital, Manhasset, N.Y.
Trauma Adaptive Recovery Group Education and Therapy for Adolescents (TARGET-A)	Physical or sexual abuse, exposure to domestic or community violence, disaster, traumatic loss, or high stress and behavioral problems.	Students with trauma symptoms such as anger, anxiety, or problems controlling their emotions. Various means of selection.	Grades 5–12, ages 10–18	Alleviation of depression, anxiety, guilt, and problems with relationship trust; improvement of body self-regulation, memory, interpersonal problem solving, stress management.	3–26 group sessions, separated by gender, held weekly or biweekly, of varying duration; or 12 individual and family sessions of varying duration.	Developed originally for adolescents in Boys and Girls Clubs and community programs, and has been refined for use with preadolescents, as a gender-sensitive intervention for girls, and in juvenile-justice and mental health outpatient and residential programs and detention centers, including schools in those settings. TARGET-A is adaptable to other school settings.	Not yet formally evaluated, but being evaluated in two research studies with urban, low-income, predominantly minority (African American, Latino and Latina) youths and parents in juvenile justice settings. Designated "promising and acceptable" by the NCTSN.	Manuals for use with individuals and groups (Ford and Cruz, 2006). Materials are currently available in English.	For mental health clinicians with school personnel co-leaders: 1-day training sessions are offered at least once a year at the University of Connecticut Health Center; customized on-site training and consultation available.	Julian Ford (860-679-2360, FordJ@psychiatry.uchc.edu), University of Connecticut Health Center, www.ptsdfreedom.org.

Section 4: Program Descriptions

This section of the tool kit provides a one-page description for each program. After comparing the programs using the tables in Section 3, consult this section for more details on specific programs. You may also choose to share these program descriptions with other key stakeholders, so that they can consider the program before a final decision is made.

Programs for non-specific (any type of) trauma

Better Todays, Better Tomorrows for Children's Mental Health (B2T2) (Formerly Red Flags Idaho)

Objective: B2T2 is an education program for school employees and the wider community that provides a general overview of signs and symptoms of trauma and mental illnesses in youth and barriers to treatment. It is intended to raise awareness, encourage early intervention and treatment, and reduce stigma. B2T2 emphasizes all forms of traumatic stress as well as suicide prevention.

Intended Population: This program is appropriate for all types of school faculty and staff, school volunteers, as well as various community groups such as faith-based groups, public safety, and scouting There is also a parent module.

Format: The program consists of a full-day, interactive training session, led by employees of the Institute for Rural Health at Idaho State University. The program also offers a telehealth component, which has 50 sites within Idaho and offers programs on supplemental topics such as suicide and depression in school-aged children. Training materials are online and interactive instruction through videoconference is available.

Implementation: B2T2 is currently in place in three quarters of Idaho's public school systems and is under review for use in Oregon. One unique aspects of the program is that it accommodates urban and rural communities. Since its inception in 2000, it has trained approximately 2,367 community caregivers and gatekeepers in 66 percent of Idaho's towns that contain 90 percent of the state's population. All participants are surveyed immediately post-training and 12-18 months after initial training. Survey results indicate that most feel that the program improved their knowledge of how to seek treatment (80 percent) and reduced stigma of traumatic symptoms and mental health illnesses (53 percent). 154 adults reported referring one or more children for mental health care as a result of participating in the program (Kirkwood and Stamm, 2006).

Training: Although B2T2 has only been given in Idaho by employees of the Institute for Rural Health at Idaho State University, it is expanding into in other states. Ongoing program evaluation has been conducted over its five-year history in order to improve program quality. The model is recognized as a promising practice by the National Child Traumatic Stress Network and as a best practice model program (Kirkwood and Stamm, 2004). It is currently under review by several other organizations as an evidence-based practice.

Materials: Internet-based informational and training materials, announcements, and available training dates are provided on the program's Web site (www.isu.edu/irh/bettertodays).

Funding: The program is funded by the Idaho Governor's Generation of the Child Initiative with additional support from the U.S. Department of Health and Human Services, National Institute of Mental Health, Substance Abuse and Mental Health Services Administration Center for Mental Health Services, and the Health Services Resources Administration Office for the Advancement of Telehealth.

For more information: Visit Contact Ann Kirkwood (208-562-8646, kirkann@isu.edu) at the Institute for Rural Health at Idaho State University, or visit www.isu.edu/irh/bettertodays.

Adapted from the National Child Traumatic Stress Network Fact Sheet available at: www.nctsnet.org/nctsn_assets/pdfs/materials_for_applicants/BetterTodaysTomorrows_2-11-05.pdf and from B2T2's overview at www.isu.edu/irh/bettertodays/overview.htm Contents verified and modified from phone interviews with developers in December 2005.

Cognitive Behavioral Intervention for Trauma in Schools (CBITS)

Objective: CBITS is a skills-based, group intervention aimed at relieving symptoms of Post Traumatic Stress Disorder (PTSD), depression, and general anxiety among children exposed to trauma. CBITS uses cognitive-behavioral techniques from which children learn skills in relaxation, challenging upsetting thoughts, social problem solving, and how to process traumatic memories and grief. CBITS relies on the use of drawings and on talking in individual and group settings. Between sessions, children complete assignments and participate in activities that reinforce skills learned and apply them to real life problems. CBITS also includes parent and teacher education sessions.

Intended Population: CBITS is used for children in grades 5 to 9 (ages 10 to 15) who have experienced events such as violence, natural or man-made disasters, accidents, house fires, or physical abuse or injury, and who are suffering from moderate to severe levels of PTSD symptoms. Preliminary versions of the CBITS program have been used in children as young as 8 years old. A screening procedure is recommended for use in the general school population to assist in identifying children in need of the program. A brief (less than 5 minute) screening instrument has been developed for this purpose, and should be followed by an individual meeting with a clinician to confirm the screening results. The CBITS intervention has been effectively implemented with a wide range of racially and ethnically diverse children. Several groups are currently working to implement and evaluate the CBITS intervention for Native American children, African American children, and older high school children.

Format: The program consists of ten group sessions (6-8 children per group) of approximately an hour in length, usually conducted once a week in a school setting. It is recommended that someone with clinical mental health training lead the sessions. In addition to the group sessions, participants receive 1-3 individual sessions, usually held before exercises that focus on talking about the trauma in group. CBITS also includes two parent education sessions and one teacher education session. Parent participation is encouraged, but not required. The CBITS intervention has also been delivered in other settings, such as mental health clinics.

Implementation: CBITS is currently being used in middle schools in the Los Angeles Unified School District (LAUSD). The program underwent a randomized controlled study in which children in the CBITS intervention group had significantly greater improvement in PTSD and depressive symptoms compared to those on the waitlist at a three-month follow-up. These LAUSD students were primarily Latino students. Parents of children in the CBITS intervention group also reported significantly improved child functioning compared with children in the waitlist group (Stein et al., 2003). All improvements continued to be seen at a subsequent 6 month follow-up. This work replicates an early quasi-experimental study of the program in a sample of recent immigrant children speaking Spanish, Korean, Russian, and Western-Armenian that showed similar results (Kataoka et al., 2003). ;

Training: Depending on the level of pre-existing expertise and the availability of an on-site cognitive-behavioral therapy expert, the recommended training of the mental health clinician varies.

Materials: A step-by-step guide to each session, including scripts and examples for use by the group leader, common obstacles and their solutions, and handouts and worksheets for group participants is available. Copies of the treatment manual (Jaycox, 2003) in English, only can be ordered from Sopris West Educational Services (800) 547-6747, www.sopriswest.com.

For more information: Contact Audra Langley (ALangley@ucla.edu).

Adapted from the National Child Traumatic Stress Network Fact Sheet available at: www.nctsnet.org/nctsn_assets/pdfs/materials_for_applicants/CBITSfactsheet_21105.pdf. Contents verified and modified from phone interviews with developers in December 2005 and updated in June 2006.

Community Outreach Program - Esperanza (COPE)

Objective: COPE is a parent-child intervention that aims to address behavior and social-emotional problems among traumatized children who have been unable to attend traditional school counseling successfully. The program relies on cognitive behavioral therapy to teach coping skills training, affective identification and processing, trauma narrative, and risk reduction. However, it also uses parent-child interactive therapy to improve family interactions and intensive case management and advocacy to find services for family members (e.g. substance-abuse treatment for parents) or to address the family's basic needs.

Intended Population: COPE is used with children ages 4 to 17 who are traditionally underserved, including African-American and Hispanic (mostly Mexican) populations and those of low socioeconomic status, who have behavior and social-emotional problems and have barriers to accessing and remaining in traditional mental health treatment. The program can be offered for ongoing or past trauma. COPE has successfully been used with rural and urban children and recent immigrants. It is offered in both Spanish and English.

Format: The program includes individual child and parent sessions and joint sessions, conducted in a combination of school, community, and home settings. It is recommended that someone with clinical mental health training lead the sessions. COPE consists of 12 to 20 weekly or biweekly sessions, 45 to 90 minutes in length, with follow-up booster sessions. Outreach and case management are essential components to the program.

Implementation: COPE was developed for use in and by schools but with a focus on parental involvement and the family. COPE has been implemented in over twenty schools in three counties in South Carolina, covering both urban and rural populations, as well as in other schools throughout the United States. COPE has been ongoing since 1997 and there are plans for future implementation in New York and San Diego. Several case studies and descriptions have been published on COPE (e.g., de Arellano et al., 2005) and there is currently ongoing data collection. A systematic review has been funded for 2007. Trauma-focused cognitive behavioral therapy (Cohen et al., 2004) and parent-child interaction therapy (Chaffin et al., 2004; Eyberg et al., 2001) have been shown to be effective but their combination with intensive care management has not been directly evaluated yet.

Training: Therapists from the National Crime Victims Research and Treatment Center have delivered COPE as have therapists from a local Department of Mental Health. Trainees require a full day of training, thorough reading of the treatment manuals and related journal articles, and supervision for 1-3 hours of joint and/or individual sessions each week for 6-10 cases. Ongoing consultation is also provided.

Materials: Materials, in both Spanish and English, are available upon request.

For more information: Contact Dr. Michael de Arellano, director of COPE (843-792-2945, dearelma@musc.edu) at the National Crime Victims Research and Treatment Center Medical University of South Carolina in Charleston, S.C., (www.musc.edu/ncvc).

Adapted from the National Child Traumatic Stress Network Fact Sheet available at: www.nctsnet.org/nctsn_assets/pdfs/materials_for_applicants/COPE_2-11-05.pdf. Contents verified and modified from phone interviews with developers in December 2005.

Multimodality Trauma Treatment (MMTT) or Trauma-Focused Coping

Objective: MMTT is a skills-based, peer-mediated group intervention aimed at relieving symptoms of Post Traumatic Stress Disorder (PTSD), depression, anxiety, anger, and external locus of control among children exposed to trauma. It relies on cognitive-behavioral techniques to teach such skills as anxiety and grief management, anger coping, and narrative exposure.

Intended Population: MMTT has been used with students from the fourth grade through high school who have experienced events such as disasters or exposure to violence, murder, suicide, or fire. PTSD or subthreshold but prominent symptoms after a traumatic event are criteria for eligibility. The program is not recommended until after one month has passed since the traumatic incident. It is not intended to serve as crisis counseling or psychological first aid but instead focuses on longer term trauma-related symptoms. MMTT can address intrafamilial violence and abuse in individual treatment or clinic-based groups where homogeneity of group membership can be assured and treatment can be adapted to the child's needs.

Format: The program consists of fourteen group sessions (6-8 children per group), held weekly during class time and lasting a minimum of 45-50 minutes but ideally 50-60 minutes. There is also one individual assessment session prior to group work and one individual pull-out session midway through the group sessions. It is recommended that someone with clinical mental health training (a master's degree or higher) deliver the program.

Implementation: MMTT is currently used in several school districts in the U.S. It was initially implemented in two elementary schools and two junior high schools. An NIMH-funded controlled study of this initial stage showed decreases in PTSD, depressive, and anxiety symptoms in 14 treated students, 7 of whom were African-American, 5 Caucasian, 1 Asian, and 1 American Indian (March et al., 1998). Additional studies in two more elementary schools, a high school, and a community-based clinic revealed similar results (Amaya-Jackson et al., 2003). MMTT has also been adapted to other settings, including clinical and residential treatment settings.

Training: Trainees are expected to have a master's degree or higher in clinical mental health training and have a basic understanding of PTSD and related symptoms. Training consists of a readiness assessment for cognitive behavioral therapy and participation in 1-2 days of intensive, skills-based training. Trainees are also expected to read the manual and select articles. Initial training will be following by ongoing expert consultation for 4 to 6 months. An Organization Readiness Assessment is also required for the school. Advanced training is available for schools that would like to build a capacity for training and supervising MMTT on their own.

Materials: The manual, in English only, is available free of charge.

For more information: Contact either Ernestine Briggs-King, PhD, director, Trauma Evaluation and Treatment Program (919-419-3474 ext. 228, Ernestine.Briggs@duke.edu) or Robert Murphy, PhD, executive director (919-419-3474, Robert.Murphy@duke.edu), at the Center for Child and Family Health in Durham, N.C. and Duke University Medical Center where they are faculty members along with treatment developers Drs. John March and Lisa Amaya-Jackson.

Adapted from the National Child Traumatic Stress Network Fact Sheet available at: www.nctsnet.org/nctsn_assets/pdfs/materials_for_applicants/MMTT_fact_sheet_final.pdf. Contents verified and modified from phone interviews with developers in December 2005.

School Intervention Project (SIP) of the Southwest Michigan Children's Trauma Assessment Center (CTAC)

Objective: SIP is an inclusive classroom model that aims to establish and maintain safety, improve relational engagement, and build self-regulation skills, while providing opportunities to make meaning of students' experiences and enhance teachers' knowledge, skills, and confidence.

Intended Population: SIP is intended to address, within the classroom, the unique needs of traumatized children as well as those children without known histories of trauma. The program is currently being implemented across a continuum of ages including students in Head Start, elementary, and middle school level. The SIP intervention can be modified for high school students, and CTAC anticipates working in high schools and other alternative school settings in the future. SIP has been successfully used with Caucasian, African American, and other minority students.

Format: SIP consists of manualized materials to be used in the classroom throughout the school year. Following initial training, teachers will implement manualized activities and interventions that reflect an understanding of the impact of trauma on their students. Professional development will simultaneously support this paradigm shift through critical incident review process.

Implementation: SIP has been implemented in the Kalamazoo Public Schools in Kalamazoo, Michigan, for the past two years by CTAC staff. CTAC staff delivered the program in two elementary schools and one middle school and were indirectly involved, through consulting, in one middle school. For the 2006-07 school year, SIP will be implemented in six elementary regular education classrooms, four special education and one regular education middle school classrooms, and a charter academy designed for adolescents. Qualitative data has been gathered through reflective writing and exit interviews, revealing positive reports of decreased behavioral problems and increased student problem-solving throughout school settings. Limited quantitative data is also being analyzed.

Training: Training for teachers implementing SIP consists of a two-day workshop that focuses on complex trauma and neurodevelopmental considerations. In addition, teachers are introduced to the SIP manualized materials and engaged in learning activities that address common classroom behavior as well as strategies for prevention and intervention.

Materials: The SIP manual is available, in English only.

For more information: Contact Mary Blashill (269-387-7025, BlashillM@certauth.cc.wmich.edu) or Jim Henry (269-387-7073, james.henry@wmich.edu) at the Southwest Michigan Children's Trauma Assessment Center, University of Western Michigan (www.wmich.edu/traumacenter).

Contents obtained from phone interviews with developers in December 2005 and updated in July 2006.

Trauma-Focused Cognitive Behavioral Therapy (TF-CBT)

Objective: TF-CBT is a clinic-based individual and group treatment that is aimed at relieving behavioral and emotional problems, depression, anxiety, Post Traumatic Stress Disorder (PTSD), sexualized behaviors, trauma-related shame, and mistrust among children with trauma. In addition, a grief-focused version of TF-CBT has been developed specifically for children experiencing traumatic loss. TF-CBT uses an eclectic mix of intervention techniques, including cognitive behavioral therapy, to build and enhance management of thoughts and feelings, interpersonal trust, social competence, parenting skills, and family communication. TF-CBT also includes individual caretaker and joint caretaker-child sessions.

Intended Population: TF-CBT is used with children ages 4 to 18 who have experienced either single or multiple traumatic life events, including sexual abuse, other interpersonal violence, and traumatic grief and loss. A diagnosis of PTSD is not required but the program is aimed at children with significant behavioral or emotional problems related to trauma. This program can be used at any point after a trauma, as long as the current symptoms are related to an index trauma. TF-CBT has been successfully adapted to special populations including Latino and those with hearing-impairments.

Format: TF-CBT can be delivered either as an individual and joint caretaker-child intervention or as a group intervention. Both consist of 12 to 16 sessions, 60 to 90 minutes in length, and are recommended to take place weekly, but the frequency can be modified to meet clinical needs. For the individual intervention, TF-CBT offers individual sessions for both caretaker and child. It is recommended that someone with clinical mental health training (master's degree or higher) deliver the TF-CBT program.

Implementation: TF-CBT was developed for the clinical setting and has not been tested in a schools setting. However, there is on-line training now available that school counselors have been using and there are plans for follow-up training of some school-based clinicians who have taken the on-line training. Also, in the near future there will be a study of TF-CBT use by school-based therapists in South Carolina. For the clinical setting, a series of randomized controlled trials have shown TF-CBT to be superior to nondirective play therapy and supportive therapies in children with multiple traumas. TF-CBT has also been shown to improve the symptoms it addresses, its effect on children enhanced by the caretaker component. Twelve journal publications have demonstrated positive results, mainly for sexually abused children (e.g., Cohen, Deblinger, Mannarino, and Steer, 2004) as well as traumatic loss (Cohen and Mannarino, 2004; Cohen, Mannarino, and Knudsen, 2004).

Training: Training consists of an introductory, intensive skills-based training for one to two days followed by one to two days of advanced training, followed by ongoing consultation for six months. Introductory training, with video examples, is available at www.musc.edu/tfcbt. Clinicians can log in, complete the training, and receive ten free Continuing Medical Education credits. During the first month of operation, one hundred people finished the online training.

Materials: The program developer's treatment book(s), related materials, and the Readiness Assessment are available. A Spanish version of the program is currently under development.

For more information: Contact Noelle Davis (davisno@umdnj.edu) at the Child Abuse Research Education and Service (CARES) Institute at the University of Medicine and Dentistry of New Jersey's School of Osteopathic Medicine or Anne Marie Kotlik (akotlik@wpahs.org) at West Penn Allegheny Health System and the Medical University of South Carolina.

Adapted from the National Child Traumatic Stress Network Fact Sheet available at: www.nctsnet.org/nctsn_assets/pdfs/materials_for_applicants/TF-CBT_fact_sheet_2-11-05.pdf. Contents verified and modified from phone interviews with developers in December 2005.

UCLA Trauma/Grief Program for Adolescents (Original) and Enhanced Services for Post-hurricane Recovery: An Intervention for Children, Adolescents and Families (Adaptation)

Objective: The UCLA Trauma/Grief Program is an individual and group intervention that aims to alleviate anxiety, depression, somatic complaints, risk-taking, aggressive and antisocial behaviors, complicated grief, and Post Traumatic Stress Disorder (PTSD) among traumatized or bereaved youth. It does so through cognitive behavior therapy (narrative reconstruction, psychoeducation, cognitive restructuring, developing coping skills and managing activity). This program has been adapted into the Post-Hurricane Recovery Intervention, which aims to relieve specific post-traumatic stress symptoms, generalized and separation anxiety, depression, inappropriate coping responses, and family conflict or lack of support related to the trauma. It does so by increasing emotional awareness and emotion expression and enhancing a variety of other skill areas, such as communication, coping, and problem-solving.

Intended Population: The UCLA Trauma/Grief Program is aimed at youth ages 11to 18 who have experienced moderate to severe trauma from such events as bereavement, accidents, community violence, natural and man-made disasters, war, and terrorist events. The Post-Hurricane Recovery Intervention is to be used with youth ages 8 to 18 who have experienced hurricane-related trauma including personal injury, life threat, witnessing of injury or destruction, or having a loved one threatened or injured, as well as relocation, loss of contact with friends, and family hardships. The program is intended for intermediate or long-term recovery and thus is best used after at least one to two months have passed since the trauma. Both programs use a two-step screening protocol administered in classrooms or to individual students.

Format: The UCLA Trauma/Grief Program consists of 10 to 24 individual, group, parent, and family sessions. The Post-Hurricane Recovery Intervention consists of 10 individual, 50-minute sessions held once a week plus up to 3 optional joint parent-child sessions and may be adapted to a group setting. It is recommended that someone with clinical mental health training deliver sessions for both programs, whether in school or clinical settings.

Implementation: The UCLA Trauma/Grief Program has been implemented in primary and secondary schools in various states and countries including: five different school districts in communities with high levels of community violence; numerous schools in New York City following the events of September 11, 2001; and secondary schools in post-war Bosnia. In the latter site, a randomized controlled study was conducted. Results indicate significant treatment reductions in PTSD and depression and improvements in academic performance and classroom behaviors (Layneet al., 2001). Several other publications report similar results (Saltzman, Steinberg, et al., 2001; Saltzman, Pynoos, et al., 2001; Layne, Pynoos, and Cardenas, 2001; Goenjian et al., 1997; Goenjian et al., 2005). The Post-Hurricane Recovery Intervention is slated for use in various settings, including schools, in Gulf States impacted by recent hurricanes. Because of its recent introduction, it has not yet been evaluated.

Training: Training for both programs consists of an initial 2-day workshop followed by ongoing supervision and consultation.

Materials: Screening measures, interview protocol, the manual, and the workbook for the UCLA Trauma/Grief program are available. The manual, handouts, and screening materials for the Post-Hurricane Recovery Intervention are also available.

For more information: Contact Bill Saltzman (wsaltzman@sbcglobal.net), UCLA Trauma Psychiatry Program.

Adapted from the National Child Traumatic Stress Network Fact Sheet available at: www.nctsnet.org/nctsn_assets/pdfs/materials_for_applicants/UCLA_Tr_Grief_pgm_for_adol_2-11-05.pdf. Contents verified and modified from phone interviews with developers in December 2005.

Programs for disaster-related trauma

Friends and New Places

Objective: Friends and New Places is a "cognitive contextual" model that addresses cognitive processes regarding a traumatic event in the context of various environments, such as family, school, and community. It is drama-based and is designed for students experiencing traumatic changes in their lives, such as those created by hurricanes Katrina and Rita. The program is intended to reframe how children think about their experiences in a new environment, both at school and at home. It is based on the principles that families are strong and children are strong, and it works to bring out that strength and make it evident to children. The program also stresses that therapy should be meaningful, fun, and appropriate to the culture of the participants.

Intended Population: Friends and New Places is used with all school-aged children, grades K-12.

Format: The program consists of six sessions (6 to 20 children per session, depending on the level of experience of the facilitators) of approximately 60 minutes in length, held weekly. Each session has a theme, such as adjusting to new situations, dealing with anxieties, and coping with depression. All sessions include acting out scenes around the topic and pointing out improvements or solutions to how to deal with various situations, allowing students to be active and draw analogies between their activities and their feelings and reactions to experiences. The facilitators of the program check in weekly with the teachers about how the students are doing. The facilitators also have at least one formal contact with parents but otherwise parents are not included in the sessions. The sessions are co-led by a psychologist or social worker and a school counselor.

Implementation: Friends and New Places has existed for some time but was redeveloped specifically for Hurricane Katrina. The program was given to 1100 students displaced from areas impacted by Hurricane Katrina to the Dallas Independent School District in the school year 2005-06 and will be given again the following school year. Students involved were screened for serious mental health symptoms and those identified (125) were referred to advanced services, but all students participated in the sessions. The program has not yet been formally evaluated.

Training: A full day of training is required to familiarize the facilitators with the model.

For more information: Contact Jenni Jennings (972-502-4194; jjennings@dallasisd.org), Youth and Family Services, Dallas Independent School District).

Contents provided by a phone conversation with the developer in June 2006.

Healing After Trauma Skills (HATS)

Objective: HATS is an evidence-informed intervention manual for use with classrooms, groups, or individuals to relieve re-experiencing trauma, anxiety, fear, numbing, avoidance, clingy behavior, mood changes, arousal, and other trauma-related symptoms among children who have experienced a natural or man-made disaster. It relies on the principles of cognitive behavioral therapy to build positive coping skills.

Intended Population: HATS is used with children in kindergarten, elementary, and early middle school (ages 4-12) who have experienced a natural or man-made trauma or disaster. It was originally developed after the 1995 Oklahoma City bombing and was altered after September 11, 2001, and again after the major Florida hurricanes. This program is not for traumatically bereaved children. It is recommended that HATS be used after at least a month has passed since the traumatic event.

Format: The program consists of 12 exercises plus three additional, optional exercises, which last between 30 and 90 minutes but that can be split into shorter segments. It is recommended that teachers or mental health professions deliver the program. The exercises also include take-home family exercises. HATS was developed for the classroom and group setting but it can be adapted to individual settings and to clinical settings.

Implementation: HATS has been implemented in many schools throughout the U.S. and the world. It has been translated into other languages by people who have requested the manual. Evaluation so far has only been qualitative but more rigorous evaluation is currently in progress.

Training: It is recommended that teachers or mental health professionals facilitate this program. However, it could be used by other professionals with a background in child development who work with children. Other than having professional training and experience, training consists of reviewing and following the manual. In-depth training is also available.

Materials: The manual, in English only, is available free of charge by request or by download at: www.nctsnet.org/nctsn_assets/pdfs/edu_materials/HATS2ndEdition.pdf.

For more information: Contact Robin H. Gurwitch, Ph.D. (405-271-6824 ext. 45122, robin-gurwitch@ouhsc.edu) at the University of Oklahoma Health Sciences Center and the Terrorism and Disaster Center of the National Child Traumatic Stress Network.

Contents adapted from the HATS Manual at: www.nctsnet.org/nctsn_assets/pdfs/edu_materials/HATS2ndEdition.pdf. Contents verified and modified from phone interviews with developers in December 2005 and updated in June 2006.

The Journey to Resiliency (JTR): Coping with Ongoing Stress

Objective: JTR is a school-based psycho-educational group intervention designed to help adolescents with posttraumatic stress (PTS) symptoms to better cope and function in school and at home. The program aims to alleviate PTS symptoms, such as reoccurrence of event, avoidance, numbing, and hyper-arousal symptoms, as well as somatic complaints, functional impairment, and generalized anxiety**.**

Intended Population: JTR is used for children in grades 6th through 12th with PTS symptoms who have experienced the threat of or exposure to traumatic stressors including: terrorism, war, and natural disasters. Children are selected for the group through several screening instruments administered by a psychologist but PTSD is not required for participation.

Format: The program consists of six group (6 to 10 children per group) sessions, each two hours in length, given by the school counselor within the school setting. All sessions include homework review, warm-up exercises relating to the session theme, exploration of feelings, psycho-educational material, practical coping skills training, and a closure exercise followed by a new homework assignment. The sessions include working on particular issues of exposure and dealing with triggers as well as with affect regulation and cognitive processing of the traumatic experiences.

Implementation: JTR has been used and evaluated in Israel. In a pilot study, two groups of 18 participants in the program showed significant reductions of PTS symptoms, somatic complaints, and generalized and separation anxiety symptoms compared to two control groups of 20 children. Follow up data are currently being collected.

Training: Guidance counselors must undergo 24 hours of training, including four 2-hour supervisory sessions of the program given by the trainer.

Materials: Guidance counselor manual and student handouts

For more information: Contact Rony Berger (riberger@netvision.net.il), NATAL, Israel Trauma Center for the Victims of Trauma and War, Tel Aviv, Israel.

Content provided by developer in June 2006.

Maile Project

Objective: The Maile Project is a psycho-educational program developed for students with unremitting post-traumatic stress disorder (PTSD) symptoms following Hurricane Iniki in Hawaii. This program has also been adapted as a school-based counseling intervention to address terrorism-related exposure and associated symptoms. The program is resilience-focused and seeks to support normal processes of recovery in children. The program focuses on restoring a sense of safety, grieving losses and renewing attachments, adaptively expressing disaster-related anger, and achieving closure about the disaster in order to move forward. The Maile Project was designed to provide a structured method to help children review their disaster-related experiences while receiving support to master uncompleted psychological tasks.

Intended Population: This program is used both with children in elementary and middle school (2nd through 7th grades) and with adolescents (8th through12th grades) who have experienced a disaster and who have been identified through self-reported screening as showing PTSD symptoms. The intervention was conceptualized as a package that included screening of children to identify those continuing to have problems, followed by intervention. However, the intervention could be used separately rather than as part of an integrated screen-and-treat approach.

Format: The program consists of four individual or group (4 to 8 children per group) sessions held weekly for the length of a classroom period (40 to 60 minutes). The program can be provided by school counselors, clinical psychologists, or social workers but should be provided by those who are experienced with working with children in schools. The four sessions have the following themes: Safety and Helplessness, Loss, Mobilizing Competence and Issues of Anger, Ending and Going Forward. In each session, children identify challenges, express feelings about those challenges, think about the significance of those challenges, and come up with forward-looking ways of integrating those challenges into the present. The sessions use a combination of play, use of expressive art, and talk. In the group treatment, children are also engaged in cooperative play and discussion.

Implementation: In a randomized 3-cohort study the Maile Project showed reductions in trauma-related problems among 214 children who underwent either group or individual versions of the program. The group version was as effective as the individual format but had better retention of children. The children who participated came from all 10 elementary schools on the island of Kauai. The intervention was delivered 2 years after Hurricane Iniki. The main ethnicities represented in the sample were Hawaiian or part-Hawaiian (30 percent), white (25 percent), Filipino (20 percent), and Japanese (9 percent; Chemtob, Nakashima, and Hamada, 2002).

Training: School counselors or clinicians are given three days of training regarding post-disaster trauma psychology and 1 ½ days of didactic training specific to the treatment manual. In addition, group supervision should be provided weekly to ensure consistent delivery of the protocol.

Materials: Two treatments manuals are available, for 2nd through7th grades and 8th through 12th grades. Each manual covers individual and group format and provides session-by-session protocols that outline each session's content and provide a specific repertoire of activities designed to elicit material relevant to each session. A standard play-therapy kit with play and art materials to use is also available.

For more information: Contact Claude M. Chemtob (claude.chemtob@mssm.edu).

Contents adapted from Chemtob, Nakashima, and Hamada, 2002. Contents verified with developer in June 2006.

Overshadowing the Threat of Terrorism (OTT) and Enhancing Resiliency Among Students Experiencing Stress (ERASE-S)

Objective: OTT and ERASE-S are school-based, psycho-educational interventions that aim to prevent and reduce children's posttraumatic stress (PTS) symptoms, somatic complaints, functional impairment, separation anxiety and generalized anxiety**. OTT** (Berger et al., 2003). is designed to help children cope with severe traumatic conditions, such as the threat of and exposure to terrorism, while **ERASE-S** is more appropriate for daily stressors and includes resiliency strategies such as building self-esteem and dealing with communication and assertiveness.

Intended Population: ERASE-S and OTT are used for children in grades 3 to 10. OTT also has a version for 1st and 2nd graders. OTT is intended for use with those who have experienced the threat of or exposure to a traumatic stressor including: terrorism, war, natural disaster (e.g., the Tsunami), or a large-scale accident. ERASE-S is intended for use with those who have exposed to stressful or traumatic conditions. Although neither OTT nor ERASE-S is restricted to highly symptomatic children or children with PTSD, it is expected that students who have been significantly affected by stress and trauma will benefit most from the programs. Both programs have been applied cross-culturally to Israeli and Palestinian students; in addition, ERASE-S has been given to Sri Lankan and Turkish students.

Format: OTT and ERASE-S consist of weekly classroom sessions (about 20 children per group) 90 minutes in length. OTT includes 8 sessions, ERASE-S includes 12. All sessions include homework review, warm-up exercises relating to the session theme, exploration of feelings, psycho-educational material, practical coping skills training, and a closure exercise followed by a new homework assignment. There is also a new version of OTT for younger children grades 1 and 2 with 10 sessions of 45 minutes. OTT and ERASE-S can be provided through local public schools by teachers who are acquainted with the pupils and parents.

Implementation: OTT and ERASE-S have been used and evaluated in Israel and Palestine. In a randomized controlled trial, 70 children in 2nd though 6th grade who took part in OTT showed significant reductions of PTSD symptoms, somatic complaints, and generalized and separation anxiety symptoms two months after the intervention, as compared to controls (Berger, Pat-Horenczyk, and Gelkopf, Under Review). OTT has also been evaluated in two unpublished studies, both showing some benefits of the program: among 107 7th though 8th grade students exposed to ongoing missile attacks, among 408 pupils 2nd though 6th grade students in the aftermath of one of the worst bus accidents in Israel. The ERASE-S program has also been evaluated among 125 Israeli children and 258 Palestinian 7th through 8th grade students. ERASE-S is currently being applied in Sri Lanka with 680 students in grades 3 to 12 and a randomized controlled trial is currently in progress there. The program has also been applied in Turkey with students in grades 3 to 6.

Training: Teachers must undergo 20 to 32 hours of training, including three to five 3-hour supervisory sessions of the program given by the trainer. Supervision can also be provided by Internet. The training program for ERASE-S itself has been shown to improve the perceived level of professional self-efficacy and the sense of self-mastery and to produce a more optimistic outlook regarding personal future among Sri Lankan aid volunteers after the 2004 tsunami when compared with a control group who were exposed to a more traditional seminar.

Materials: OTT: teacher's manual and a student's manual. ERASE-S: teacher's manual, psycho-educational booklet and student handouts.

For more information: Contact Rony Berger, riberger@netvision.net.il, NATAL, Israel Trauma Center for the Victims of Trauma and War, Tel Aviv, Israel

Content provided by developer and adapted from Berger, Pat-Horenczyk, and Gelkopf, Forthcoming
Contents verified and modified from communication with developer in June 2006.

Psychosocial Structured Activity (PSSA), or the Nine-session Classroom-Based Intervention (CBI), and Journey of Hope (*Save the Children)*

Objective: The Psychosocial Structured Activity (PSSA) is a short-term, classroom-based resiliency-building intervention designed to help children who have experienced a crisis to deal emotionally with difficult experiences through a series of structured play therapy activities. The intention of PSSA is to normalize students' reactions to fearful events, rebuild self-esteem, address students' reactions to what they saw, help students identify resources and coping mechanisms, and finally to help students utilize available resources and plan for the future.

PSSA is intended to be given in conjunction with a one-day workshop, called Journey of Hope, for faculty and parents to help them to process recent events, cope with current challenges, and address their own needs for self-care during these stressful times

Intended Population: PSSA is intended for children aged 5 through 18. Children who are identified through the sessions as distressed and needing additional counseling are referred to additional services.

Format: PSSA consists of nine 60 minute sessions, held three times a week over three weeks, either in a classroom or summer camp setting with no more than 20 students. Each session has four components: 1) a beginning circle, 2) a central, interactive activity such as storytelling, dancing, music, drama, or drawing; 3) a cooperative game, and 4) an ending circle where the session's lesson is reinforced. Two adult leaders are required to lead the program. In the future, Save the Children hopes to add a component for hurricane preparedness. It is recommended that someone with previous counseling, social work, or clinical experience and experience working with children conduct the sessions.

Implementation: PSSA is directly based on Robert Macy's classroom-based intervention (CBI), a 15-session program intended to offer consistent, structured play and expressive activities that can rebuild a sense of safety and control without focusing on the details of the traumatic incident(s). CBI was first used with youth gang members in the Boston area and has since helped children in Indonesia after the 2004 tsunami, in the Middle East and in Nepal. CBI has undergone impact studies that have demonstrated positive psychological changes (Khamis, Macy and Coignez, 2004). The program has been tailored to help children cope with Hurricane Katrina and has been implemented in Washington, Jefferson, East Baton Rouge, and Orleans Parishes in Louisiana and Hancock, Jackson, and Harrison Counties in Mississippi. Due to an ongoing monitoring and evaluation process, PSSA is being adjusted to be more flexible and more effective in the Gulf Coast environment.

Training: Training consists of a 3-day workshop. It is recommended that someone with previous experience working with children and with previous counseling, social work, or clinical experience conduct the sessions. Implementation guidelines must be followed carefully to assure the effectiveness of the program and to avoid any negative impact on the participants or facilitators.

Materials: There is a teacher's manual and an activity kit, with CD player, music, toys and art supplies, and 12-foot silk parachute. Save the Children also has informational packets with tip sheets for Parents, Teachers, Administrators, and Teens, as well as a compilation of cooperative games useful for summer camps and schools that are unable to implement a more structured psychosocial program.

For more information: Contact Barbara Ammirati (bammirati@savechildren.org), Erin Spencer (espencer@savechildren.org, 228-863-3577), or Yael Hoffman (yhoffman@savechildren.org, 225-803-5731) or visit www.savethechildren.org.

Information taken from www.savethechildren.org, publications on CBI, and newspaper articles. Contents verified by communication with Save the Children staff in April 2006 and consultation of the CBI 9-session manual in June 2006.

The Resiliency and Skills Building Workshop Series
By the School-Based Intervention Program (SBIP) at the NYU Child Study Center's Institute for Trauma and Stress

Objective: The Resiliency and Skills Building Workshop Series is a cognitive-behavioral, classroom intervention designed to reduce acting out behaviors, enhance and develop anger management and stress reduction skills, and increase levels of resiliency among students experiencing typical ups and downs of adolescence, as well as those experiencing low to moderate levels of psychological distress after a trauma. The Resiliency and Skills Building workshops are not a substitute for treatment of moderate to severe psychological symptoms. This program is also intended to inform students of the mental health services available at their school and to introduce them to therapists.

Intended Population: This program has been developed for use with high school students.

Format: The five 35-minute sessions are integrated into the health class curriculum and given for five consecutive days in a classroom setting (25 to 35 students). It is recommended that a team of two professionals, both with clinical mental health training, deliver these sessions. The SBIP is currently developing a curriculum for middle school aged children that consists of eight sessions held biweekly.

Implementation: The School-Based Intervention Program (SBIP) at the NYU Child Study Center's Institute for Trauma and Stress was developed within the first days after the September 11, 2001 attacks, as the Center assisted the New York City Department of Education in its response to the crisis. It has provided an estimated 7,500 children and their families in the downtown New York City public schools a range of mental health services. The Resiliency and Skills Building Workshops were developed by the SBIP as a result of a dramatic increase in suspension rates at Murry Bergtraum High School (MBHS) in Lower Manhattan the year after September 11, 2001. The program was implemented at MBHS two years after September 11, 2001. To date, approximately 2,500 students have received these workshops. The workshops have undergone two years of evaluation using data on 109 students, of whom 46 percent are Hispanic, 21 percent African-American, 17 percent Asian, 14 percent self-described as bi-racial, and 2 percent American Indian/Alaskan Native descent. Data for year 1 has shown that the program decreased student anxiety levels and suspension rates. Data for year 2 and for years 1 and 2 combined is currently being prepared for publication.

Training: Currently only employees of the SBIP have implemented the program. However, the program's goal is to train others.

Materials: The manual, Resilience and Skill Building: A Manual to Manage Anger and Increase Interpersonal Skills, and its accompanying packet of Supplemental Materials (homework, handouts, checklists) are available.

For more information: Contact Elizabeth Mullett-Hume (212-263-3682, elizabeth.mullett@med.nyu.edu) at the New York University Child Study Center (www.aboutourkids.org.

Adapted from SBIP's Resilience and Skill Building Manual and program information at: www.aboutourkids.org/aboutus/programs/trauma_stress.html#school. Contents verified and modified from phone interviews with developers in December 2005 and updated in June 2006.

Silver Linings: Community Crisis Response Program, by Rainbows

Objective: Silver Linings is a first-response, classroom or youth-group program to assist youth experiencing emotional turmoil due to loss or change caused by a crisis situation. The program is appropriate for a variety of crisis situations, such as natural disasters, death of a classmate or teacher or administrator, school closings, or violence in the school or community. The main purpose of Silver Linings is to provide a safe place among a caring group of adults and peers for students to express and explore feelings such as anger, sadness, and guilt, while participating in physical activities. Silver Linings is also intended to provide instruction in coping strategies, in particular positive reappraisal.

Intended Population: Silver Linings is available for use for three age groups: 5-8, 9-12, and adolescents. Rainbows is now creating and piloting both a pre-school and an adult version of Silver Linings.

Format: Silver Linings consists of six 30- to 45-minute group sessions that may be held over a period of two to six weeks with at least a day in between each session. Silver Linings can be facilitated by anyone who works regularly with children, including coaches, teachers, counselors, and youth group leaders. Each of the six sessions has a theme, or focus: feelings, changes, angry and fear, endings and beginnings, weathering the storms, and goal-setting. There is the option to use the creative activities to develop an expandable, "large-group" display in a public setting. Rainbows is already expanding these sessions by adding support group sessions specific to Katrina and/or hurricanes.

Implementation: Silver Linings began as a pilot in Gary, Indiana, to help people displaced by flooding and living in a shelter to deal with the changes in their lives and the loss of possessions. Silver Linings was also implemented successfully with flooded communities along the Mississippi River and with a group of artists working with troubled students in Los Angeles. After the events of September 11, 2001, Rainbows produced a special edition 2001 Silver Linings, and donated materials and training to New York City and New Jersey schools. Since then, Silver Linings has proven successful in a variety of settings and crisis situations, including with children from families of deployed soldiers in Sheboygan, Wisconsin, and in communities where there has been violent or sudden deaths due to accidents. Rainbows has sent 300 shipments of Silver Linings materials to assist hurricane victims in Alabama, Mississippi, and Louisiana and worked closely with the Louisiana and Mississippi Counseling Associations to identify schools where materials are needed. Silver Linings has not yet been evaluated but is actively collecting pre- and post-program information on participants and evaluations by facilitators.

Training: Silver Linings can be facilitated by anyone who works regularly with children, including coaches, teachers, counselors, and youth group leaders.

Materials: There are three editions of Silver Linings, for ages 5 to 8, 9 to 13, and for adolescents. Each edition includes an instructor manual and a reproducible participant booklet. Also included is a coloring story booklet, Ferdinand the Eagle, which focuses on rebuilding and generating hope. Rainbows received an Allianz Group grant for responding to hurricanes Katrina and Rita and thus may be able to provide materials free of charge.

For more information: Contact Laurie Olbrisch (800-266-3206 x 12, laurie@rainbows.org) or visit www.rainbows.org.

Information adapted from a variety of RAINBOWS materials, www.rainbows.org, and newspaper articles. Contents verified with the developers in May 2006 and updated in July 2006.

UCLA Trauma/Grief Enhanced Services for Post-hurricane Recovery

Please see the UCLA Trauma/Grief Program description in the section of non-specific trauma (page 32).

Programs for traumatic loss

Loss and Bereavement Program for Children and Adolescents (L&BP)

Objective: The Loss and Bereavement Program is a group intervention program designed to alleviate anxiety, heightened imagery, misconceptions about death, and scary dreams among children who have experienced a permanent loss of a loved one due to death. The program uses an eclectic mix of intervention techniques to help children understand death, discuss and answer questions about death, and follow Dr. J. W. Worden's "four tasks of mourning": accept the reality of the loss, experience the pain of grief, adjust to living without the deceased, and emotionally relocate the deceased and move on with life.

Intended Population: The Loss and Bereavement Program is used with children, ages 6 through to adolescence, who have experienced the death of a parent, caregiver, or other significant family member or friend and is experiencing simple or complicated bereavement. School counselors refer students to the program. The Loss and Bereavement Program can be used for recent losses as well as for longer term recovery. The program has been successfully used with inner-city, Hispanic, and African-American populations.

Format: The program consists of 12 group sessions, 60 to 90 minutes in length, that meet weekly along with one or two joint sessions with the surviving parent or caregiver and the child. It is recommended that sessions be led by someone with clinical mental health training.

Implementation: The Loss and Bereavement Program has been implemented in New York City with funds from the NYC Office of Mental Hygiene. Evaluation of the program is limited. Its initial pilot study was done in 1991. There is indication that attendance records improve. Students report that they like the program.

For more Information: Contact the Loss and Bereavement Program office (212-632-4692) or Dr. Nina Koh, program director (212-632-4492 or 212-795-9888) of the Jewish Board of Family and Children's Services (www.jbfcs.org).

Contents obtained from phone interviews with developers in December 2005.

PeaceZone (PZ)

Objective: PeaceZone (PZ) is a school-based program that is designed to increase students' ability to make positive decisions, avoid risk-taking behavior, and heal from trauma and loss. A secondary goal of the PZ program is to assure that adults are able to reinforce the core concepts with children, both at home and in school. Two approaches to violence prevention are integrated into PZ: social skill building and conflict resolution and healing from trauma, grief and loss. Psychomotor expressive activities (visual arts, music, dance, etc.) and community service shape the key healing activities. PZ is based on social cognitive therapy and the research of Howard Gardner (Frames of Mind). It emphasizes self-control, self-respect, problem solving, and cooperation.

Intended Population: PZ is used with all elementary students, ages 4-11 (grades K-5), in a classroom setting. Data indicate that the PZ is particularly helpful for children who have experienced some type of loss, whether from divorce, death, or exposure to violence. Students identified as in need of additional, individual support services are referred to counselors and other mental health personnel.

Format: The program consists of six classroom units, each containing four classroom sessions, approximately 30 minutes in length, for a total of 24 sessions. PZ is designed to be delivered in the traditional elementary-school classroom setting of approximately 25 students. The entire program can be presented in six weeks, but it should be continued and reinforced throughout the school year with supplemental booster activities. The six units cover the following themes: the Louis D. Brown Story, Pledge for Peace, Trying your best, Self-Control, Thinking and Problem Solving, and Cooperation. The last lesson of each unit links the topic to a community service activity. The community service activities are "healing through helping" strategy. In addition, there is a School Climate Change Module. For best implementation of the program, it is recommended that lead teachers at each grade level and a half-time school counselor support both classroom and school-wide activities and that the school community commits to the use of the common PZ language.

Implementation: PZ was created in 1998 by the Harvard Youth Violence Prevention Center, the Lesson One Company, and the Louis D. Brown Peace Institute. The program was developed and implemented in four Boston public elementary schools, reaching 1342 students. An evaluation for the Department of Education was conducted for three of the four schools in 2004 by the Harvard School of Public Health. Three of the schools were approximately 75 percent African American with a range of 8 to 16 percent Hispanic students. One of the three schools had 6percent Asian students. The remaining students in the three schools were white. The fourth school was 43 percent Hispanic, 34 percent white, 10 percent African American and 13 percent Asian. Pre- and post-program surveys conducted in grades 3-5 in three intervention schools showed reductions in self-reported victimization (boys 28-37 percent, girls 30-39 percent) and self-reported mild to severe depression (boys 25 to 40 percent, girls 14 to 40 percent).

Training: Teachers and administrators participate in a day-long training that consists of information about grief and loss, how symptoms of grief and trauma can manifest themselves behaviorally, and how grief and trauma have an impact on academic achievement.

Materials: Separate teacher's and student's manuals for grades K to 1, 2 to 3, and 4 to 5 (Prothrow-Stith, Chery, Oliver, Feldman, Chery, & Shamis, 2005) are available through Research Press Publishers, rp@researchpress.com , 800-519-2707 .

For more information: Contact Dr. Deborah Prothrow-Stith (617-495-7777; dphpdesk@hsph.harvard.edu), Harvard School of Public Health, Boston, Mass.

Contents adapted from write-up provided by developer and confirmed with developers in July 2006.

Rainbows

Objective: Rainbows is a grief support organization that provides intervention and prevention curricula for children and youth who have experienced divorce, separation, or death of parents, or have experienced a myriad of other loss or painful transitions. The main purpose of Rainbows is to provide a loving, safe atmosphere in which participants know someone cares for them and is willing to listen to them. Rainbows curricula are intended to provide grief support, foster emotional healing, boost self-esteem, and teach coping mechanisms.

Intended Population: Rainbows is comprised of a pre-school edition (SunBeams, ages 3 to 4), an elementary edition (Rainbows, ages 5 to 14), and an adolescent edition (Spectrum) There is also a program for college-age and adults called Kaleidoscope as well as one called Prism for single and stepparents. Rainbows curricula have been used successfully by children and adults of diverse races and religious denominations around the world.

Format: Rainbows Elementary Edition consists of 12 group (3 to 5 participants) sessions broken into 2 sets of 6 sessions with a Celebrate Me Day after each set. The length of each session depends on the age group and the curricula used, but ranges from 25 to 120 minutes. Each student uses an age-specific journal, or activity book, which are private and confidential. Each session consists of discussion, sharing, activities, and reflection, focused on an aim and rationale. The 12 sessions cover the following themes: 1) self, 2) feelings, 3 and 4) divorce, death, and loss, 5) anger and hurt, 6) fears and worries, 7) family, 8) belonging, 9) stepfamily, 10) acceptance, 11) coping tools, and 12) reaching out to others. The Celebrate Me Days cover self esteem, guilt, trust, coping tools, and forgiveness, and can be done in conjunction with the other Rainbows groups at the school, faith community or agency sponsoring the programs. (SunBeams and Spectrum follow formats similar to that of the Rainbows Elementary Edition).

Implementation: Rainbows has been used throughout the United States. and in 16 other countries. Rainbows demonstrated high participant and parent satisfaction when evaluated in 2000 by Drs. Laurie Kramer and Gary Laumann of the University of Illinois at Champaign-Urbana.

Training: There are two training levels, dependent on one's role in the community: Local Coordinator/Facilitator Training, and Registered Director Certification Training. Local Coordinators and Facilitators are volunteer adults hand chosen by sites who are trained by Rainbows to offer support, understanding and guidance through their own listening skills and the Rainbows materials; training takes 6-9 hours. Rainbows can be facilitated by clinicians and nonclinicians who have leadership skills, a motive of genuine care and concern, good listening skills, and capability of keeping confidence. Registered Directors are responsible for the implementation, quality, and growth of Rainbows in a geographic region and require the capability to market, train, and follow up with registered sites; training requires 6-day certification institute.

Materials: There are different instructor manuals, journals, games and activities for the different age-group programs (SunBeams, Rainbows, Spectrum, Kaleidoscope or Prism). Rainbows Registered Directors work with potential sites to complete an implementation process to become a Registered Rainbows Site.

For more information: Contact Laurie Olbrisch at (800-266-3206 x 12, laurie@rainbows.org) or visit www.rainbows.org.

Information adapted from a variety of Rainbows materials and www.rainbows.org. Contents verified with the developers in May 2006 and updated in July 2006.

Three Dimensional Grief (also known as the School-Based Mourning Project)

Objective: Three Dimensional Grief is a group intervention process to facilitate mourning and grief among children who have experienced permanent loss from death. The program uses a mix of approaches and techniques – developmental, psychodynamic, child-centered play therapy, and gestalt – to build children's readiness to engage, emotional literacy, and sense of ego-integrity.

Intended Population: This program is used with school-aged children who have experienced the death of a friend, parent, caregiver, or other significant family member. Children are referred to Three Dimensional Grief by teachers and counselors. The program can be used for recent losses or for longer term recovery.

Format: The program consists of 45- to 90-minute group sessions (6 to 8 children per group) held weekly. It is recommended that only someone with clinical mental health training, who has familiarity with grief and group work, lead the sessions. The program is very adaptable, and thus very dependent on the mental health clinician delivering the program. It can be given for eight sessions or can be adapted to last the entire school year.

Implementation: Three Dimensional Grief has been implemented in public, charter, and parochial schools in Washington, D.C. It has been used in 30 schools in the past six years and is currently in 12 to 15 schools. This program has been successfully used with African-American populations and populations of low socio-economic status. There has been a 3-year pre-post study using the Reynolds Anxiety and Draw Persons measurement. Currently, there is ongoing evaluation of the past 2 years. Publications on the program include a journal article and a book chapter (Skarlew et al., 2004; Skarlew et al., 2002).

Training: It is recommended that someone with clinical mental health training who has familiarity with grief and group work deliver this program. Three Dimensional Grief is very reliant on the clinician's skill in using a range of activities as best matches the group's needs and setting. Training consists of 1 to 2 days, with at least a half day of clinical review and at least another half day of active practicing of the program. Training is followed with another training day and monthly consultations.

Materials: The manual, references, and resource lists, all in English only, are available.

For more Information: Contact Susan Ley (202-624-0010, sley@wendtcenter.org) or Dottie Ward-Wimmer (202-624-0010, dottie@wendtcenter.org) at the Wendt Center for Loss and Healing (www.wendtcenter.org) in Washington, D.C.

Content obtained and verified from interviews with the developers in December 2005 and from Sklarew et. al. (2002) and updated in June 2006.

Programs for exposure to violence

The Safe Harbor Program: A School-Based Victim-Assistance and Violence Prevention Program

Objective: Safe Harbor is a comprehensive, multifaceted program that addresses violence, victimization, and related trauma. It includes counseling, workshops, school-wide campaigns, peer leadership development, and outreach to parents, staff, and the community. Another key component is a designated room, described in full below, to create a safe environment for the other activities. The counseling component aims to relieve behavioral and/or psychological concerns students may be experiencing: acting out, depression, and other trauma symptoms in students who have had exposure to violence. It teaches communication skills, positive self-talk meant to boost self-esteem, as well as healthy coping skills directed at the self and in interactions with others. Group counseling uses a trauma education and violence prevention curriculum. Workshops are on various violence-prevention topics.

Intended Population: Safe Harbor is used with students in middle school and high school (6th through 12th grade). The designated room, workshops, and school-wide campaigns are open to the entire school population. The counseling is restricted to those with exposure to violence, including sexual abuse, domestic violence, bullying and harassment, terrorism, natural disasters, and child abuse. Students are referred to Safe Harbor counseling by teachers or school counselors. This program can be used for recent or ongoing violence and for long term treatment of trauma related to violence in the past.

Format: The Safe Harbor counseling component consists of 11to 17 individual or group sessions (6 to 10 youth per group) held weekly. A key component of the Safe Harbor program is that all counseling and groups take place in a room designated as the "Safe Harbor" in the school. The room should be able to accommodate groups of 10 to 15 students, and should be decorated as a safe, comfortable, inviting place (sofas, art supplies, colorful posters, books, games, etc.). Workshops can be given to entire classrooms (30 students). It is recommended that someone with clinical mental health training deliver and coordinate the Safe Harbor programs and staff the Safe Harbor room.

Implementation: Safe Harbor has been implemented at the Meyzeek Middle School in Louisville, Ky., Long Beach Preparatory in Long Beach, Ca., and in New York City in four schools: two in the Bronx, one in Brooklyn and one in Manhattan. Safe Harbor has also been used in other parts of the United States and in the Virgin Islands.

Training: Training of social workers or mental health clinicians can take 6 hours to 3 days, depending on the trainee's skills.

Related Program: Safe Horizon also offers another program, very similar to Safe Harbor, with the exception that it is focused on domestic violence and teen relationship abuse. The Relationship Abuse Prevention Program (RAPP) is currently in thirty schools, including three which Safe Horizon operates. Neither program has been formally evaluated yet.

Materials: Although Safe Horizon offers services in many languages and is willing to accommodate any specific requests, written materials regarding the Safe Harbor program have not yet been provided in languages other than English. Thus, both the counseling curriculum and facilitation manual are available in English only.

For more information: Contact Christian Burgess (212-629-6298, wburgess@safehorizon.org) at Safe Horizon, New York (www.safehorizon.org).

Adapted from the National Child Traumatic Stress Network Fact Sheet available at: www.nctsnet.org/nctsn_assets/pdfs/materials_for_applicants/Safe_Harbor_Program_2-11-05.pdf. Contents verified and modified from phone interviews with developers in December 2005.

Programs for complex trauma

Life Skills/Life Story (Formerly Skills Training in Affective and Interpersonal Regulation / Narrative Story-Telling or STAIR/NST)

Objective: Life Skills/Life Story is a two-module, group or individual intervention in which the first module focuses on building resilience while the second addresses resolving problems such as depression, dissociation, and Post Traumatic Stress Disorder (PTSD) symptoms. The treatment has been developed for girls who have experienced complex, multiple and/or sustained trauma. Life Skills targets emotional and social competency building, emotional regulation skills, social skill development, positive self-definition, and goal setting. Life Story addresses emotional processing of the traumas and in the context of developing a positive life narrative and future plan.

Intended Population: The program is used with girls ages 12 to 21 who have experienced complex, multiple, and/or sustained trauma related to sexual or physical abuse, community violence, domestic violence, or sexual assault. A PTSD diagnosis is not required but participants should display trauma-related symptoms and have a history of repeated exposure to violence. This program is not a single incident crisis intervention, but rather for recovery from sustained problems in functioning related to chronic symptoms and derailed development resulting from sustained trauma. It can be used for youth who experience an acute trauma and have a history of previous trauma. Life Skills/Life Story has been successfully conducted with ethnically diverse populations, including African-American and Hispanic.

Format: Life Skills and Life Story can be conducted in either individual or group sessions (4 girls per group with one therapist, or 6 to 8 girls per group with two therapists). It is recommended that someone with clinical mental health training lead the sessions. Life Skills consists of ten sessions and Life Story consists of six sessions, all held once a week. Each module can be done without the other.

Implementation: Life Skills/Life Story was developed for use in a free-standing community mental health program but has been implemented in a variety of settings, including residential school settings, after school programs, and lunch periods. It is currently being implemented as a NCTSN Learning Collaborative in six sites including school, outpatient community, outpatient hospital, and inpatient hospital settings. A completed study of Life Skills/Life Story indicated that, compared to a no treatment group, high school and middle school girls experienced a reduction in PTSD symptoms, depression, dissociation, and conduct and interpersonal relations, and improvement in emotion regulation capacities and social skills. A randomized trial of the program is ongoing in a residential school setting. Life Skills/Life Story has been shown to have positive results in a completed randomized control study of adult women with histories of sustained childhood trauma (Silva et al., 2003; Cloitre et al., 2002).

Training: So far, training for Life Skills/Life Story has been completed with community mental health providers, school psychologists, hospital inpatient and outpatient providers, and psychology and social work trainees. Training includes one day of workshops, weekly supervision by phone, and monthly in-person group supervision for the clinician's first group.

Materials: The manual, worksheets, and treatment materials are provided at training workshops.

For more information: Contact Marylene Cloitre, PhD, director (212-263-2471, marylene.cloitre@MED.NYU.EDU) at the Institute for Trauma and Stress, The New York University Child Study Center, New York.

Adapted from the National Child Traumatic Stress Network Fact Sheet available at: www.nctsnet.org/nctsn_assets/pdfs/materials_for_applicants/STAIRNST_2-11-05.pdf. Contents verified and modified from phone interviews with developers in December 2005 and updated in July 2006.

Structured Psychotherapy for Adolescents Responding to Chronic Stress (SPARCS)

Objective: SPARCS is a group intervention that was specifically designed to address the needs of chronically traumatized adolescents who may still be living with ongoing stress. SPARCS focuses primarily on six domains of functioning in order to help teens to cope more effectively, make better choices, and cultivate supportive relationships (DeRosa and Pelcovitz, in press; DeRosa and Pelcovitz, 2005). These domains include problems with emotion regulation and impulsivity, self-perception, relationships, somatization, alterations in attention and consciousness, and struggles with their own purpose and meaning in life. SPARCS is predominantly cognitive-behavioral and draws upon Dialectical Behavior Therapy and two other mental health programs, Trauma Adaptive Recovery Group Education and Therapy (TARGET) and the UCLA Trauma/Grief Program.

Intended Population: SPARCS has been used for adolescents between the ages of 12 and 19 who have been exposed to chronic traumatic stress (including interpersonal violence, community violence, and life-threatening illness). A diagnosis of Post Traumatic Stress Disorder is not required. Identification of trauma history and current psychological distress is sufficient to select students; the SPARCS developers recommend using assessments that are sensitive to clinical changes, such as the Youth Outcome Questionnaire Self-Report (YOQ-SR 30.1: www.oqfamily.com).

Format: SPARCS consists of 16 group sessions (6 to 10 children per group), approximately one hour in length, conducted weekly in a school setting. Sessions can be split in half and conducted biweekly to accommodate shorter class periods in a school setting. It is recommended that someone with clinical mental health training deliver this program. The program has found it helpful to collaborate with school personnel, teachers, administrators and other support staff, before and during the treatment to address organizational readiness and facilitate group members' generalization of coping skills introduced in treatment. Group treatment is not always feasible; therefore, development of SPARCS-I as an individual treatment is currently underway.

Implementation: SPARCS is currently being piloted in schools and outpatient settings in California, Georgia, Illinois, New York, North Carolina, and Wisconsin. In initial pilots of the intervention participants' scores improved on the Youth Outcome Questionnaire and participants' satisfaction with the group was high. In addition, school administrators noted a dramatic decrease in physical confrontations and fights after the intervention began. Anecdotal reports from other sites have also been positive which include outpatient, day treatment, and resident treatment settings. The interventions and programs upon which SPARCS draws have empirical evidence to support their effectiveness. Further evaluation is currently in progress.

Training: Training consists of two 1-day training sessions (1 prior to program implementation and 1 one month into program) and bi-monthly consultations throughout.

Materials: A training and clinician guide and color activity handouts for group members are available. Some handouts are available in Spanish.

For more information: contact Victor Labruna, PhD, (516-562-3245, vlabruna@nshs.edu), North Shore University Hospital.

Adapted from the National Child Traumatic Stress Network Fact Sheet available at: www.nctsnet.org/nctsn_assets/pdfs/materials_for_applicants/SPARCS_2-11-05.pdf. Contents verified and modified from phone interviews with developers in December 2005 and updated in July 2006.

Trauma Affect Regulation: Group Education and Therapy For Adolescents (TARGET-A)

Objective: TARGET-A was developed to help trauma survivors understand how trauma changes the body and brain's normal stress response into a survival-oriented "alarm" reaction that can lead to posttraumatic stress disorder (PTSD). TARGET provides a practical skill-set that can be used by trauma survivors and family members to de-escalate and regulate extreme emotion states, to manage intrusive trauma memories, and to restore the capacity for information processing and autobiographical memory. TARGET teaches a sequence of seven (7) skills described as the FREEDOM steps.

Intended Population: TARGET-A (for adolescents) has been used with children aged 10 to 18 who have been exposed to physical or sexual abuse, domestic or community violence, disasters, severe accidents, traumatic loss, or who are otherwise experiencing stress-related behavioral or emotional problems. A diagnosis of PTSD is not required. Youths who are considered good candidates for this program can be identified by problems with anger, anxiety, or emotional control. TARGET-A is effective for children who have had either recent or past trauma, and may be useful as a brief or long-term form of treatment.

Format: The program can be done in groups (6 to 8 children per group; separated by gender and age), or in individual or family sessions. The length of the group intervention ranges from 3 to 26 sessions depending on the setting. The individual intervention is 12 sessions. It is recommended that the group facilitator or individual therapist have mental health training. Groups may be co-led by teachers or other staff who need not have mental health training.

Implementation: TARGET-A (Ford and Cruz, 2006) was developed originally for adolescents in Boys & Girls Clubs and community programs, and has been refined for use with pre-adolescents, as a gender sensitive intervention for girls, and in juvenile justice and mental health outpatient and residential programs and detention centers, including in schools in those settings. TARGET-A is adaptable to other school settings. TARGET-A is being evaluated in two research studies with urban, low-income, predominantly minority (African-American, Latino/Latina) youths and parents: (1) as a group intervention in Connecticut juvenile justice detention centers (funded by the Connecticut Court Support Services Division), and (2) in a randomized clinical trial study as a one-to-one therapy with juvenile justice- or delinquency-involved girls with PTSD (funded by the Office of Juvenile Justice and Delinquency Programs).

Training: TARGET training is offered at least once a year at the University of Connecticut Health Center (see www.ptsdfreedom.org) On-site training and consultation can be provided to agencies and adapted to the specific needs and goals of the site and the population served.

Materials: Manuals have been developed for use with individuals (12 sessions; Ford, 2006) and groups (3 to 10 sessions; Ford and Cruz, 2006). The materials are currently available in English.

For more information: Contact Julian Ford at the University of Connecticut Health Center (860-679-2360, FordJ@psychiatry.uchc.edu) or visit www.ptsdfreedom.org.

Adapted from the National Child Traumatic Stress Network Fact Sheet available at: www.nctsnet.org/nctsn_assets/pdfs/materials_for_applicants/TARGET_2-11-05.pdf. Contents verified and modified from phone interviews with developers in December 2005 and updated in June 2006.

Section 5: How to Find Funding to Support Use of These Programs

As the program descriptions show, trauma-recovery programs typically require personnel with special training, either professional mental-health training or training specific to the program. Simply buying and implementing a curriculum or program manual is unlikely to produce positive results unless the implementers receive training and support from the program developers or local experts. Thus, some additional funding is typically required to initiate and sustain such programs.

Funding for mental health programs can come from a number of different sources. According to a report by the Substance Abuse and Mental Health Services Administration (SAMHSA) (Foster et al., 2005), the top sources of funding used by U.S. schools for mental health intervention services are the Individuals with Disabilities Education Act (63 percent of schools); state special-education funds (55 percent); local funds (49 percent); state general funds (41 percent); Medicaid (38 percent); and Title I of the Elementary and Secondary Education Act of 1965, Improving Academic Achievement of the Disadvantaged (20 percent). The top sources of funding for mental health prevention services are Title IV, Safe and Drug-Free Schools and Communities (57 percent of schools); local funds (43 percent); and state general funds (39 percent).

Here we summarize information current as of June 2006 about funding for school mental-health activities, including funding specific to communities affected by hurricanes Katrina and Rita. This information can change rapidly, however, and it will take some investigation to learn which resources might be available in any particular location or school.

The following Web sites may be helpful:
www.hhs.gov/katrina/fedpayment.html
www.samhsa.gov/statesummaries/index.aspx
www.samhsa.gov/grants06/default.aspx

1. Federal Emergency Management Agency (FEMA)/SAMHSA Crisis Counseling Assistance and Training Program (CCP) Grants

CCP grants provide funding for counseling outreach and for training local crisis counselors to provide assistance after federal relief workers leave a disaster area. Through an interagency agreement with FEMA, SAMHSA monitors the CCP, which is funded by FEMA. State mental health agencies and tribal authorities are eligible to apply.

Eligible entities may apply for the Immediate Services CCP Grant (which provides funding for up to 60 days of counseling services) and the Regular Services CCP Grant (which provides funding for up to 9 months of counseling services). The application for the Immediate Services CCP Grant is due within 14 days of a presidential declaration of disaster; the application for the Regular Services CCP Grant is due within 60 days of a presidential declaration.

CCP grants have supported school mental-health programs following FEMA-declared disasters, as in New York after September 11, 2001.

It may be possible for schools or other agencies to link with the state agency that applied for these funds in order to implement a mental health program. To learn how the funding will be spent, you will need to find out which state agency received the funding and contact that agency directly.

As of October 14, 2005, fifteen CCP grants had been approved related to hurricanes: Alabama ($1,564,109), Arkansas ($20,000 initially, further funding pending), Arizona ($187,336), California ($1,003,982), Colorado ($348,333), Florida ($1,461,517), Iowa ($102,000), Indiana ($192,5530), Louisiana ($6,790,608), Massachusetts ($64,000), Maryland ($111,499), Missouri ($542,250), Mississippi ($2,413,498), Nebraska ($46,789), Oklahoma ($365,568), Pennsylvania ($261,270), Rhode Island ($36,910), South Carolina ($378,003), Tennessee ($127,584), Texas ($3 million initially, further funding pending), Washington, D.C. ($47,184), Wisconsin ($110,233), and West Virginia ($45,7910) (Williams, 2005). Other applications were still under consideration, so more may have been funded subsequently. In addition to the $6.1 million previously committed, another $5.1 million in funding has been approved. To date, more than $11.2 million has been approved for crisis counseling in Louisiana. See www.fema.gov/news/newsrelease.fema?id=23940.

2. SAMHSA Emergency Response Grants (SERG)

These SAMHSA grants fund mental-health and substance-abuse services when local resources are overwhelmed and other resources are unavailable.

For fiscal year 2005, SAMHSA has provided Emergency Response Grants to Florida ($11,000,000), Louisiana ($200,000), Texas ($150,000), Mississippi ($150,000), and Alabama ($100,000) to ensure that mental-health assessment and crisis counseling are available in areas affected by Hurricane Katrina (www.samhsa.gov/grants/2005/SM05-ER.aspx).

Using these funds, states took a variety of actions. Louisiana created a team of behavioral health specialists to provide counseling to disaster workers and first responders. Alabama created a pool of funding to support clinical assessments and immediate direct services. Texas supported existing methadone providers to allow for services to evacuees in shelters. Mississippi provided emergency support for populations in mental-health treatment facilities.

We are uncertain whether these funds can be used to support school mental-health services. Contact your state department of health to find out what programs are being funded and whether any other opportunities exist for you to access these SAMHSA emergency funds.

3. U.S. Department of Education Project School Emergency Response to Violence (SERV)

This program is designed to support mental health services for students exposed to violent events. Since the hurricanes in 2005, Project SERV funds have been awarded to state educational authorities in Louisiana, Texas, and Mississippi and are pending in Alabama. Information about the status of funding in hurricane-affected states is available from:

Louisiana: Monique Preau (monique.preau@la.gov) and Donna Nola-Ganey [donna.ganey@la.gov]
Mississippi: Nikisha Ware (nware@mde.k12.ms.us)
Texas: Cory Green (cory.green@tea.state.tx.us)

4. U.S. Department of Education Grants for the Integration of Schools and Mental Health Systems (http://www.ed.gov/programs/mentalhealth/index.html)

Administered by the Office of Safe and Drug-Free Schools, these grants provide funds to improve students' access to mental health services by creating innovative linkages between school systems and mental health systems. Each program is intended to enhance, improve, or develop collaborative efforts between school-based service systems and mental-health service systems. The goals for the programs are to provide, enhance, or improve prevention, diagnosis, and treatment services to students; enhance crisis intervention services; provide professional training; provide technical assistance to systems and families; ensure linguistically appropriate and culturally competent services; and evaluate the effectiveness of the program.

Eligible applicants are state educational agencies (SEAs), local educational agencies (LEAs), and Indian tribes. LEAs or consortia of LEAs that have received funds or services or will receive FY2006 funds under the Safe Schools/Healthy Students Initiative (CFDA 84.184L) are not eligible.

The project period for this grant is up to 18 months. Each year approximately 20 awards for approximately $150,000 to $350,000 will be made, depending on the scope of the projects. In FY 2005, the first year of this grant program, 20 awards were made, for a total of $4.9 million.

For information contact Dana Carr (202-260-0823, dana.carr@ed.gov), Office of Safe and Drug-Free Schools, 400 Maryland Ave., S.W., Room 3E242, Washington, D.C. 20202.

5. Medicaid

Schools with existing arrangements with local community mental-health providers, or with a preexisting mental-health unit, can bill Medicaid through these providers for any clinical mental-health services provided to students.

Although students normally need to be Medicaid-eligible, some locales have relaxed this restriction in the aftermath of Hurricane Katrina.

6. Private Insurance

Some commercial insurance providers may reimburse school mental-health clinicians for clinical services provided after a disaster.

7. Local and National Foundations and Businesses

Some local and national foundations or businesses have supported mental health services in schools for hurricane victims as their way of contributing to the community's recovery. Once a program has been selected, school officials can approach local funding sources to request support.

8. State Victims of Crime Compensation (VCC) Funds:

VCC funds can be used to support a variety of services, including mental health services, for individuals who are experiencing symptoms as the result of an exposure to a crime. Some student survivors of Katrina may be eligible for support if they were exposed to crime during or after the hurricane. Specific criteria for eligibility and information about available funds can be obtained from the office in each state.

For information on your state's VCC fund and how to apply, visit the National Association of Crime Victim Compensation Boards Web site at www.nacvcb.org. In Louisiana, the Crime Victim Compensation Board is administered by the Louisiana Commission on Law Enforcement.

9. Other Possible Funding Mechanisms

- Medicaid's Early Periodic Screening, Diagnosis, and Treatment (EPSDT) Program (www.cms.hhs.gov/MedicaidEarlyPeriodicScrn/)
- State Children's Health Insurance Program (www.cms.hhs.gov/home/schip.asp)
- Maternal and Child Health (Title V) block grant (https://perfdata.hrsa.gov/mchb/mchreports/Search/core/MchAppContmenu.asp)
- Bureau of Primary Health Care Healthy Schools grant (bphc.hrsa.gov/bphc/)
- Substance Abuse Prevention and Treatment (SAPT) block grant (www.samhsa.gov/Matrix/programs_treatment_SAPT.aspx)

- Community Mental Health Services block grant (CMHSBG) (www.mentalhealth.samhsa.gov/publications/allpubs/KEN95-0022/)
- Safe Schools/Healthy Student Initiative (www.sshs.samhsa.gov/)
- Federal grants for mental health services (www.federalgrantswire.com/mental_health_services_health_federal_grants.html
- No Child Left Behind (www.nasponline.org/pdf/SchoolMentalHealthProvisions.pdf)

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Appendix A

How Can Schools Help Students Immediately After a Traumatic Event?

In the immediate aftermath of a traumatic event, the focus is on stabilizing and supporting students and their families. One promising model for this phase of early recovery is called Psychological First Aid. This model involves meeting basic survival and safety needs first and then tending to the coping needs of those affected. Extensive materials are available at www.nctsnet.org/nccts/nav.do?pid=typ_terr_resources_pfa.

Other resources available online include the following:

American Academy of Pediatrics: Resources to Help Cope with Natural and Other Disasters. www.aap.org/new/disasterresources.htm. Provides information on a number of topics, ranging from preparing to handle disasters to responding to children's emotional needs during times of crisis.

American Psychological Association: Disasters and Terrorism. www.apahelpcenter.org/articles/topic.php?id=4. Provides helpful information about improving mental health after natural disasters and acts of terrorism. Includes information in English and Spanish.

American Red Cross: Disaster Services Publications: Materials for Teachers and Schools. www.redcross.org/pubs/dspubs/tchrschl.html. Provides teachers and schools with activities and lesson plans that can be used to help children cope with tragic events and teach them how to prepare for different types of disasters.

American School Counselor Association: Hurricane Resources. www.schoolcounselor.org/content.asp?contentid=420. Designed to help schools serving students displaced by Hurricane Katrina to acquire necessary supplies (books, clothes, etc.); also provides links to additional resources.

Centers for Disease Control and Prevention (CDC): Disaster Mental Health Resources. www.bt.cdc.gov/mentalhealth/. Provides information and resources on a variety of topics, ranging from tips for talking about disasters to suicide prevention.

Federal Emergency Management Agency (FEMA):

Recovering from Disaster. www.fema.gov/rebuild/recover/after.shtm. Provides practical information on how to clean up one's home after a disaster, health and safety guidelines, and links to resources and information on the emotional and mental effects of disasters.

Resources for Parents and Teachers. www.fema.gov/kids/teacher.htm. Provides parents and teachers with information on a number of topics ranging from school safety to terrorism, as well as educational and empowering activities to help children learn about and cope with different types of disasters.

National Association of School Psychologists (NASP): Crisis Resources. www.nasponline.org/NEAT/crisismain.html. Provides both students and teachers with resources on a range of issues, from Hurricane Katrina to violence prevention.

National Center for Children Exposed to Violence (NCCEV): Publications and Latest Research. www.nccev.org/resources/publications.html. Provides parents and teachers with the latest research on various topics relating to children and violence.

National Center for PTSD, U.S. Department of Veterans Affairs. www.ncptsd.va.gov. Has information and resources primarily pertaining to PTSD.

National Child Traumatic Stress Network (NCTSN). www.nctsn.org. Provides information and resources for parents, educators, the media, and health professionals on issues relating to child trauma. The Web site and publications are available in Spanish and English.

National Education Association (NEA): Crisis Communication Guide and Tool Kit. www.nea.org/crisis/index.html. Provides information and resources for educators for improving a school's response to crisis and helping vulnerable staff and students during times of crisis.

National Institute of Mental Health: Helping Children and Adolescents Cope with Violence and Disasters. www.nimh.nih.gov/publicat/violence.cfm. Provides information on a host of trauma-related issues, such as treatment options for PTSD and the ways children and adolescents react to trauma.

Substance Abuse and Mental Health Services Administration (SAMHSA): Mental Health Topics: Disaster/Trauma. www.mentalhealth.samhsa.gov/topics/explore/disaster/. Provides relevant information as well as links to information and resources related to disaster and trauma, such as the American Red Cross Web site. Additionally, the site lists the number of a call center for inquiries relating to mental health.

U.S. Department of Education: Tips for Helping Students Recovering from Traumatic Events. www.ed.gov/parents/academic/help/recovering/part.html. Lists tips for students, coaches, parents, counselors, and administrators on coping with traumatic events. This information is also provided in booklet form, available for download from the Web site.

Online Publications Related to Hurricanes Katrina and Rita

Can Do and the Storm: A Story About New Beginnings. Available free at www.thecandoduck.com. This book is intended to help parents and teachers talk to elementary-age children about the hurricanes and the lives that were changed. It also aims to help children think about and share their feelings about their experiences with the recent hurricanes. Contact the authors, Dr. Morton D. Sosland, and Dr. Esther Deblinger, codirector, CARES Institute, University of Medicine and Dentistry, New Jersey School of Osteopathic Medicine (a member of NCTSN) through the Web site or ducktormorty@thecandoduck.com.

After the Storm: A Guide to Help Children Cope with the Psychological Effects of a Hurricane. Dr. Annette M. La Greca (University of Miami) and 7-Dippity, Inc. www.7-dippity.com/other/After_The_Storm_(Special_Edition_2005).pdf. This book has educational and fun activities for parents and children to help both learn about hurricanes Katrina and Rita and to help children cope with the stress.

Rebuilding Louisiana through Education: Creating and Maintaining Healthful Psychosocial Environments in the Aftermath of Disasters. Louisiana Department of Education. www.doe.state.la.us/lde/uploads/8043.pdf This packet provides informative materials for parents, educators, and professionals on a variety of topics, such as signs of stress in children and facilitating the integration of displaced students into new schools.

Helping Young Children and Families Cope with Trauma. Harris Center for Infant Mental Health Violence Intervention Program and Safe Start, Louisiana State University Health Sciences Center. arkedu.state.ar.us/news/pdf/helping_young_children_and_families_cope_with_trauma.pdf.

When the Hurricane Blew. Hurricane Kids Network. www.hurricanekidsnetwork.org. This is a story written by fourth graders to help children understand and cope with the confusion and chaos that occurs before, during, and after a hurricane.

Appendix B

How Can Mental Health Staff and Other School Personnel Help Each Other and Themselves?

During times of stress, staff members and school personnel have the burden of taking care of others while sometimes coming under great stress themselves. This stress can affect not only their personal lives but also how they perform their professional responsibilities. Addressing this stress can be important to ensuring their own recovery as well as that of their students. The following resources address self-care for staff members.

American Psychological Association: Tapping Your Resilience After a Natural Disaster: Pointers for Practitioners. www.apapractice.org/apo/katrina/resilience.html#. Provides psychologists with tips on self-care, recognizing professional challenges, and remaining resilient after a natural disaster.

Centers for Disease Control and Prevention (CDC): Hurricane-Related Information for Health Care Professionals. www.bt.cdc.gov/disasters/hurricanes/hcp.asp. Provides health care professionals with guidelines and protocols for medical emergencies, such as infection control following hurricanes. Also has temporary medical forms available for download for patients who do not have access to their medical information.

Children's National Medical Center: Disaster Self Care Action Plan for School Teachers. www.cnmc.org/dcchildrens/about/pdf/SelfCareActionPlan.pdf. Provides a contact sheet and a checklist that teachers can use to prepare themselves and their families for a traumatic event and cope with stress in the aftermath.

National Center for PTSD and National Center for Child Traumatic Stress:

Provider Self Care. www.ncptsd.va.gov/pfa/Self_Care_for_Providers.pdf. Provides a list of dos and don'ts to help mental health workers cope with the stresses of their jobs and protect their own mental health.

Working with Trauma Survivors: What Workers Need to Know. www.ncptsd.va.gov/facts/disasters/fs_working_disaster.html. Provides rescue workers, journalists, mental health workers, and volunteers with information on how to work with trauma victims and how to avoid burnout.

Substance Abuse and Mental Health Services Administration (SAMHSA):

Care Tips for Survivors of a Traumatic Event: What to Expect in Your Personal, Family, Work, and Financial Life.

www.mentalhealth.samhsa.gov/publications/allpubs/KEN-01–0097/default.asp

Has tips and pointers to help adults identify, cope with, and alleviate symptoms of stress caused by traumatic events.

Appendix C

Index of Programs