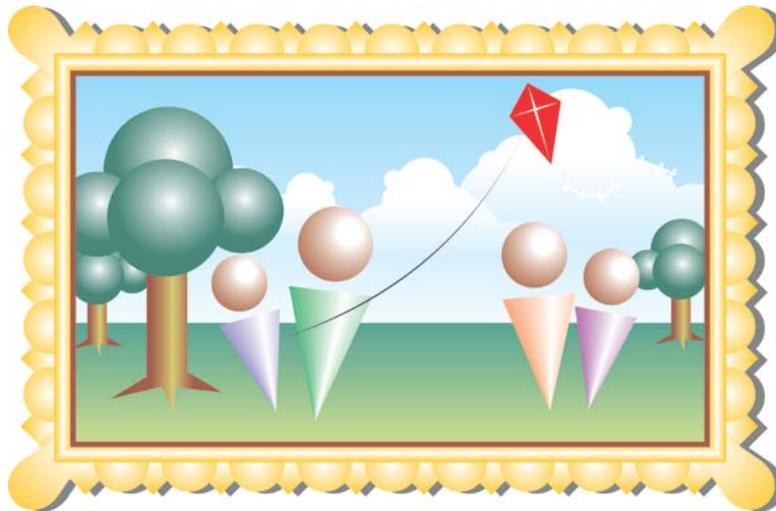


# Using Data and Services to Meet the Disaster Mental Health Needs of Youth and Families: A Planning and Resource Guide

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**TDC**

**Terrorism and Disaster Center**  
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A PARTNER IN  
**NCTSN**

The National Child  
Traumatic Stress Network

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### **The Terrorism and Disaster Center at the University of Oklahoma Health Sciences Center**

The Terrorism and Disaster Center (TDC), in the Department of Psychiatry and Behavioral Sciences at the University of Oklahoma Health Sciences Center, is part of the National Child Traumatic Stress Network (NCTSN), a national network funded by the Substance Abuse Mental Health Services Administration to improve the standard of care for traumatized children and to increase their access to care. TDC focuses on achieving an effective, nationwide mental health response to the impact of terrorism and disasters on children, families, and communities. TDC works to achieve this goal through the development and evaluation of trainings and educational materials, interventions, and services aimed at addressing the mental health needs of those who experience terrorism and disaster-induced trauma. Visit <http://tdc.oushc.edu> for more information.



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## Using Data and Services to Meet the Disaster Mental Health Needs of Youth and Families: A Planning and Resource Guide

This document, *Using Data and Services to Meet the Disaster Mental Health Needs of Youth and Families: A Planning and Resource Guide*, is intended to help disaster planners understand youth and family mental health issues and address these issues in disaster planning and response. Disaster planners may work for federal, state, or local government, or they may work in any of the other entities that comprise the Disaster System of Care (See Section 2).

In comprehensive, effective disaster planning, the mental health needs of youth—including infants, young children, adolescents, and young adults—and their families must be considered. Unfortunately, according to the Centers for Disease Control and Prevention’s recommendations from the National Advisory Committee on Children and Terrorism (NACCT, 2003, p. ii), “the majority of disaster plans and guidelines do not take into account the unique needs and vulnerabilities of children and adolescents.”

To address the mental health needs of youth both before and after a disaster, it is necessary to recognize the unique issues and concerns specific to age and development which may be missed if all young people are either lumped together as “kids” or subsumed with the needs of adults.

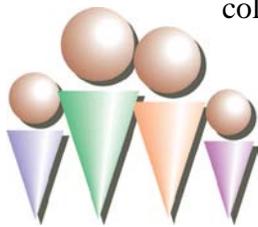
### Youth Mental Health Following Disasters

Youth reactions to disaster are commonly overlooked and misunderstood. Thus their needs may be neglected in the disaster planning process and disaster response. Noting this, CDC’s 2003 National Advisory Committee on Children and Terrorism report called for immediate action to address these concerns in planning for future terrorist attacks (NAACT, 2003).

Youth are not immune to the effects of disaster. Their reactions differ from those of adults and are influenced by their age, developmental level, and cognitive capacity to understand the event and its consequences. Youth may be frightened or anxious by what they do not understand, and misperceptions may lead to inaccurate interpretations and attributions. Not only does development shape a youth’s reactions to trauma, trauma may also adversely affect the youth’s development (Osofsky, 2007; Pfefferbaum, Houston, North, & Regens, 2008).

While their reactions may be quite different than those of adults, youth's reactions generally parallel those of their parents (Pfefferbaum & North, 2008). In the context of their own distress, parents tend to underestimate youth's reactions, perhaps reflecting their preoccupation with other issues or denial needed to buffer them from the suffering of their children (Silverman & LaGreca, 2002). Or parents may simply not know what adverse reactions to look for in their children following a disaster. Additionally, youth may try to conceal their distress to avoid further upsetting parents and others around them and a desire to appear autonomous or adult-like may prevent older youth from reaching out to parents or other adults for help following a disaster (Jacobs, Vernberg, & Lee, 2008). Thus, parents and other adults cannot be assumed to accurately recognize and address the disaster needs of youth. Instead, youth themselves must be the focus of routine and systematic attention in preparedness, response, and recovery (NAACT, 2003).

Youth may be a major source of anxiety for their parents, and adults with children may experience more adverse reactions following an event than adults without children. Stuber and colleagues (2002) found greater distress in parents than in adults without children in residents of Manhattan after the 2001 World Trade Center attacks.



The greater stress experienced by parents may be related to the physical, economic, and emotional burdens of caring for their children and the distress associated with concern for the welfare of their children in the context of disaster.

It is possible to reach adults, families, and communities through children because parents may be receptive to services for their children. For this reason, services with a focus on youth also may reach adults, families, or a community. While adults may avoid professional or community services for themselves, they may be receptive to services offered in the community, including professional services, when adults see the outcome of those services benefitting their children.

Ultimately, disaster mental health services planning must consider the specific needs of youth. To do so, services must be comprehensive, developmentally appropriate, and family focused. Parents and families should be included in determining the needs of youth, and disaster mental health services should incorporate family participation whenever possible. Services should provide a parent component that includes education about the impact of disaster on youth, adults, and families; ideas for improving coping skills (of youth and adults); and suggestions for improving parenting skills following a disaster.

## Sections in this Document

The goal of this document is to help disaster planners address the specific disaster mental health needs of youth and families through planning and response.

After reading this document, disaster planners should:

- understand how data collection can determine youth and family mental health needs and guide disaster mental health service delivery (Section 1),
- be aware of the types of disaster mental health services available for use with youth and families (Section 2),
- understand what disaster mental health training would be beneficial for themselves, their workforce, and their organization (Section 3).

Each section of this document provides an overview of the topic and a list of resources for readers wanting more in-depth information.

## Resources

More information on youth and family disaster mental health and disaster mental health planning and response is available from the sources listed below.

### **YOUTH AND FAMILY DISASTER MENTAL HEALTH**

#### ***Disaster Mental Health Primer: Key Principles, Issues and Questions***

Centers for Disease Control and Prevention (CDC)

<http://www.bt.cdc.gov/mentalhealth/primer.asp>

#### ***Reactions of Children to a Disaster***

Substance Abuse and Mental Health Services Administration (SAMHSA)

<http://mentalhealth.samhsa.gov/publications/allpubs/ken01-0101/default.asp>

Substance Abuse and Mental Health Services Administration (SAMHSA), Disaster Technical Assistance Center (DTAC)

<http://mentalhealth.samhsa.gov/dtac/>

### **DISASTER MENTAL HEALTH PLANNING AND RESPONSE**

#### ***2010 Report to the President and Congress***

National Commission on Children and Disasters

<http://www.childrenanddisasters.acf.hhs.gov/>

American Red Cross Disaster Services

[http://www.redcross.org/services/disaster/0,1082,0\\_319\\_,00.html](http://www.redcross.org/services/disaster/0,1082,0_319_,00.html)

FEMA for Kids

<http://www.fema.gov/kids/>

***IASC Guidelines on Mental Health and Psychosocial Support in Emergency Settings***

Inter-Agency Standing Committee

[http://www.who.int/mental\\_health/emergencies/guidelines\\_iasc\\_mental\\_health\\_psychosocial\\_june\\_2007.pdf](http://www.who.int/mental_health/emergencies/guidelines_iasc_mental_health_psychosocial_june_2007.pdf)

***Mental Health All-Hazards Disaster Planning Guidance***

Substance Abuse and Mental Health Services Administration (SAMHSA)

<http://www.mentalhealth.samhsa.gov/publications/allpubs/SMA03-3829/default.asp>

***National Response Framework***

[http://www.dhs.gov/dhspublic/interapp/editorial/editorial\\_0566.xml](http://www.dhs.gov/dhspublic/interapp/editorial/editorial_0566.xml)

***Preparing for the Psychological Consequences of Terrorism***

Institute of Medicine

<http://www.iom.edu/report.asp?id=11573>

***Recommendations to the Secretary of Health and Human Services***

National Advisory Committee on Children and Terrorism (NACCT)

<http://www.bt.cdc.gov/children/>

United States Senate Ad Hoc Subcommittee on Disaster Recovery

<http://hsgac.senate.gov/public/index.cfm?FuseAction=Subcommittees.DisasterRecovery>

Voluntary Organizations Active in Disaster (VOADs)

<http://www.nvoad.org/>

## Section 1 - Collecting Data to Determine Youth and Family Mental Health Needs and to Guide Service Delivery Following a Disaster

Data collected both before and after a disaster can be used to identify youth and family disaster mental health needs and to inform the delivery of disaster mental health services in a community. Without data, determining what disaster mental health services are needed in a community after an event is complicated. Therefore disaster planners are encouraged to develop plans for what and how disaster mental health data will be collected *before* a disaster occurs.



Disaster mental health data collection takes several different forms, including surveillance, needs assessment, screening, clinical evaluation, and program evaluation. Each of these data collection efforts allows disaster planners to systematically observe trends and changes in time, place, and persons. Analyzing and interpreting data observations should help identify appropriate disaster mental health actions and services that can aid youth, family, and community recovery.

Table 1 illustrates how each disaster mental health data collection effort corresponds to the phases of a disaster. An explanation of each disaster mental health data collection form follows this table.

Table 1. Disaster Mental Health Data Collection and Disaster Phases

| Preparedness (Pre-event) | Response (Event)    | Recovery (Post-event) |
|--------------------------|---------------------|-----------------------|
|                          |                     |                       |
| Surveillance             | Surveillance        | Surveillance          |
|                          | Needs Assessment    | Needs Assessment      |
|                          | Screening           | Screening             |
|                          | Clinical Evaluation | Clinical Evaluation   |
| Program Evaluation       | Program Evaluation  | Program Evaluation    |

## Surveillance

According to the Centers for Disease Control and Prevention (2001), “surveillance is the ongoing systematic collection, analysis, interpretation, and dissemination of data regarding a health-related event for use in public health action to reduce morbidity and mortality and to improve health.”

Surveillance data can be used to guide public health action and to inform program planning and evaluation.

Ideally, a determination of what surveillance data are available (or the development of plans to begin collecting surveillance data if mental health surveillance data are not currently being collected) should occur prior to a disaster. Surveillance mental health data may be collected by a variety of sources (such as local, state, regional, or national public health organizations); therefore, disaster planners must take time to determine what surveillance data are available and the source of the data.

Surveillance is an *ongoing* process. In the case of a disaster, surveillance data collected *after* an event can be compared to surveillance data collected *before* the event (often referred to as baseline data) to determine the health or mental health effects of a disaster on the community. For example, if a disaster planner has baseline data (collected prior to a disaster) on rates of child abuse in a community, then surveillance data collected after a disaster showing a significant increase in child abuse (compared to the baseline data) would indicate that there is more violence against youth in the community, perhaps as a result of stress associated with the disaster. To address this increase in child abuse, a disaster planner might initiate a public information campaign to provide community members with strategies for dealing with stress and preventing violence in the home and provide resources for families needing help.

Post-disaster surveillance data are most useful when they can be compared to pre-disaster surveillance data, but unfortunately the surveillance of mental health data is not routine. Therefore, pre-event or baseline mental health surveillance data may be unavailable to discern what impact a disaster has had on a community’s mental health. Thus, disaster planners should determine what mental health surveillance data are routinely collected by local, state, regional, or national health authorities, and they may want to mount an effort to augment what is currently available or collected.

With regard to what mental health surveillance data should be collected, Galea and Norris (2006, p. 187) recommend ongoing “surveillance focusing on key indicators of current depression, posttraumatic stress, dysfunction, anxieties/fears, and psychosocial resources, punctuated with occasional disease-specific surveys that provide reliable estimates of current



psychological disorders.” If the surveillance data recommended by Galea and Norris (2006) are collected routinely in a community, similar data could be obtained after a disaster to determine changes associated with the event. Reliably documenting changes in emotional conditions can help disaster planners determine the mental health services needed following a disaster.

Pre-event surveillance might also determine substance use (sales of alcohol, benzodiazepines, antidepressants, and pain killers, and arrests for drug use or driving while intoxicated) before and after a disaster (Institute of Medicine, 2003). If community levels of substance use/abuse have increased following a disaster, public education, prevention, and clinical interventions addressing substance use/abuse may be indicated.



Community rates of depression, anxiety, or substance use can be determined through case reporting; for instance, a doctor’s office in a community might report to the state department of health or mental health how many cases of depression he or she sees on a monthly basis. Another method to measure community rates is through surveys; a phone survey might be conducted in the community to ask individuals how many people in their household experience anxiety. Data can also be gathered from private or public organizations; for example, the police department may record how many child abuse complaints and/or arrests are made in a community.

Surveillance data might also be used to characterize a community in terms of how many residents have special needs and where those residents live. For example, surveillance data may provide information on how many families with children, racial and ethnic minorities, immigrants and refugees, elderly, individuals with disabilities, and veterans reside in a community (IOM, 2003). Identifying the community’s demographics and needs of its inhabitants will help disaster planners fashion specific disaster mental health services.

Furthermore, geo-mapping analysis can help disaster planners visually compare the location of special needs or at-risk populations with the available disaster mental health services. A spatial mismatch between need and available services can help disaster planners determine where to locate services (IOM, 2003).

Ideally, mental health data surveillance will occur prior to a disaster, immediately after a disaster, and throughout the disaster recovery process. Ongoing surveillance will allow disaster planners to monitor the mental health of the community; tracking changes in emotional and behavioral indicators (see next page) in the community will help determine when and at what rate the community returns to pre-disaster levels of mental health wellness.

## Surveillance

### What surveillance data can be collected?

- **Community levels of:**
  - Depression
  - Anxiety
  - Posttraumatic stress
  - Conduct problems
  - Substance use and abuse
  - School absences, graduation rates
  - Child abuse, elder abuse
  - Birth, marriage, and divorce rates
  - Motor vehicle accidents
  - Violent crime, domestic violence
- **Community utilization of mental health services**
- **Community demographics**
  - Number and location of youth, elderly, minorities, immigrants, refugees, veterans, individuals with special needs

### When can surveillance data be collected?

- **Before, during, and after a disaster**

### How are surveillance data collected?

- **Case reporting by physicians and health and mental health providers**
- **Surveys (phone, mail, Internet)**
- **Private and public (government) organizations designated to collect, record, and provide data**

## Needs Assessment

Needs assessment is used to help determine community need for services by providing an estimation of the nature, severity, and extent of adverse psychological, behavioral, and functional impact of a disaster on members of a community. Needs assessment can also be used to identify what groups should be screened for additional (or more comprehensive and/or intensive) disaster mental health services and the location of these groups within a population. Needs assessment can also collect information on what challenges have emerged for children and families following a disaster. For example, a needs assessment may focus on how a disaster has disrupted the delivery of existing (pre-disaster) community services to ascertain how children and families are affected by a disaster. Thus needs assessment can provide a snapshot of community disaster mental health issues and can point to where in a community further screening is appropriate.

Needs assessments can be based on a variety of data sources. For example, surveillance data can be analyzed to indicate the impact of a disaster on a community. A random survey of community members close to the disaster may be conducted in person or via telephone, mail, or computer to help determine community need. When using surveys for a needs assessment, Pynoos and colleagues (2005) recommend using brief scales that measure disaster exposure, trauma, and loss (adapted to fit the specific disaster), as well as the distress and adversities a person has experienced. Interviews or focus groups with disaster victims and/or service providers in the community may be conducted to gain an understanding of what disaster mental health services are currently needed. For example, a survey that assesses the mental health impact of a disaster may be given to students in a school that has been affected by the disaster to ascertain how prevalent the need for mental health services is among students. The results could inform administrative decisions about how to meet this need. Needs assessment can take place through a variety of organizations in a community, such as churches, after-school programs, community centers, or government agencies.

Needs assessments may also be conducted through post-disaster unmet needs committees. Such committees may be formed in the aftermath of a disaster to help determine and address community needs which may change over the course of recovery. Unmet needs committees may be comprised of representatives from across the community, including health and mental health providers, case managers, school representatives, government representatives, and clergy. Unmet needs committees may conduct needs assessments with disaster victims or disaster providers and volunteers at any time following a disaster to help determine the current level of need among survivors or across the community.

Following the assessment, services should be identified in the community that can be utilized to meet existing need. A needs assessment may indicate that existing community services and

resources are sufficient to meet community need, or alternatively, might justify bringing in services from outside the community. For instance, mental health providers from a neighboring city may be brought in temporarily to help provide counseling and support to disaster victims if the needs of youth and families affected by a disaster are greater than can be handled by providers located in the community.

A needs assessment can also help determine who needs services and where those services are needed. For example, a needs assessment might indicate the greatest need for mental health services exists among students from schools closest to the site of the disaster. Such an indication would allow disaster planners to ask mental health providers located farther away to establish school-based services temporarily to help the students at the school where the need is greatest. A needs assessment will provide evidence to support such action.

A needs assessment may identify groups of people in a community who should be screened to determine who among the at-risk group would benefit from community services and/or clinical evaluation. Screening is described in the next section.

### **Triage: Needs assessment in the acute aftermath of an event.**

Triage is a form of needs assessment that occurs in the acute emergency response phase of a disaster. Triage involves collecting data from survivors to gain an initial understanding of how the disaster is affecting individuals and to connect those affected by the disaster to available services (Pynoos, Schreiber, Steinberg, & Pfefferbaum, 2005).

At the disaster site, emergency responders conduct an initial triage of survivors with physical injuries. Additional triage may take place at disaster shelters, disaster service centers, family reception centers, and family assistance centers (NCTSN and NCPTSD, 2006). These sites will likely serve large numbers of youth and families in the immediate aftermath of a disaster.

In these post-disaster settings, triage involves collecting information about youth and family disaster experiences, injuries, psychological reactions, functioning, and immediate needs. This information will be used primarily to connect youth and families to available services. For instance, a youth exhibiting severe anxiety in a disaster shelter may be referred to a disaster mental health provider working in the shelter. Triage is oriented toward ensuring the safety and security of youth and families. The process focuses on determining immediate needs and matching those needs to available services in the acute aftermath of an event.

Triage data can also be used to gain a preliminary understanding of overall community need resulting from the disaster. If triage data are to be used for more than individual assessment, they must be recorded in a systematic way that allows for analysis. For example, if all triage data collected at an emergency shelter are entered into a database, the data can provide

preliminary guidance on how many youth and families were affected by the disaster, what constitutes common disaster experiences and reactions, and what immediate needs exist.

An informed triage may involve in-person contact and informal conversation with youth and families affected by a disaster. Often shelter workers talk to families to get a sense of their needs and then refer the family to available services. While this informal triage process may work well for matching available resources to existing need, such an interview may not have the systematic structure and content that allows for triage information to be entered and tracked in a database.

More structured triage processes may use paper and pencil interview instruments or computer- or web-based interview tools that include an automatic calculation of need based on the results of the interview. Structured triage interviews should be brief and sensitive to the traumatic experiences of disaster victims and their families. PsySTART is an example of a computer-based triage tool (Schreiber, 2008). Other triage models, such as Continuous Integrated Triage (<http://www.deep.med.miami.edu/x493.xml>), include an assessment of psychosocial and mental health needs. Formal triage tools such as these can provide an overview of community need for services based on an aggregation of the information gathered.

## Needs Assessment

### What needs assessment data can be collected?

- **Disaster experience**
  - Exposure
  - Loss
  - Trauma
  - Physical injury
- **Disaster reactions**
  - Psychological distress
    - Depression
    - Posttraumatic stress
    - Anxiety
    - Grief
  - Functioning
    - Change in school performance

- School absences
- Conduct problems
- Substance use and abuse

### When can needs assessment data be collected?

- **After a disaster and may be repeated to determine how community need is changing**

### How are needs assessment data collected?

- **Surveillance**
- **Interviews, focus groups, and surveys with youth and families affected by disaster**
- **Interviews, focus groups, and surveys with providers and volunteers working in the post-disaster environment**

## Screening

Screening involves assessing youth and families to determine need for disaster mental health services with a focus on linking those with identified need to available services (Pynoos et al., 2005). Screening is intended to discover if youth and families are having problems as a result of the disaster. Screenings should use brief, global questions about disaster experiences and reactions. When a screening identifies a youth or family member with problems, the screening should be followed by a clinical evaluation (which is described in the next section). Following a disaster, not all youth and family members will need mental health services. The screening process will help identify those who would benefit from services.

Screening should take place following a disaster for those youth and adults who experienced the disaster, were near the disaster, or lost family/friends in the disaster. Screening should be conducted with an understanding of what mental health services are available in the community so that those who are determined to need services can be referred for appropriate care. Screening should occur after the acute phase of a disaster has passed and can be repeated as necessary.

Screening disaster-exposed youth and families can help identify those at increased risk for developing persistent:

- mental distress,
- functional impairment,
- developmental disturbance,
- psychiatric disorder.

Screening tools should be tailored to match the circumstances of the disaster. Disaster planners are encouraged to include the most essential questions so as to keep the screening brief. For example, a youth's disaster exposure is virtually always a key data point to include in a screening tool. While all youth living in a community that experiences a disaster can develop significant difficulties following the event, a youth who, for example, witnesses the event personally or a youth whose family member was injured or killed will be at greater risk for adverse reactions than will a youth who was less directly exposed to the event.

Screening measures should be tailored to match the time in which the screening takes place. For example, in the acute aftermath of an event, screening should focus on immediate needs and the life disruption caused by the disaster. As more time passes, screening tools should focus on secondary adversities arising as a result of the disaster experience.

See the Resources section near the end of this chapter for information on specific disaster screening instruments.

## Screening

### What screening data can be collected?

- **Disaster experience**
  - Exposure
  - Loss
  - Trauma
  - Physical injury
- **Disaster reactions**
  - Psychological distress/disorders
    - Depression
    - Posttraumatic stress
    - Anxiety
    - Grief

- Functioning
  - Conduct problems
  - School problems
  - Family and friend problems
  - Sleep problems
  - Health problems
  - Substance use and abuse

### When can screening data be collected?

- **After disaster, may be repeated as needed**
- **Can be conducted any time after a disaster when concerns emerge about the effects of the disaster on youth and families**

### How are screening data collected?

- **Surveys**

## Clinical Evaluation

Youth who are identified as potentially needing more help with psychological or behavioral issues should receive a comprehensive evaluation by a mental health professional prior to receiving mental health services. This process is known as a clinical evaluation. This need for additional mental health services could be determined formally as the result of a screening process, or could be determined more informally such as when a family member recognizes that a youth could use professional assistance dealing with emotional or behavioral reactions to a disaster.

Clinical evaluation uses interview and comprehensive assessment instruments with youth to determine appropriate services needed (Lewis & King, 2002). Therefore a clinical evaluation is more lengthy and robust than a screening and requires the knowledge and expertise of a trained clinician. Clinical evaluations may indicate reactions that meet criteria for a psychiatric diagnosis or reactions that many not reach this level but would still benefit from a focused intervention. The clinical evaluation is important to helping the clinician determine the best course and type of treatment.

A clinical evaluation should ascertain and explore a youth's disaster experience: exposure to the event, any injury from the event, losses related to the event, and stressors resulting from the event. Additionally, the evaluation should investigate a youth's behavioral reactions to the event, family experience of the disaster (how the family was affected by and reacted to the event), youth's developmental history, youth's psychiatric history, and family psychiatric history. The clinical evaluation should also determine whether a youth has had any traumatic experience prior to the disaster. Clinical evaluation of a youth should also include an interview with the youth's parent(s).

## Clinical Evaluation

### What clinical evaluation data can be collected?

- **Disaster experience**
  - Exposure
  - Loss
  - Trauma
- **Disaster reactions**
  - Psychological distress/disorders
    - Depression
    - Posttraumatic stress
    - Anxiety
    - Grief
  - Functioning
    - Conduct problems
    - School problems
    - Family and friend problems
    - Sleep problems
    - Health problems
    - Risk behaviors
    - Substance use and abuse
- **Previous non-disaster-related trauma**

### When can clinical evaluation data be collected?

- **After disaster, following a formal or informal determination of need for clinical evaluation**

### How are clinical evaluation data collected?

- **Interviews with youth and parents**
- **Psychological testing**
- **Assessments/inputs from other informants (such as teachers)**

## Program Evaluation

Program evaluation involves the assessment of activities and outcomes of defined interventions, programs, or policy initiatives (Rosen & Young, 2003; Rosen, Young, & Norris, 2006). When disaster mental health services are implemented following an event, data are needed to determine the success of those services and whether those outcomes meet the goals and objectives of the program. Program evaluation includes monitoring and measuring program activities, outputs, and outcomes.

To evaluate a program, it must be defined and described. One way to describe a program is through a logic model that illustrates the inputs, activities, outputs, and outcomes of a program (<http://www.managementhelp.org/evaluatn/outcomes.htm>). Logic models can be quite complex or they can be very simple to provide a basic overview of a program.

- **Program inputs** are things such as funding, staff, facilities, and other resources that make a program work.
- **Activities** are the things that a program does, such as providing counseling to youth and families or distributing informational flyers at schools and community centers.
- **Outputs** are the measureable achievements produced by the program activities. Outputs include the number of youth and adults who receive counseling or the number of schools and community centers where flyers are distributed.
- **Outcomes** are the benefits that are achieved by the program. Outcomes may include reduced anxiety and depression among youth and families who attend counseling or could include increased understanding of the mental health effects of experiencing a disaster among youth who received an informational flyer at school.

Program evaluation involves measuring these inputs, activities, outputs, and outcomes to determine if a program is working as intended (<http://www.cdc.gov/mmwr/preview/mmwrhtml/rr4811a1.htm>). Program evaluation can include process evaluation, which assesses how a program is being implemented, and outcome evaluation, which assesses if a program achieves its intended results (Bliss & Emshoff, 2002). Program monitoring is a type of process evaluation that occurs while the program is underway and is intended to determine if a program is being properly implemented. For example, program monitoring may focus on how many youth and families are receiving disaster mental health counseling to ascertain if a program is providing the quantity of services intended. If program monitoring determines that not enough youth and families are receiving counseling, then changes to the program can be made; for example, more counselors might be hired. Outcome evaluation focuses on whether a program achieves the goals of the program. An outcome evaluation might assess youth and families who received counseling to determine if they experienced a reduction in anxiety and depression as intended by the program.

## Program Evaluation

### What clinical evaluation data can be collected?

- **Program inputs**
  - Resources that allow a program to work (staff, facilities, funding)
- **Program activities**
  - Things that a program does (provide counseling, distribute informational flyers)
- **Program outputs**
  - Measureable achievements produced by program activities (number of counseling sessions delivered, number of informational flyers distributed)
- **Program outcomes**
  - Benefits achieved by a program (reduced anxiety among youth and families attending counseling, increased awareness of mental health impact of disasters)

### When can program evaluation data be collected?

- **After a child and family disaster mental health program has been initiated**

## How are program evaluation data collected?

- **Interviews, focus groups, and surveys with program participants and program staff**

## Ongoing Data Collection throughout the Phases of a Disaster

Ideally, none of the data collection approaches described in this section (surveillance, needs assessment, screening, clinical evaluation, or program evaluation) will be one-time events. Rather, these data collection efforts should be repeated or sustained as needed to assess the status and changes in youth and family emotions, behavior, and functioning over the course of a disaster, monitoring the process of recovery. Sustained data collection may also focus on how new experiences and adversities affect recovery.

The mental health needs of a community following a disaster are not likely to be static. Community needs may decrease due to natural recovery or because the disaster mental health services established in the community reduce levels of community distress. The community mental health needs also may increase because of secondary stressors in the recovery environment or because of ongoing or additional threats (Institute of Medicine, 2003). Even more complicated, mental health needs may decrease for some while they increase for others. Other needs may remain unmet throughout the aftermath of a disaster.

Because community needs may change, the current state of community mental health needs must be monitored throughout the recovery process. This means that it is typically not sufficient to base decisions about what disaster mental health services are offered throughout the course of a disaster based on a single analysis of surveillance data, needs assessment, or screening. Ongoing analysis of surveillance data, repeated needs assessments or screenings, and/or sustained program evaluation will likely be necessary to determine if community disaster mental health needs are being addressed by the available services. For example, needs assessment or screening surveys may be repeated periodically (perhaps every two or



three months) in schools to determine how mental health indicators are changing. As recovery occurs and overall school disaster mental health need decreases, school officials may make decisions to alter the services to be more attuned to the current need.

Over time emotional and behavioral indicators may increase or decrease, and the community need may also change qualitatively. That is, the type of services determined to be necessary as the result of the initial data collection may not be the type of services that are appropriate several months after the event. For example, early screenings may indicate a need for services

that address posttraumatic stress in youth and families who directly experienced the disaster while later needs assessments may reveal depression to be the major problem for people in the community. To understand the changing needs of the community, data collection must be ongoing.

## Resources

More information on disaster mental health data collection is available from the sources listed below.

### SURVEILLANCE

#### *Evaluating Public Health Surveillance*

Centers for Disease Control and Prevention

Updated guidelines for evaluating public health surveillance systems.

<http://www.cdc.gov/mmwr/preview/mmwrhtml/rr5013a1.htm>

Galea, S., & Norris, F.H. (2006). Public mental health surveillance and monitoring. In F.H. Norris, S. Galea, M.J. Friedman, & P.J. Watson (Eds.), *Methods for disaster mental health research*, (pp. 177-193). New York: The Guilford Press.

#### *Introduction to Public Health Surveillance*

Northwest Center for Public Health Practice

<http://www.nwcphp.org/training/courses-exercises/courses/introduction-to-public-health-surveillance>

### VULNERABILITY MAPS

Morrow, B.H. (1999). Identifying and mapping community vulnerability. *Disasters*, 23, 1-18.

[http://sciencepolicy.colorado.edu/about\\_us/meet\\_us/roger\\_pielke/envs\\_5120/week\\_12/Morrow.pdf](http://sciencepolicy.colorado.edu/about_us/meet_us/roger_pielke/envs_5120/week_12/Morrow.pdf)

### NEEDS ASSESSMENT

#### *Assessing Community Needs and Resources*

The Community Tool Box

[http://ctb.ku.edu/en/tablecontents/chapter\\_1003.htm](http://ctb.ku.edu/en/tablecontents/chapter_1003.htm)

### SCREENING/CLINICAL EVALUATION TOOLS – POSTTRAUMATIC STRESS

Child PTSD Symptom Scale

[http://www.nctsnct.org/nccts/nav.do?pid=msr\\_detail&id=5](http://www.nctsnct.org/nccts/nav.do?pid=msr_detail&id=5)

Impact of Event Scale Revised

<http://mailer.fsu.edu/~cfigley/Tests/IES.doc>

National Child Traumatic Stress Network's Hurricane Assessment and Referral Tool for Children and Adolescents

[http://www.nctsn.org/nctsn\\_assets/pdfs/intervention\\_manuals/referraltool.pdf](http://www.nctsn.org/nctsn_assets/pdfs/intervention_manuals/referraltool.pdf)

Trauma Symptom Checklist for Children

<http://www3.parinc.com/products/product.aspx?Productid=TSCC>

UCLA PTSD Reaction Index for DSM IV

<http://kb.nctsn.org/SPT--FullRecord.php?ResourceId=295>

### **SCREENING/CLINICAL EVALUATION TOOLS - DEPRESSION**

Children's Depression Inventory

<http://www.pearsonassessments.com/depressioninvent.aspx>

### **SCREENING/CLINICAL EVALUATION TOOLS - ANXIETY**

Revised Children's Manifest Anxiety Scale

[http://portal.wpspublish.com/portal/page?\\_pageid=53,234661&\\_dad=portal&\\_schema=PORTAL](http://portal.wpspublish.com/portal/page?_pageid=53,234661&_dad=portal&_schema=PORTAL)

### **SCREENING/CLINICAL EVALUATION TOOLS - BEHAVIOR**

Child Behavior Checklist

<http://www.aseba.org/products/forms.html>

Revised Behavior Problem Checklist

<http://www3.parinc.com/products/product.aspx?Productid=RBPC>

### **SCREENING/CLINICAL EVALUATION TOOLS – GENERAL**

Additional information about screening/clinical evaluation tools for youth is available in:

American Academy of Child and Adolescent Psychiatry. (1998). Practice parameters for the assessment and treatment of children and adolescents with posttraumatic stress disorder.

*Journal of the American Academy of Child and Adolescent Psychiatry*, 37, 4S-26S.

American Academy of Child and Adolescent Psychiatry. (2007). Practice parameter for the assessment of the family. *Journal of the American Academy of Child and Adolescent Psychiatry*, 46, 922-937.

Balaban, V. (2006). *Psychological assessment of children in disasters and emergencies. Disasters*, 30, 178-198.

Shaw, J.A., Espinel, Z., & Shultz, J.M. (2007). *Children: Stress, trauma and disasters*. Tampa, FL: Disaster Life Support Publishing.

### **PROGRAM EVALUATION**

#### ***Basic Guide to Program Evaluation***

Free Management Library

[http://managementhelp.org/evaluatn/fnl\\_eval.htm](http://managementhelp.org/evaluatn/fnl_eval.htm)

#### ***Framework for Program Evaluation in Public Health***

Centers for Disease Control and Prevention (CDC)

<http://www.cdc.gov/mmwr/preview/mmwrhtml/rr4811a1.htm>

#### ***Research Methodology and Program Evaluation***

Disaster Research Training (DRT) for Children and Families – Northwest Center for Public Health Practice

<http://www.nwcphp.org/training/courses-exercises/courses/drt>

#### ***Workbook for Designing a Process Evaluation***

Georgia Department of Human Resources, Division of Public Health

<http://health.state.ga.us/pdfs/ppe/Workbook%20for%20Designing%20a%20Process%20Evaluation.pdf>

### **SOURCES OF DATA ON MENTAL HEALTH AND YOUTH**

Kids Count

The Annie E. Casey Foundation

<http://www.aecf.org/kidscount/>

Mental Health Statistics

Substance Abuse and Mental Health Services Administration (SAMHSA)

<http://www.mentalhealth.samhsa.gov/cmhs/MentalHealthStatistics/>

Mental Health Work Group

Centers for Disease Control and Prevention

<http://www.cdc.gov/mentalhealth/data.htm>

Wonder

Centers for Disease Control and Prevention (CDC)

<http://wonder.cdc.gov/>

Youth Risk Behavior Surveillance System  
Centers for Disease Control and Prevention  
<http://www.cdc.gov/HealthyYouth/yrbs/index.htm>

## Section 2 – Youth and Family Disaster Mental Health Services

Youth and family disaster mental health services range in level of selectivity (which youth and families should receive which interventions) and intensity (how much time, effort, and expertise are needed to implement the interventions) (Vernberg, 2002).

The range of youth and family disaster mental health services should match the spectrum of individual responses to disasters from mild temporary distress to persistent, severe mental health disorders, as in Posttraumatic Stress Disorder (PTSD) or depression. One of the goals of the data collection procedures described in the previous section is to collect data that allow youth and families to be matched to an appropriate level of services. In other words, a youth who lives in a community where a disaster occurs and experiences mild distress in the immediate aftermath of the event should not need intensive mental health counseling. This youth may instead benefit from public health measures such as receiving information about typical disaster reactions or receiving materials detailing post-disaster coping strategies. Conversely, a youth who experiences emotional numbing, intrusive thoughts, and depression that persist for several weeks after the event may need a clinical evaluation to determine if more intensive disaster mental health counseling would be indicated.

Disaster mental health interventions that are appropriate for everyone in the community are referred to as *universal* interventions. More intensive, clinically-oriented interventions range from *selected* interventions, which are for youth and families who experience disaster distress but have little to no additional risk factors, to *indicated* interventions, which are typically longer-lasting interventions intended for youth and families who experience disaster distress and possess additional mental health risk factors such as a history of mental health disorders or high-levels of life adversity (Vernberg, 2002).

An overview of the levels of disaster mental health interventions and disaster phases is provided in Table 2 followed by descriptions of the levels of disaster mental health interventions.

Table 2. Disaster Mental Health Intervention and Disaster Phases

|                         | Preparedness<br>(Pre-event)   | Response<br>(Event)   | Recovery<br>(Post-event)   |
|-------------------------|---|---|--|
| Universal Interventions | Public information and education about disaster preparedness, resilience, and coping skills | Public information and education about the disaster, disaster response, and coping skills | Public information and education about typical reactions to disasters, coping skills, and disaster resources and services available in the community |
| Selected Interventions  | Interventions focused on increasing disaster preparedness, resilience, and coping skills    | Psychological First Aid (PFA)   | Brief Cognitive Behavioral Techniques focused on understanding reactions to events and improving coping skills                                       |
| Indicated Interventions | Interventions focused on increasing disaster preparedness, resilience, and coping skills    | Psychological First Aid (PFA)   | Cognitive Behavioral Therapy, individual counseling, family therapy, group therapy, medication   |

## Universal Interventions

Universal interventions are intended for everyone in a community. Post-event universal interventions typically include public information and education efforts (for instance, providing the community with information about typical reactions to disasters, tips for coping with those reactions and details about disaster services in the local area). Public information can be disseminated through multiple mediums and includes efforts such as distributing handouts in schools and at community centers, posting information on websites, broadcasting public service announcements on television or radio, and establishing telephone hotlines to provide community members with information and referrals.

Public information and education efforts also can be implemented/initiated prior to an event. For example, information on how to increase personal or family preparedness provided before an event can be beneficial in reducing distress during and after a disaster. Pre-event universal interventions also may include efforts to increase personal, family, or community resilience.

These interventions can be used with all members of a community and may strengthen the ability of youth, families, and communities to “bounce back” after a disaster. It may be particularly useful to implement pre-event disaster preparedness programs in schools. Providing such universal pre-event information can empower youth to take steps to prepare for a disaster, and students may also share the disaster preparedness information they receive at school with their parents and siblings, thus increasing the reach and perhaps the influence of such information.

## Selected Interventions

Selected interventions are more intensive and clinically-focused than universal interventions, but they are not traditional clinical treatment as they are intended for youth and families who experience disaster distress but have little to no additional risk factors. Selected interventions will generally be delivered by mental health providers, though some of these interventions (such as Psychological First Aid, see below) can be delivered by other groups that work with youth and families (such as teachers or disaster volunteers). These interventions can be delivered in a variety of settings including schools and community mental health centers.

### Psychological First Aid (PFA)

While various models of Psychological First Aid (PFA) exist (for example, American Red Cross, 2006; International Federation of Red Cross and Red Crescent Societies, 2009; National Child Traumatic Stress Network and National Center for PTSD, 2006; Schreiber, Gurwitsch, & Wong, 2006), PFA generally refers to an acute disaster mental health intervention or a “systematic set of helping actions” that is intended to provide a sense of safety and security for youth and families, reduce the distress related to trauma and improve functioning, and connect youth and families to available services (Everly & Flynn, 2006; Ruzek et al., 2007; Young, 2006; Vernberg et al., 2008). Early post-disaster interventions like PFA should focus on making sure the basic needs of youth and families such as safety, security, food, and shelter are met (National Institute of Mental Health, 2002) and providing psychoeducation and general ideas for effective coping after disasters.

The National Child Traumatic Stress Network and National Center for PTSD (2006) have developed a model of PFA that includes eight core actions that disaster responders can follow to help youth and families in the immediate aftermath of a disaster. These core actions include:

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**Contact and  
engagement**

**Respond to contact initiated by youth and families  
following a disaster or initiate contact in a non-intrusive,  
compassionate, and helpful manner**

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|  |  |
|--|--|
| <b>Safety and comfort</b>                                | <b>Enhance immediate and ongoing safety; provide physical and emotional comfort for youth and families</b>   |
| <b>Stabilization</b>                                     | <b>Calm and orient emotionally overwhelmed or disoriented youth and families</b>   |
| <b>Information gathering: current needs and concerns</b> | <b>Identify immediate needs and concerns, gather additional information, and tailor PFA interventions to the needs and concerns of youth and families</b>                    |
| <b>Practical assistance</b>                              | <b>Offer practical help to youth and families when addressing immediate needs and concerns</b>   |
| <b>Connection with social supports</b>                   | <b>Help establish brief or ongoing contacts with primary support persons or other sources of support, including family members, friends, and community helping resources</b> |
| <b>Information on coping</b>                             | <b>Provide youth and families with information about stress reactions and coping to reduce distress and promote adaptive functioning</b>                                     |
| <b>Linkage with collaborative services</b>               | <b>Link youth and families with available services needed at the time or in the future</b>   |

PFA adaptations have been developed for use by specific organizations such as Medical Reserve Corps and in various settings, such as in schools. Another PFA model—*Listen, Protect, Connect (LPC)*—is a series with several versions developed for different audiences (parents, teachers, and disaster workers) who would likely have the opportunity to help address the emotional needs of youth after a disaster. See the list of Resources at the end of this section for more information on locating PFA materials.

### **Brief Cognitive Behavioral Techniques**

Cognitive Behavioral Therapy (CBT) is most often utilized as a more intensive *indicated* disaster mental health intervention as described below. CBT or portions of a CBT approach also may be used in individual or group settings as a *selected* intervention. A *selected* Brief Cognitive Behavioral Technique approach might focus on providing youth and families with psychoeducation about normal or typical reactions to disasters and suggesting appropriate post-disaster coping skills or strategies for improving parenting skills. For example, the Resilience and Coping Intervention (RCI; see the Resource section for more information) brings youth together in group settings such as school classrooms or in after-school programs to discuss the challenges they faced as a result of a disaster and also share successful coping strategies with their peers. Such an intervention is *selected* in that it can be used with youth

who experienced a disaster resulting in mild distress, though this intervention would not be sufficient for youth who experience persistent, severe distress related to a disaster. These more severe reactions would require an *indicated* intervention.

## Indicated Interventions

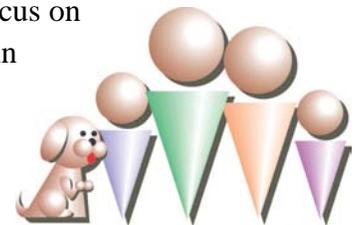
Indicated interventions are the most intensive clinical interventions and include traditional mental health interventions or traditional forms of treatment. These interventions are intended for youth and families who exhibit significant disaster distress or psychiatric conditions and/or possess additional risk factors. Indicated interventions are delivered by mental health professionals.

### Cognitive Behavioral Therapy (CBT)

Cognitive Behavioral Therapy (CBT) is a popular indicated therapeutic approach that can be used with youth and families who experience significant distress following a disaster. For example, Trauma Focused Cognitive Behavioral Therapy (TF-CBT) is recognized by the Substance Abuse and Mental Health Services Administration (SAMHSA) as an evidence-based post-disaster practice. TF-CBT is a multi-session structured therapy approach that includes components addressing parental treatment, psychoeducation, relaxation and stress management, affective expression and modulation, coping, and trauma narrative and experience processing (Cohen et al., 2009). Real Life Heroes (RLF) is another SAMHSA evidence-based post-disaster CBT practice that can be used to help school-aged youth with posttraumatic stress following a disaster (Kagan et al., 2008). CBT has also been adapted for use in schools (see Resource section for information on Cognitive Behavioral Intervention for Trauma in Schools – CBITS; Jaycox, 2003).

### Family Interventions

Disasters can cause stress and adversity for both youth and adults, which in turn can affect the entire family. Therefore post-disaster interventions should include a focus on the family when possible. This means that parents should be included in the assessment of youth, that family issues should be addressed in interventions with youth, and that the entire family should participate in treatment (Baggerly & Exum, 2008; Wells, 2006).



### Other Interventions

Other *indicated* interventions include individual therapy, group therapy, and medication. Traditional mental health counseling, either in individual or group formats, or medication may be necessary for youth and families experiencing severe distress or disorder following a disaster. The specific determination of what indicated services a youth or family needs will typically be made by a mental health provider using the clinical evaluation process described

earlier, but disaster planners will need to be involved in helping make sure that the appropriate indicated services are available in the community. Therefore, disaster planners should work with local, state, and federal mental health authorities, local and state mental health associations, and community mental health programs and professionals to determine what type of *indicated* interventions can be provided to youth and families experiencing significant distress following a disaster and to establish how and where those services will be delivered.

## Disaster System of Care

Youth and family disaster mental health services and related resources will be delivered through the Disaster System of Care. A System of Care is a coordinated collection of community-based institutions, organizations, and groups that assist people in need (<http://systemsofcare.samhsa.gov>). A Disaster System of Care consists of the institutions, organizations, and groups and individuals *that help people recover from a disaster*.

A Disaster System of Care may include disaster relief organizations, health care providers (such as hospitals, doctor's offices), social service organizations, community mental health centers, schools, faith-based institutions, youth centers, and other community programs. Ideally, the organizations in a Disaster System of Care will work together to provide a spectrum of assistance and support for people affected by a disaster. Some organizations within the Disaster System of Care will provide mental health services, while others may provide other types of resources such as information or basic assistance like food, shelter, clothes, and financial support.

### Crisis Counseling Assistance and Training Program

A key source of programmatic funding for youth and family disaster mental health services following a presidentially-declared disaster is the Crisis Counseling Assistance and Training Program (CCP), which is jointly administered by the U.S. Department of Homeland Security, Federal Emergency Management Agency (FEMA), and U.S. Department of Health and Human Service, Substance Abuse and Mental Health Administration Services (SAMHSA). CCP is intended to help individuals and communities recover from a disaster through community-based outreach and psycho educational services (<http://mentalhealth.samhsa.gov/cmhs/emergencyservices/progguide.asp>).

Following a presidentially-declared disaster, states, U.S. territories, or federally recognized tribes may apply for CCP grants that support mental health services for 60 days and/or 9 months. When awarded, CCP funding typically is provided to the state mental health authority, which in turn contracts with local mental health agencies and professionals to deliver services. CCP grants can be used to fund individual or group crisis counseling,

individual supportive or educative contact, public education, and assessment, referral, and resource linkage.

### School-based Disaster Mental Health Services

With regard to youth and family disaster mental health issues, schools are often an important source of disaster support and services. Schools provide a setting where youth can be reached and schools employ professional staff who can address youth's needs. School-based disaster mental health services can range from preparedness activities offered to all students prior to an event, to classroom-based programs on coping, to individual counseling with school mental health counselors following an event. Screening may identify youth with similar disaster experiences or risk factors who can be brought together for group counseling, which may be offered to students who are in the same classroom. Information for parents about the possible effects of disasters on youth can also be distributed through schools, and school-based counseling for students can include parents when possible. See the RAND Corporation's school tool kit in the Resources section for an overview of school-based disaster mental health service programs.

## Resources

More information on youth and family disaster mental health services is available from the following sources.

### YOUTH AND FAMILY RESILIENCE

Disaster Resilience Enhancement Training (DRET)  
Terrorism and Disaster Center at the University of Oklahoma  
<http://www.oumedicine.com/body.cfm?id=3746&oTopID=3739>

Penn Resilience Training For College Students  
Positive Psychology Center, University of Pennsylvania  
[http://www.nrepp.samhsa.gov/programfulldetails.asp?PROGRAM\\_ID=105](http://www.nrepp.samhsa.gov/programfulldetails.asp?PROGRAM_ID=105)

Project ACHIEVE  
<http://www.projectachieve.info>

Resilience and Coping Intervention (RCI)  
Terrorism and Disaster Center at the University of Oklahoma  
<http://www.oumedicine.com/body.cfm?id=3748&oTopID=3739>

Resilience Guide for Parents and Teachers

American Psychological Association

<http://www.apahelpcenter.org/featuredtopics/feature.php?id=39&ch=1>

Strengthening Families Program

<http://www.strengtheningfamiliesprogram.org>

### **COMMUNITY RESILIENCE**

Building Community Resilience for Children and Families

[http://www.oumedicine.com/Workfiles/College%20of%20Medicine/AD-Psychiatry/CR\\_Guidebook.pdf](http://www.oumedicine.com/Workfiles/College%20of%20Medicine/AD-Psychiatry/CR_Guidebook.pdf)

Building Resilience in Rural Communities: Toolkit

University of Queensland and University of Southern Queensland

[http://learningforsustainability.net/pubs/Building\\_Resilience\\_in\\_Rural\\_Communities\\_Toolkit.pdf](http://learningforsustainability.net/pubs/Building_Resilience_in_Rural_Communities_Toolkit.pdf)

Community and Regional Resilience Institute (CARRI)

<http://www.resilientus.org/>

Community Assessment of Resilience Tool (CART)

Terrorism and Disaster Center at the University of Oklahoma

<http://www.oumedicine.com/body.cfm?id=3747&oTopID=3739>

Community Resilience Manual: A Resource for Rural Recovery and Renewal

Centre for Community Enterprise

<http://www.cedworks.com/communityresilience01.html>

### **PSYCHOLOGICAL FIRST AID (PFA)**

Community-based Psychosocial Support

International Federation of Red Cross and Red Crescent Societies

<http://psp.drk.dk/sw40688.asp>

Listen, Protect, Connect – Model & Teach: Psychological First Aid (PFA) for Students and Teachers

[www.ready.gov/kids/\\_downloads/PFA\\_SchoolCrisis.pdf](http://www.ready.gov/kids/_downloads/PFA_SchoolCrisis.pdf)

Listen, Protect, Connect: Psychological First Aid for Children and Parents

[http://www.ready.gov/kids/\\_downloads/PFA\\_Parents.pdf](http://www.ready.gov/kids/_downloads/PFA_Parents.pdf)

Listen, Protect, Connect: Family to Family, Neighbor to Neighbor  
[http://www.ready.gov/kids/\\_downloads/LPC\\_N2N\\_508.pdf](http://www.ready.gov/kids/_downloads/LPC_N2N_508.pdf)

Psychological First Aid (PFA): Helping Others in Times of Stress  
<http://www.redcross.org>

Psychological First Aid (PFA): Field Operations Guide, 2<sup>nd</sup> Edition  
National Child Traumatic Stress Network, National Center for PTSD  
[http://nctsn.org/nccts/nav.do?pid=typ\\_terr\\_resources\\_pfa](http://nctsn.org/nccts/nav.do?pid=typ_terr_resources_pfa)

Psychological First Aid (PFA): Field Operations Guide – Medical Reserve Corps Adaptation  
[www.medicalreservecorps.gov/File/MRC\\_Resources/MRC\\_PFA.doc](http://www.medicalreservecorps.gov/File/MRC_Resources/MRC_PFA.doc)

### **COGNITIVE BEHAVIORAL THERAPY (CBT)**

Cognitive Behavioral Intervention for Trauma in Schools (CBITS)  
[http://www.tsaforschools.org/index.php?option=com\\_content&task=view&id=81&Itemid=69](http://www.tsaforschools.org/index.php?option=com_content&task=view&id=81&Itemid=69)

Real Life Heroes (RLH)  
[http://www.nrepp.samhsa.gov/programfulldetails.asp?PROGRAM\\_ID=226](http://www.nrepp.samhsa.gov/programfulldetails.asp?PROGRAM_ID=226)

Trauma-Focused Cognitive Behavioral Therapy (TF-CBT)  
[http://www.nrepp.samhsa.gov/programfulldetails.asp?PROGRAM\\_ID=217](http://www.nrepp.samhsa.gov/programfulldetails.asp?PROGRAM_ID=217)

Trauma-Focused Cognitive-Behavioral Therapy (TF-CBT): Web-based learning course  
<http://tfcbt.musc.edu/>

### **FAMILY INTERVENTION**

Baggerly, J., & Exum, H.A. (2008). Counseling children after natural disasters: Guidance for family therapists. *The American Journal of Family Therapy*, 36, 79-98.

Wells, M.E. (2006). Psychotherapy for families in the aftermath of a disaster. *Journal of Clinical Psychology: In Session*, 62, 1017-1027.

### **DISASTER MENTAL HEALTH INTERVENTIONS**

National Registry of Evidence-based Programs and Practices, Substance Abuse and Mental Health Services Administration  
<http://www.nrepp.samhsa.gov/>

Ritchie, E.C., Watson, P.J., & Friedman, M.J. (Eds). (2006). *Interventions following mass violence and disasters*. New York: Guilford Press.

### **SYSTEMS OF CARE**

Systems of Care

Substance Abuse and Mental Health Services Administration (SAMHSA)

<http://systemsofcare.samhsa.gov>

### **THE CRISIS COUNSELING ASSISTANCE AND TRAINING PROGRAM (CCP)**

Crisis Counseling Program Guidance and Information

<http://mentalhealth.samhsa.gov/cmhs/emergencyservices/progguide.asp>

### **SCHOOL DISASTER MENTAL HEALTH SERVICES**

Jaycox, L.H., Morse, L.K., Tanielian, T., & Stein, B.D. (2006). *How schools can help students recover from traumatic experiences: A tool kit for supporting long-term recovery.*

Santa Monica, CA: RAND Corporation.

[http://www.rand.org/pubs/technical\\_reports/2006/RAND\\_TR413.pdf](http://www.rand.org/pubs/technical_reports/2006/RAND_TR413.pdf)

## Section 3 – Youth and Family Disaster Mental Health Training for Disaster Planners and Responders

Disaster planners and responders who serve youth and families through disaster planning and response will benefit from disaster mental health training. Appropriate training includes in-depth and experiential coverage of the core topics discussed in this document: youth and family disaster mental health reactions, the use of data to inform youth and family disaster mental health service delivery, youth and family disaster mental health services, and integration of youth and family mental health issues into disaster preparedness and response activities.

Training on these subjects is often available from state and local mental health authorities, state and local mental health associations, and the American Red Cross (check your local Red Cross chapter for training opportunities). Training also may be available from federal partners like the Substance Abuse and Mental Health Services Administration Disaster Technical Assistance Center (DTAC; <http://mentalhealth.samhsa.gov/dtac/>) and national entities such as the National Child Traumatic Stress Network (NCTSN; <http://www.nctsn.org>). Additionally, the Terrorism and Disaster Center (TDC) at the University of Oklahoma Health Sciences Center’s Child and Family Disaster Research Training and Education (DRT) program incorporates all of these topics in a single, multi-modular training curriculum (<http://www.oumedicine.com/body.cfm?id=3764>). The Northwest Center for Public Health Practice, a participant in the DRT program, has made several DRT modules available online (<http://www.nwcphp.org/training/courses-exercises/courses/drt/?searchterm=Disaster%20Research%20Training>).

Disaster planners and responders also will benefit from training on Psychological First Aid (PFA), which provides basic actions that can help mental health and non-mental health providers and volunteers decrease the distress experienced by youth and families following disasters and may also help improve youth and family functioning. Contact the National Child Traumatic Stress Network (NCTSN; <http://www.nctsn.org>) or the American Red Cross (<http://redcross.org>) for information on PFA training. Online PFA training is available from the NCTSN (<http://learn.nctsn.org>). Additionally, the Center for Disaster and Extreme Event Preparedness (DEEP Center) at the University of Miami has training on “Safety, Function, Action,” which is a framework for achieving and maintaining health and well-being for disaster responders and those they seek to help (<http://www.deep.med.miami.edu/x156.xml>).

Finally, disaster planners should be trained in crisis and emergency risk communication. This training will help planners execute successful public information and



education campaigns and will improve/increase effective and clear communications throughout the disaster response. The Centers for Disease Control and Prevention (CDC) offers a publication on crisis and emergency risk communication as well as online and in-person training opportunities (<http://www.bt.cdc.gov/cerc/>).

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